West Essex Health and Care Partnership

West Essex Provider Forum

Integrated Neighbourhood Teams (INT) Proactive Care Model

Wednesday 22 October 2025

Sara Chaudhry and Anna Flanagan

Working together
for a healthier future

Integrated Neighbourhood Teams - Vision and Success Criteria

Integrated Neighbourhood Teams Vision Statement:

"Working together as an Integrated Neighbourhood Team to improve people's outcomes and experience by meeting the health and social care needs of the local population"

01.

Person Centred Care

Each Integrated Neighbourhood Team will ensure individuals have person centered care plans coordinated by a named lead professional

02.

Pro-active

Each Integrated Neighbourhood Team will respond to information shared to pro-actively identify the needs of individuals and the local population

03.

Performance

Each Integrated Neighbourhood Team will enable collaborative, flexible working with simple care pathways that prevent duplication and develop trust across the team

04.

Workforce

Each Integrated Neighbourhood Team will bring together a skilled workforce of professionals across health and social care, supported by a single leadership team, to promote multi-disciplinary problem solving and utilise all available community assets

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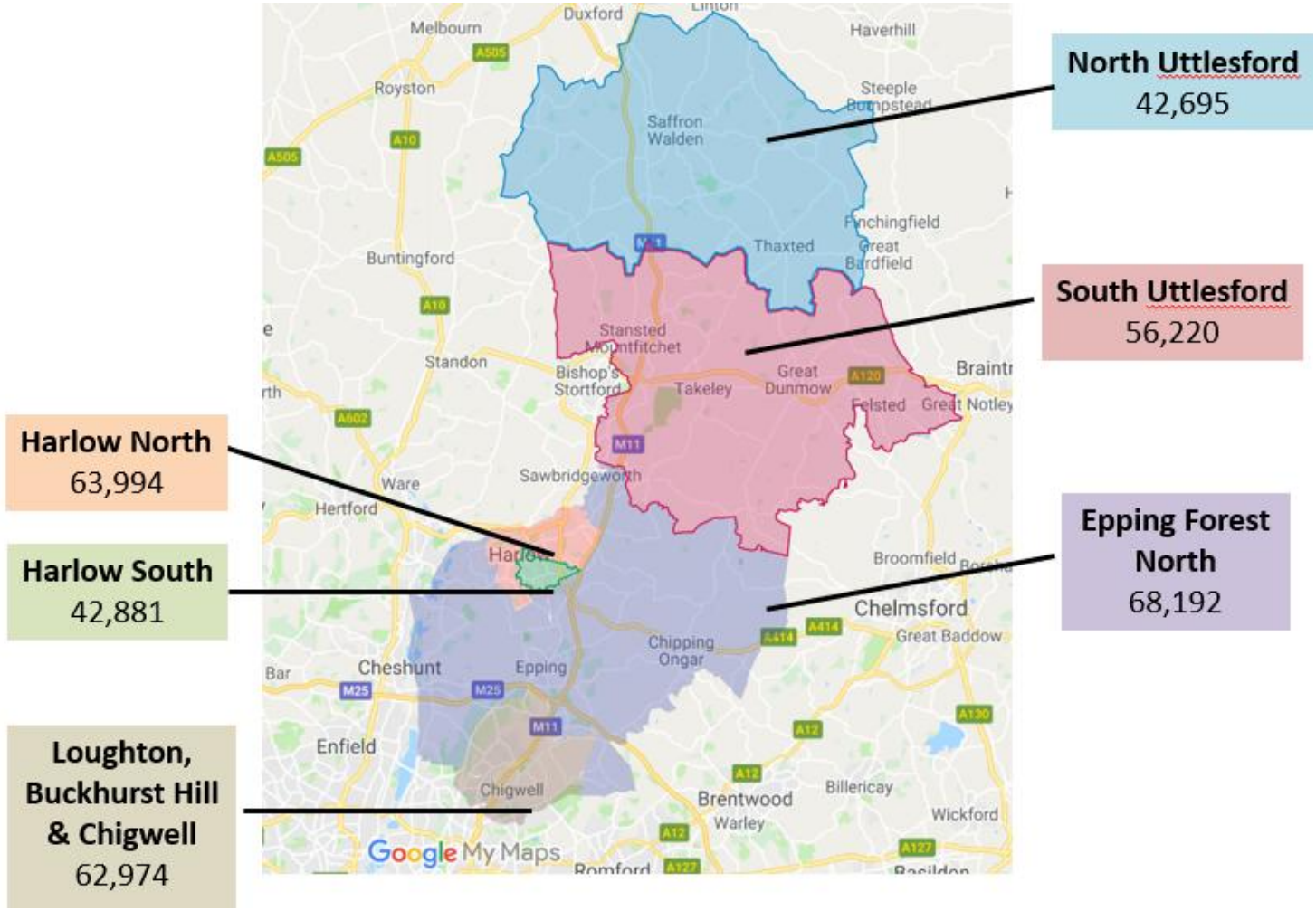
West Essex INTs (correct June 2025)



