Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 2018**
Subject:	**Integrated Community Care Portfolio**

Summary:

This report updates the Health Scrutiny Committee for Lincolnshire on the implementation of the Integrated Community Care portfolio and the progress that has been made in four of the key programme areas: Neighbourhood Working; GP Forward View; the Integrated Accelerator programme; and the KPMG and Optum commissioned work. The report identifies the key successes and issues.

Actions Required:

To note the progress on the delivery of the Integrated Community Care Portfolio.

1. Background

1.1 National Context

Where once the primary purpose of the health and care system was to provide episodic treatment for acute illness, it now needs to deliver joined-up support for growing numbers of older people and people living with long-term conditions.

To meet this challenge, the NHS and its partners must break down barriers between services and give greater priority to promoting population health and wellbeing.

Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England. Their development represents a fundamental and far-reaching change in how the NHS works across different services and with external partners.

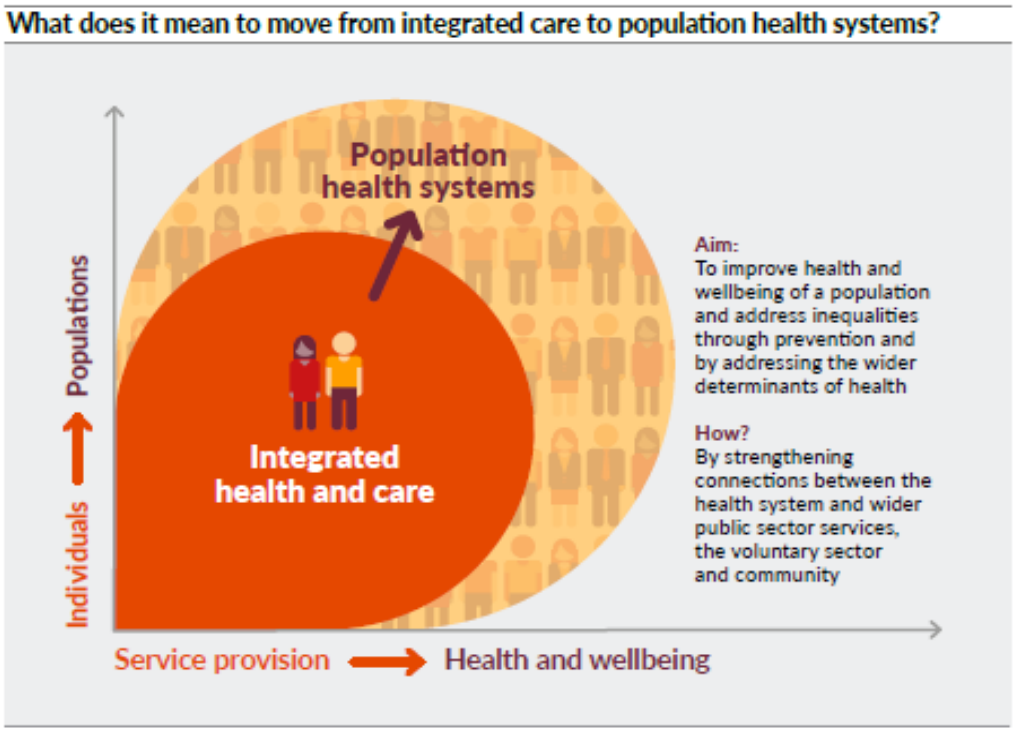
These ‘place-based’ partnerships will be given more control over local funding and services in the hope that they can make better use of resources and improve the health and wellbeing of their populations.

ICSs have no basis in legislation, and rest on the willingness and commitment of organisations and leaders to work collaboratively and there is no national blueprint to guide the way.

In June 2017, NHS England selected ten areas to develop the first ICSs. A further four were announced in May 2018, and others will follow. They are expected to become increasingly important in planning services and managing resources in the future.

Supporting the development of an Integrated Care System remains one of the key areas of focus for Lincolnshire. The aim is that colleagues from across the whole system come together to ensure that the services that are delivered by all partners for people in Lincolnshire work together to promote health and wellbeing.

The illustration below shows the next step from integration at a statutory and service level to population health systems which include the local community assets and the wider determinants of heath.



