Integrated Neighbourhood Teams

March 2025

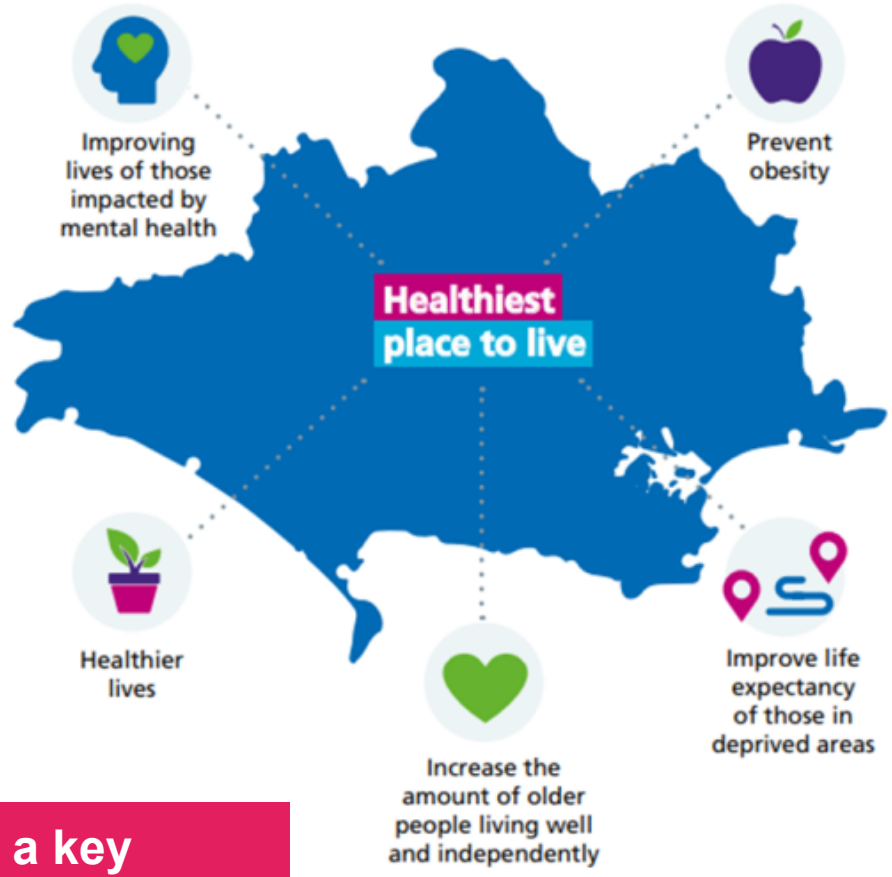
Improving health and wellbeing in Dorset

Our Dorset vision is to work together to deliver the best possible improvement in health and wellbeing.

Our priorities are:

- Prevention and early help
- Thriving communities
- Working better together

Our Joint Forward Plan sets out priority outcomes.



The development of Integrated Neighbourhood Teams is a key component, although not the entirety of the work to realise this ambition.

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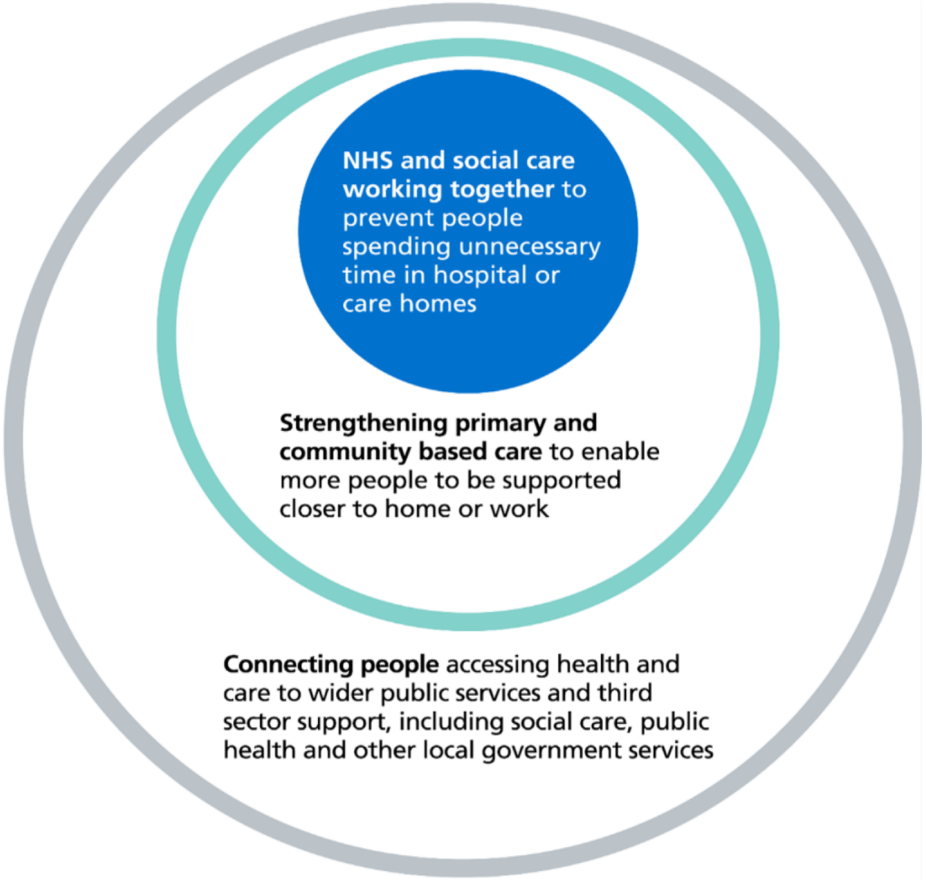
Vision for all neighbourhoods (NHSE Neighbourhood Health Guideline 2025/26)