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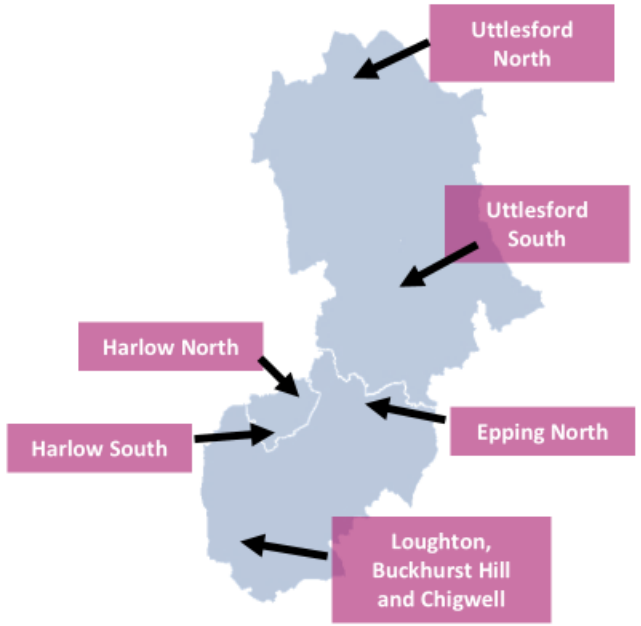
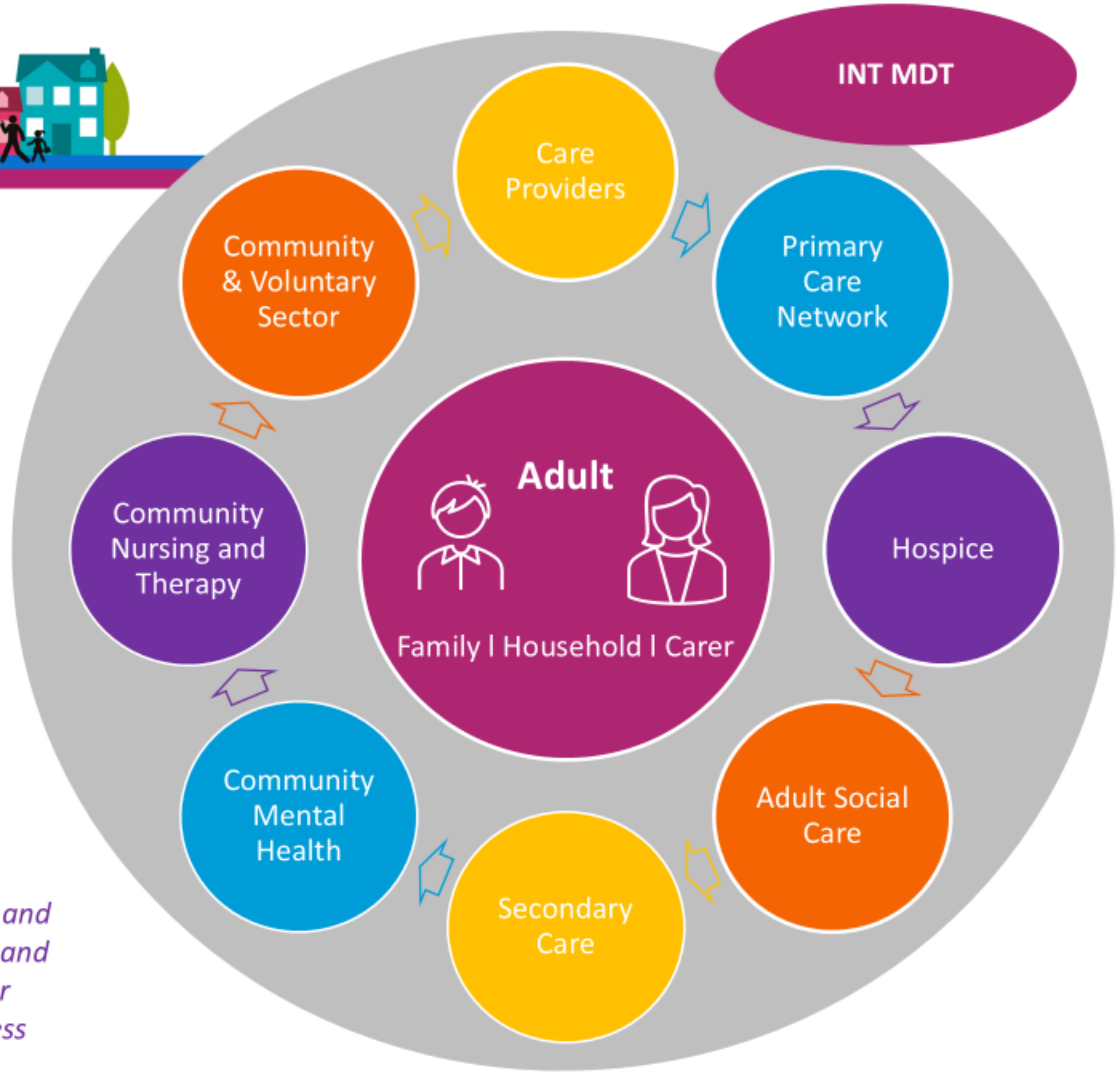
Delivering Care Closer to Home - Integrated Neighbourhood Teams (INTs)