Ref: Kings Fund: A Year of Integrated Care Systems Sept 2018

The table below illustrates the early learning from the initial ICS sites – the key enablers and barriers to progressing in local systems, and learning for Lincolnshire.

Table 1 Factors that help or hinder progress in local systems

Enablers	Barriers
• Collaborative relationships • Shared vision and purpose • System leadership • Clinical leadership and engagement • Partnerships with local authorities • A meaningful local identity • Established models of integrated working • Stability of local finances and performance • Funding to support transformation • A permissive and supportive national programme	• The legislative context does not support system working • A legacy of competitive behaviours • Regulation and oversight is not aligned behind ICSs • Frequently changing language and the lack of a clear narrative • Leaders face competing demands • Funding pressures can both help and hinder progress

1.2 Lincolnshire Context

In seeking to establish an effective Integrated Care System it is necessary to raise the profile of services that are provided outside the acute hospital (including mental health in-patient settings). Our ambition is that as a Lincolnshire system, our default position is that care will be provided in the community unless there is a clinical need or value for money reason that care and treatment should be provided in an acute hospital setting.

As such the development of care closer to home, Integrated Community Care (ICC), is a priority for the Lincolnshire system as it is the foundation of our ambition to improve the health and wellbeing of our population. The ICC programme will apply to all service areas and for all age groups. Our aim is to develop care and treatment arrangements that promote partnerships not only across General Practice and statutory bodies but with the third sector, independent agencies and specifically with the person themselves.

Care and treatment will be delivered to support the individual needs and promote quality of life. As such a key element of our work will be to work with individuals, communities and the wider population to raise awareness of how to reduce the risk of getting a condition, what changes an individual can make to their life-style to reverse or manage a long term condition, what support they can get from within their local communities and how to make best use of the care and treatment provided by their GP, other health and care professionals and partners in the third sector.

In recognising the need to raise awareness and promote the development of ICC, the Lincolnshire Sustainability and Transformation Partnership (STP) work plan was redefined so that there was alignment of activities to four pillars. One of these pillars is described as Integrated Community Care and includes a range of transformational programmes which focus on the key priorities in terms of impact, deliverables and scalability.

- Neighbourhood Working
- Primary Care
- Integrated Accelerator Programme (NHSE)
- Agreeing a single vision of the Integrated Care System for Lincolnshire
- Building capacity and capability to use data to provide knowledge and intelligence that will enable us to commission and deliver care and treatment that improves outcomes for local residents.

2. Integrated Community Care Board

During recent engagement events people living in Lincolnshire communities have told us that they want high quality services to be provided locally to where they live. Based on this, the Integrated Community Care Board agreed a clear vision and ambition for the future development of services.

All care and treatment will be delivered in the community unless it can be evidenced that the service / function needs to be delivered in an acute setting.

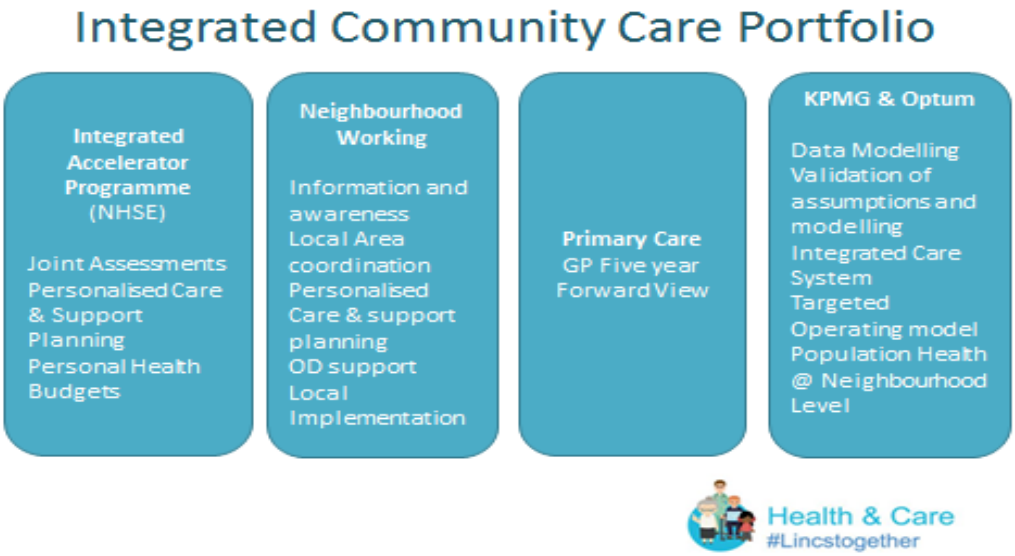
By focusing on our communities we can reserve our hospital services for those who really need it. Integrated Community Care brings together the ambitions of local people and professionals, encourages partnerships, innovation and use of technology to deliver accessible high quality health and care which is easier to access.