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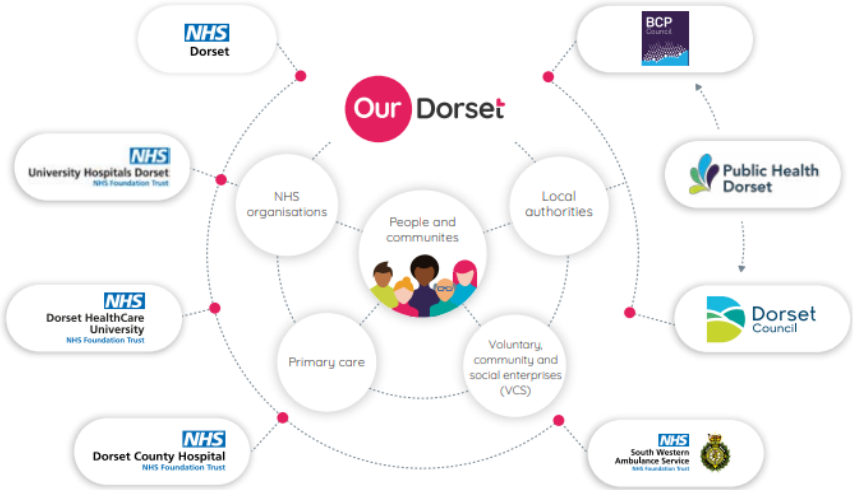
How will Integrated Neighbourhood Teams (INTs) help?

Integrated multidisciplinary teams with a shared ambition to improve health and wellbeing for the population they serve, supporting:

- Better holistic care
- Improved outcomes
- Improved efficiency
- Enable better preventative and early intervention services
- Prevent hospital admissions
- Community engagement
- Reduce care costs



Why will INTs be better for local people?

MORE

- Joined-up focus on prevention to help you stay well for longer in your community.
- Information and support so that you can stay well, take better control of your own health to reduce the risk of developing ill health.
- Access to streamlined support so when you become ill or have an urgent need, you can see the right person the first-time round.
- Proactive, personalised support from a multidisciplinary team for your chronic or complex health and care needs.
- Services co-designed with local communities.

LESS

- Need to travel to a hospital for care, as more care and support will be provided in the community.
- Health complications and poor outcomes for adults and children with complex needs because of the support available locally from a mixed team of health and care professionals.
- Need for you to repeat your story to different staff because the team works closely together and have access to shared health and care information.

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Over the next 2 years we are asking INTs to focus on:

Build the teams

1. Bring teams together, so that teams know each other and what they do

2. Streamline systems and processes to release capacity to support increased proactive care

Integrate care

3. Integrate care around individuals with complex health and social needs (adults and children)

4. Work with partners to streamline care pathways and improved access to more specialist services

Targeted population cohorts

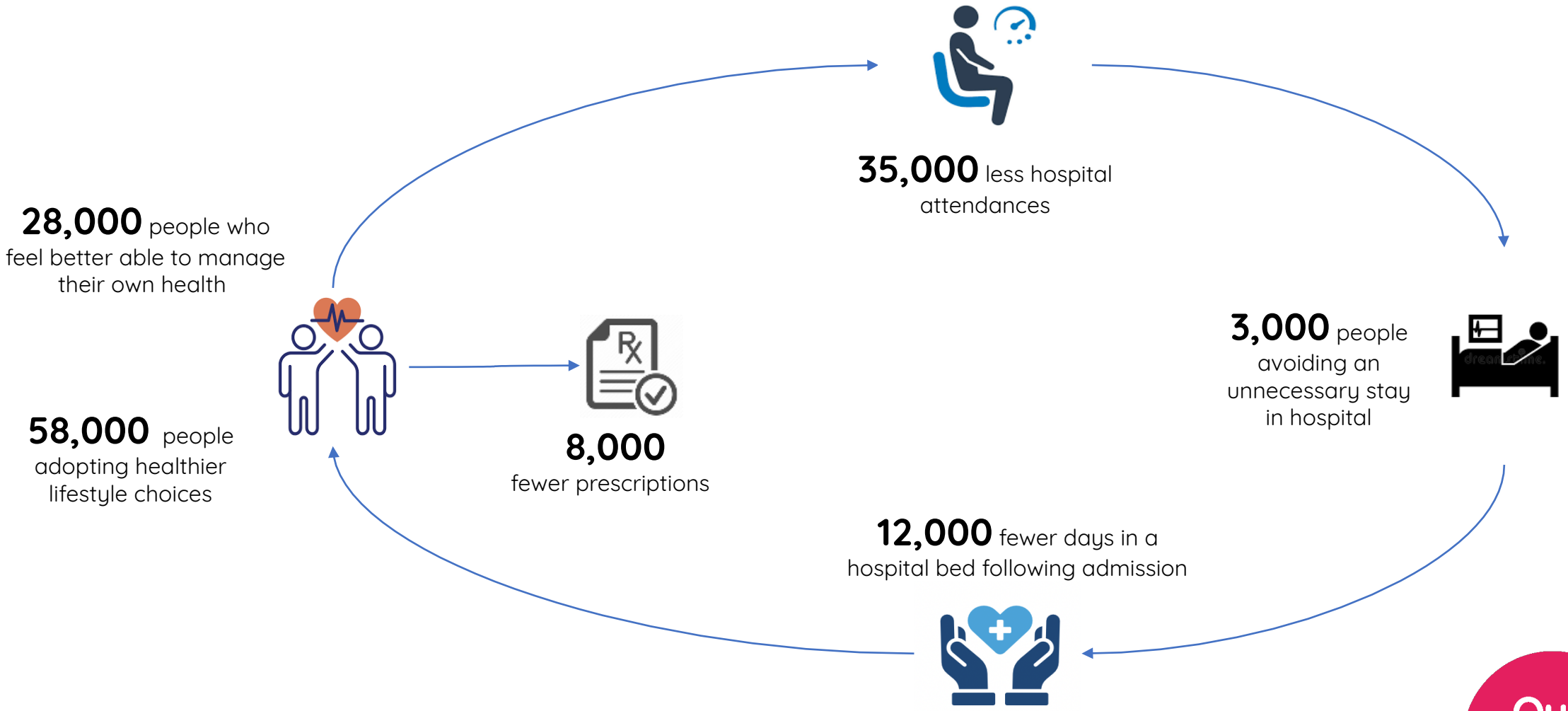
5. Use data to identify 'rising risk' population cohorts and engage with partners and communities to redesign the local care and support offer

6. Support the delivery of agreed system primary and secondary prevention priorities

Improve population health

Focus on the person → **Focus on the population**

Expected impact



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Connecting Teams

Weymouth and Portland lunch and learn sessions

- 35 services/ organisations have already shared information, leading to significant increase in the before and after scores where teams were asked if they felt they understood other's services.
- Sessions also include talks on current good practice from senior subject matter experts in the system.

Purbeck

- Services within the INT have created posters to share with team members
- Planning is underway to produce a series of short video clips highlighting what services are available across the Purbeck INT footprint and how they can be accessed.

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Bringing teams together to make a difference to the local population

Weymouth and Portland

- Joint frailty triage meetings are now in place bringing together the Community Rehabilitation, PCN Frailty, Adult Social Care and Virtual Care teams.
- The new lower limb multidisciplinary team meeting has been established in Portland with Practice and District Nurses jointly reviewing the patients that each team sees.
- The INT are also establishing 'shadowing' between the teams to increase understanding of each other's roles and to identify further opportunities to strengthen integrated working.

Purbeck

- Using population health data for their communities to inform where they should start in terms of bringing teams together. Emerging opportunities include Frailty, Obesity and Mental Health so the teams supporting these areas are coming together to see how the current services can work more closely and remove barriers to them being able to provide integrated care.

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