INT Leadership Team x 6

Clinical Locality Lead
PCN Clinical Directors
EPUT Heads of Service (Nursing, Therapy and Mental Health)
St Clare Hospice Lead
Adult Social Care Team Manager
CVS Lead
ICB Lead
District Council Communities Leads



"Since the INTs have been re-established the working relationships with GP Practices, Social Prescribers and our EPUT colleagues has never been better. Communication has proven key to this working partnership and has a direct positive impact on the adults we support. By meeting weekly formally and working together informally between meetings we are ensuring reduced duplication of work, a streamlined referral process and a clear and cohesive MDT approach when working with adults and families."

ASC Team Manager, West Essex

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West Essex INTs Journey so far

21/22

- Creation of PACTS (Primary care aligned core teams)
- Alignment of organisations/ services to PCNs in West Essex

22/23

- Rebranding to Integrated Neighbourhood Teams (INT)
- Organisational Development Programme
- INT Leadership Teams formed

23/24

- Co-designed West Essex Blueprint for INT Proactive Care
- Worked with Population Health Management Team to test searches and risk stratification
- Implementation of Proactive Care Blueprint and rollout of Proactive Care

24/25

- INT Plans commenced to reduce NEL admissions by 25%
- Proactive Care moving to business as usual

25/26

- Implementation Guide for Proactive Care embedded
- New combined searches run in all INTs
- Targeted projects within each INT initiated to enhance proactive care

Pro-active care planning , care delivery and management of complex patients

Aim

To work as an Integrated Neighbourhood Team to support our complex patients, through pro-active care planning and delivery, enabling earlier intervention and prevention, and reduction in escalation of need, improving outcomes for our population.

Approach

1. To design, test and implement our Integrated Neighbourhood Team model for Pro-active care planning, care delivery and management of complex patients.
2. Taking a Population Health Management approach to cohort identification including risk stratification
3. Working as a multi-disciplinary team (MDT) supported by an INT Coordinator
4. Assigned named lead professionals
5. Caseload of between 30-50 patients.

Principles

1.We learn to understand and customise care for Adults based on **conversations.**
2.We do not provide a current service to someone; we **build services around needs** not prescribe solutions
3. Named Lead Professionals will be assigned based on **what matters most to the adult.**
4.We understand and respond to the Adults with **what they need, when they need it.**
5. Adults won't be discharged from the caseload. We **stay with the Adult** and their network, each interaction is not a new one, it is a **continuation**.