To enable us to achieve this the ICC board have also developed a set of principles that will guide our work programme and decision making.

These principles are :

- Engage local people to help us design and develop community services so that these reflect their needs and the things that matter to them;
- Test, analyse and challenge emerging findings, particularly from the data modelling and population health analytics;
- Developing innovative system level solutions which have the required scale of impact;
- Providing solutions that work from an individual's rather than organisational perspective, move from silo working to system thinking;
- Agree and commit the resources necessary for the successful completion of the programme;
- Support and enable, through their organisational and system leadership, rapid testing of potential solutions;

The ICC board have prioritised four key programmes as outlined below. The development of community services is ongoing in other areas such as Mental Health, Elective Care, Cancer and Children and Families as part of these programmes of work. As the ICC board becomes more established these key programmes will be included so that the principles of ICC are aligned to all services across Lincolnshire.



3. Neighbourhood Working

Neighbourhood working is the term used to describe the coming together of all services in a defined geographical area to support the needs of a local population of between 30,000 and 50,000 people. It is an essential element of the Lincolnshire STP as it allows us to ensure that services are delivered to ensure both equity of access and the demographic needs of a local population. For example in Lincoln city there is a greater number of young people and families whilst on the East coast there are more older people living with a number of long term conditions.

The delivery of local services also enables us to recognise the important contribution of other agencies including but not limited to, District councils, the third sector and local independent providers. The development of services for local residents and investment in local assets will encourage partnerships and innovation to address the challenges experienced, for example, investment in high quality technology could enable patients to have access to consultations with clinicians in other areas without having to travel.

The vision for Neighbourhood working is simple:

It is the heart of our Integrated Community Care offer. The person and their support networks are our focus. Health care the voluntary services and other local agencies will work in partnership to empower them to take an active role in their health and wellbeing with greater control and choice.

3.1 The Operating Framework

The five key functions of the operating framework are now clearly identified and defined and are being utilised to support the development of local services.

These are set out below :

i. Understanding the local population – through an **identification** process such as public health demographics and risk stratification of a local primary care population.

ii. A range of **local area coordination** is required to enable an individual to understand the level of support they require through self-navigation, aided navigation and supported coordination.

iii. The individual, core neighbourhood team and network identify a key worker if required and co-produce a **person centred care and support plan.**

iv. The core neighbourhood team and network deliver the plan supporting the individual to reach their agreed outcomes.

v. The individual care and support plan is regularly reviewed to manage any changing needs and requirements.