Expected Short Term Outcomes

Improved experience for the adult and their household/carer
Improved experience for workforce

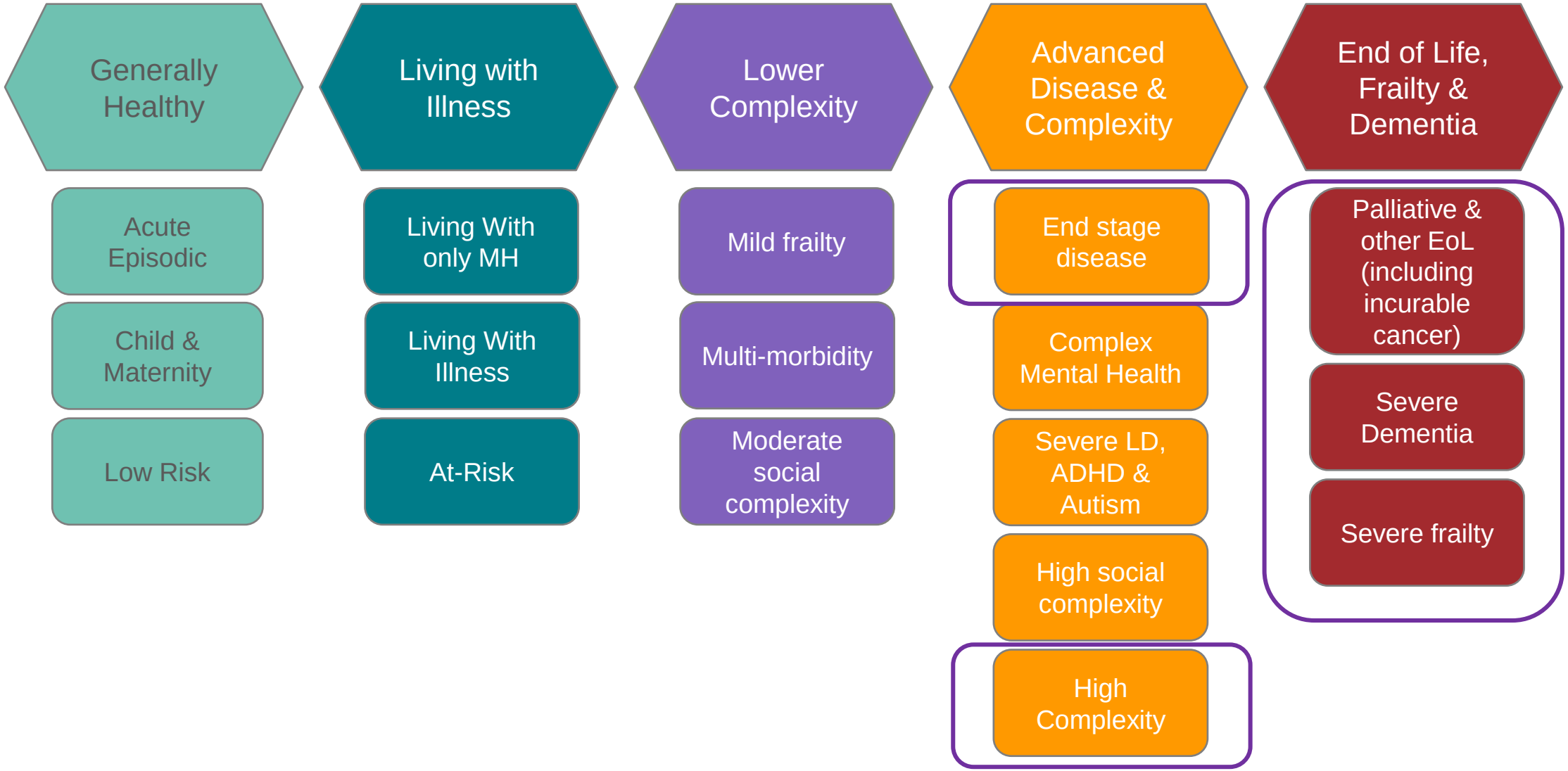
Expected Medium Term Outcomes

Reduction in escalation of need, avoiding unnecessary hospital admissions for cohort
Proportion of people with a long term condition who feel able to manage their condition
Improved quality of life

Expected Long Term Outcomes

Increased Healthy Life Expectancy
Increased Life Expectancy
Reduction in unplanned care

Delivering Proactive Care Through INTs: Identifying the Cohort



Integrated Neighbourhood Teams - Proactive Care Blueprint

Identify the Cohort

Identify cohort using Population Health Segmentation Model.

Apply risk stratification to prioritise cohort based on the needs of your neighbourhood (PCN Data Pack).

EMIS/S1 Reports written, supported by ICB PHM Team and run in PCN patient record systems.