3.2 Neighbourhood Working Progress

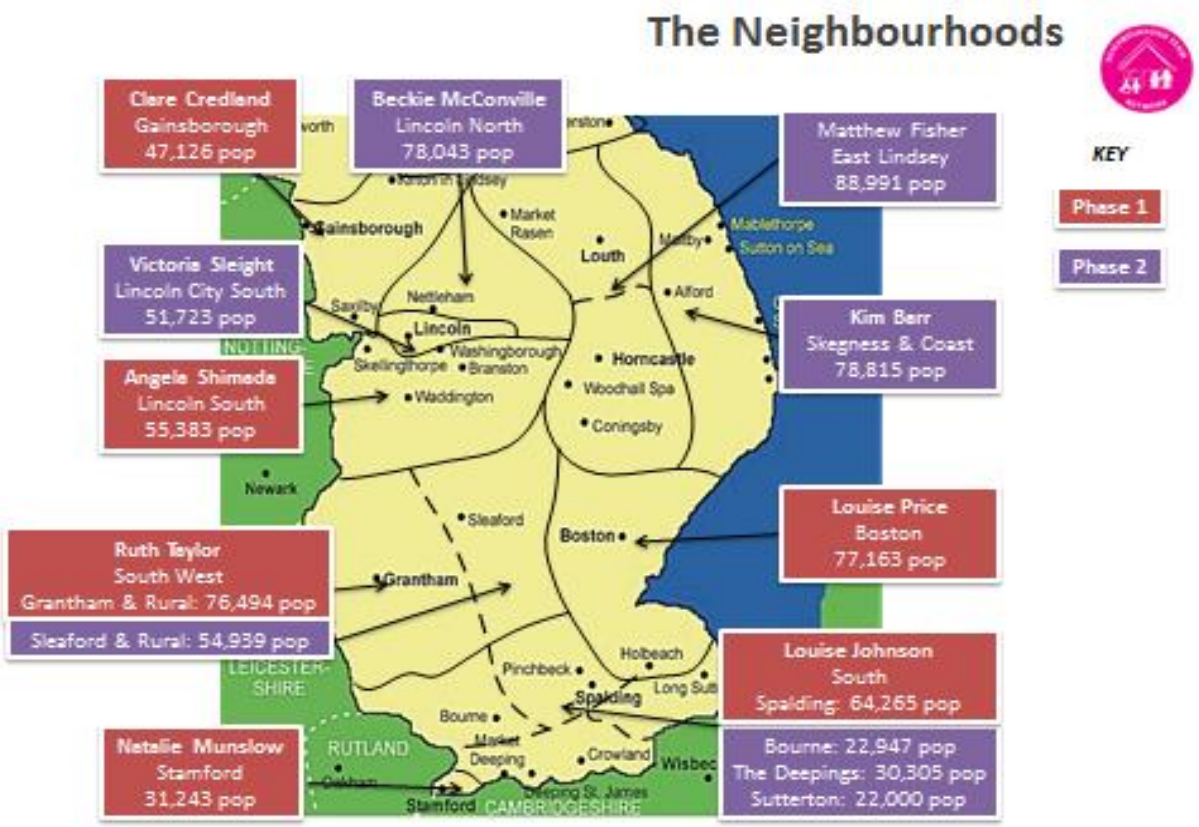
The Neighbourhood Working approach is now being implemented across the whole County with 10 Neighbourhood Leads having been appointed supporting 12 areas. These Neighbourhood Leads come from different professional background including nursing, social work and allied health professionals. They have also worked in a range of clinical settings and with different patient groups including individuals who are frail, children and people with mental illness.

The richness of their combined experience is an asset to Lincolnshire. As a team they will ask the difficult questions, provide the visibility of patient and staff experience, encourage us all to think differently and be the catalyst to supporting new ways of working that will improve outcomes for patients.

Over the last six months the Neighbourhood Leads and GP practices in the local area have been working closely with their communities and staff working in the area, to agree key areas of focus which will have the greatest impact.

The Neighbourhood Lead's role is to provide the local leadership to bring together service users and colleagues in the local area so that they can better understand local needs and identify opportunities to improve services. Early successes have been the reduction in duplication of assessments and the building of links that support people to have quicker access to local expertise.

Neighbourhood	Neighbourhood Lead	Current Focus
Boston	Louise Price	Frailty Personalised Care and Support planning
Gainsborough	Clare Credland	Frequent attenders at Secondary Care Personalised Care and Support planning
Lincoln City South	Victoria Sleight	Mental Health
Lincoln South	Angela Shimada	Care Homes
Lincoln North	Becky McConville	End of Life & palliative Care
Stamford	Natalie Munslow	Frailty and links to Acute services
East Lindsey	Matthew Fisher (comm Jan 19)	Frailty – Home visiting
Skegness and Coastal	Kim Barr	Frailty and Extra Care
South West	Ruth Taylor	Personalised Care and Support planning
South	Louise Johnson	Continence and Carers



3.3 Neighbourhood Working Across Lincolnshire

Whilst Neighbourhood working is key to promoting care for local communities and reducing silo working between organisations it is recognised that there is an inherent risk of creating new silos that result in barriers between neighbourhood areas. For that reason the neighbourhood is considered as one of the building bricks that will come together to support the needs of the wider Lincolnshire population. In essence, local services will be enhanced by additional support / specialism delivered for a wider population – generally 250,000 (current CCG footprint) and then 750,000 (current total Lincolnshire population).

The level of resource required will again be determined by local need, for example, dedicated palliative and end of life teams or specialist diabetic nurses will work across a number of neighbourhoods.

To enable this, the Lincolnshire community will develop standardised pathways that will be adopted throughout the county although they may be delivered differently in a local area. The framework is currently being applied for Frailty, Diabetes and End of Life. The development of pathways will be supported by Clinical experts from our clinical cabinet. As pathways are developed it will be possible to review resource allocation and realign funding to support local service delivery.

During the last year other key pieces of work have been progressed to provide the foundation for integrated community care these include :

a. **Library of Information and Services** – has been developed in partnership with LCC and the STP, and will offer the public and staff a central repository of services and functions across the county.

The service will also offer both 'live webchat' and telephone contact for advice and guidance.

The service will be 'soft launched' in November 2018.

b. **Local Area Coordination** – Care Navigation and Social Prescribing is now being piloted across the County – with partnership working between the Lincolnshire Voluntary Sector infrastructure, primary care and the voluntary and third sector organisations, including a connection into the Wellbeing service.

Individuals who have been offered a non–medical solution have had a different and alternative experience and in one case the individual has built up enough confidence to start volunteering at a local group, having not been able to leave their property due to anxiety.

c. **Personalised Care and Support Planning –** now forms part of the Integrated Accelerator programme being led by NHS England. This has given the Neighbourhood working project the impetus and momentum to really start to drive this forward. See section 5.

In order that we can evaluate and monitor our progress a number of working measures have been agreed. These will evolve and develop as we begin to understand how we can bring together the data held in different settings to help us understand what is happening at a local level.

Outcome Measures for Neighbourhood Working (April 2018-March 2019) Finalised Version 8.3 13/09/18

	Outcome	Measure	Expected Direction of Travel	Baseline	Target
1.	People are supported by an integrated approach to assessment and care and support planning	Number of integrated Personalised Care and Support Plans completed	↑	Will commence as part of the accelerator programme	
2.	People are enabled to die in their preferred place of death	Percentage of people who die in their preferred place of death	↑		
3.	People access a range of non-statutory services to support their health and wellbeing needs	Increase the availability of non-statutory as an alternative to statutory services.	↑		
4.	People are supported to live as independently as possible at home	Number of long term residential and nursing home placements.	↓		
		Number of NEL admissions to Secondary Care *	↓		
		Number of A&E attendances. (Secondary Care Data)*	↓		
		Number of people accessing crisis services (mental health)*	↓		
5.	People, and their carers, have a positive experience when they access care and support.	Service user and carers satisfaction survey			
6.	People are supported to return home quickly and safely, after a hospital admission	Number of individuals who are still at home 91 days after a hospital discharge.*	↑		
		25% reduction in length of stay in hospital for individuals with one or more of the frailty syndromes	↓		
		Achieve 3.5% DTOC - secondary care (Secondary Care Data) *	↓		

3.4 Enablers

Organisational Development and behaviour change

This continues to be a key enabler for the Neighbourhood Working programme with the focus of the conversation to understand ‘what matters to the individual’ not ‘what’s the matter with them’, using a strength based approach, positive risk taking and de-medicalising their situation when appropriate.

There is also a growing consensus across Lincolnshire of the value of rapid testing which has been used across a range of programmes recently. It has been recognised that when done well, this approach can quickly deliver tangible changes such as improving a clinical pathway, whilst also increasing motivation, engagement and communication across organisational boundaries.

With this in mind we have been developing a comprehensive OD (organisational development) programme with funding support from the Integrated Accelerator Programme (IAP) and Lincolnshire workforce advisory board (LWAB) and has personalisation and rapid testing at the heart of it – this has been and is being made available to all Neighbourhoods and across the wider portfolio.