Support developing an effective intervention for the cohort using logic models

Add to the Caseload

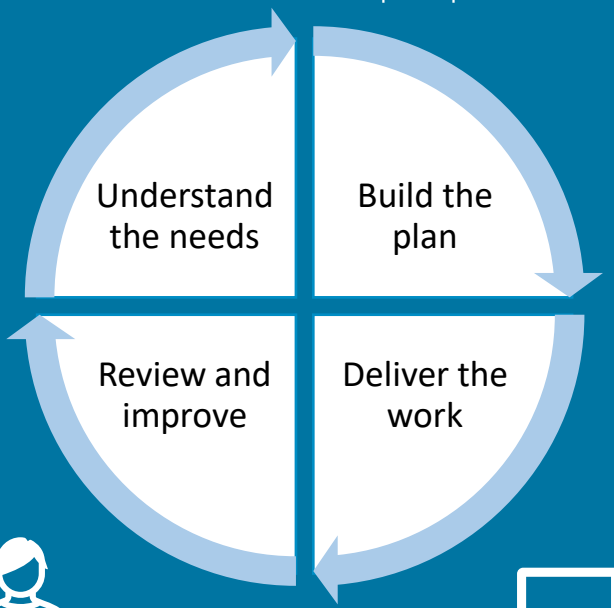
Review prioritised cohort with INT.

Agree who and how to make first contact with the adult.

INT Care Coordinator adds adult to the Caseload – SNOMED Code “On Integrated Care Pathway” 818241000000105.

Delivering Proactive Care

Named Lead Professional



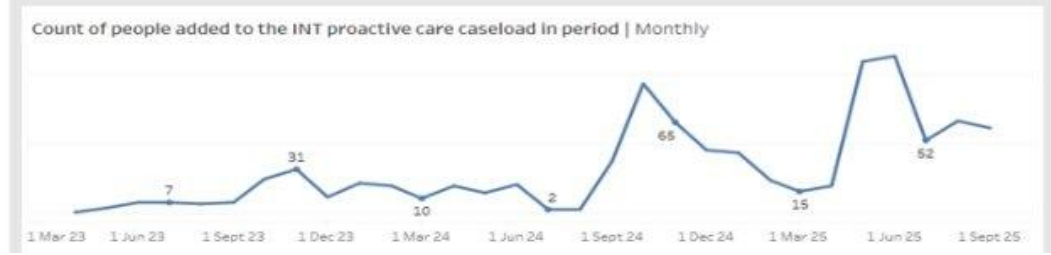
INT Coordinator

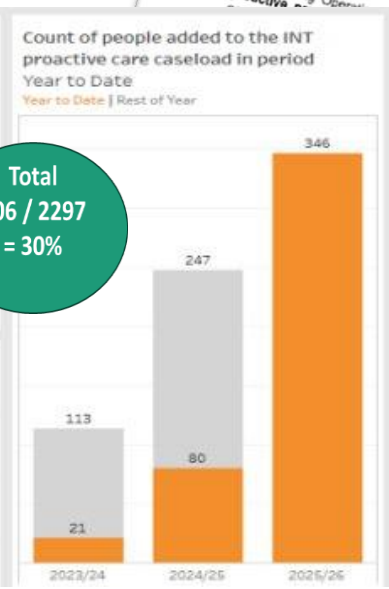
Shared Care Record

Continuous improvement cycle

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

Delivering Proactive Care Through INTs: Tools





Total
706 / 2297
= 30%

Hertfordshire and West Essex Integrated Care System

Current Number of patients identified for INT proactive care

Please note: Patient numbers on the INT proactive care cohorts fluctuate as patients dynamically step up or down from the caseload

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Jean’s story

Jean is 95, lives alone in a house and uses a walking frame. While on holiday in December 2024 Jean sustained a fractured neck of femur, has atrial fibrillation and chronic kidney disease. She was identified as eligible for the proactive care caseload from the population health management searches as she frail, at risk of falls, has advanced disease and complexity.

Jean was added to the INT proactive care caseload, and a holistic assessment was undertaken by the Community Matron. An identification code was added to Jeans medical records so that system partners were aware she was part of the proactive care cohort.

Jean was identified as suitable for a home visit from her Named Lead Professional, which in this case was the Community Matron. The matron examined her legs and found pitted oedema at the top of her thighs. The Community Matron brought Jean's case to the INT Proactive Care MDT meeting to discuss with other professions. The doctor requested an X-Ray, blood tests and an Echo Cardiogram.

Outcomes:

- Jean was diagnosed with mild heart failure
- She was referred to heart failure nurse
- Jean will remain on the proactive care caseload to ensure regular monitoring and prevention of avoidable hosptial admission and avoidable ambulance conveyance