3.5 Information and Technology

The roll out of the Care Portal into the Neighbourhoods and into GP practices across Lincolnshire is starting to have a positive impact for example being able to see appropriate information regarding an individual's stay in hospital.

16 GP practices are currently accessing the portal with a target of 60 by March 2019. United Lincolnshire Hospitals NHS Trust (ULHT) are rolling out across their organisation, with 170 users from ULHT, Lincolnshire Community Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and St Barnabas actively using it. There is a target of 2500 users across provider organisations by end of Mar 19 - this will include Lincolnshire County Council Adult Social Care.

Digital technology is now high on the agenda for the system and is starting to be tested at Neighbourhood Level. For example, Stamford are currently running a pilot with a small number of individuals who have been identified as having a moderate level of frailty and using Apps on their phones and iPads tracking how they are on a day to day basis.

3.6 Engaging Local People

The success of neighbourhood working and integrated community care will be influenced by our ability to engage local people to help us shape local services and understand what we are seeking to achieve and how they can contribute and support us. Whilst our discussions thus far have been on self-care in relation to treating minor illness, we will be seeking to work with colleagues in public health to raise awareness and encourage everyone , irrespective of age and current health, to understand how they are a key partner in managing their health and well-being. Our focus will be in helping local people understand how they can reduce the risk of them becoming unwell, what they can do to either reverse or manage a condition, providing information and signposting people to the support available to help them and asking them to consider in advance what they can do that can enable us to treat them effectively should they become unwell. One example will be for patients to give consent that their records can be shared across key teams that may be involved in future treatment.

3.7 Neighbourhood Working – The Impact

Starting in early October an initial pilot was ran with one GP practice to review a number of patients who frequently attended A & E and had a high frailty score when using a nationally recognised assessment tool.

One patient who was identified through this review had attended A & E on 31 occasions during the last twelve months for treatment of problems associated to a catheter.

Working together the local teams completed a review to understand the nature of the catheter issues. An advanced care plan was developed with the patient and the care home team so that they knew what to do if they notice changes thus avoiding a

problem developing. The team have remained in regular contact with the care home team and after 20 days the patient had not had any further problems that had required attendance at A & E.

This simple intervention not only provided a much better experience for the individual concerned but meant that the ambulance that would have been called was available for someone else and that there was one less person attending A & E.

New Role developed as part of Neighbourhood Working – the Primary Care Coordinator.

Primary Care Coordinators are working across the South and South West of Lincolnshire as the link between Primary Care and the neighbourhood. They proactively support individuals who have a high level of frailty, offering clinical expertise but also linking up and coordinating support with colleagues from across the locality.

"I just wanted to drop you an e mail to inform you that recent changes within the Deepings practice are having a positive impact here at Rose lodge.

"The primary care co-ordinator has been working closely with resident RM and the GP. This has resulted in his falls reducing from 10 per month to zero; this is just one example of many. The weekly visit by the GP is working exceptionally well; improving patient care and reducing crisis situations and our work load so that we can spend more time with our clients."

James story

James was living with diabetes and working as a graphic designer when he permanently lost his sight. James is 30 and the loss of his sight has had a profound effect on his physical and emotional wellbeing.

Partners from across health, care and the third sector working together have supported James to:

- Receive the physical care he needed
- Understand and manage his mental health needs
- Access housing support through his local authority
- Join local support groups with other people living with a disability
- Complete a training course to maintain his independence
- Adapt and manage his disability, including using technology he is passionate about
- Seek support for his father, who is his full time carer

4. General Practice

“The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice.” GP Forward View (GPFV) 2016.

The Integrated Community Care Programme will build on the work that has been ongoing across Lincolnshire to progress the GPFV recommendations. This programme has been progressed at a local level by individual practices, by groups of practices who have come together to form a network / federation, by CCGs working with local GPs and by the STP GPFV steering group. The work programme has been facilitated and enabled by the LMC and NHS England.

During the last year there have been many successful initiatives that have made a tangible difference to patients and the professionals working within general practice. Some examples include :

- International recruitment
- Introduction of workflow optimisation
- Local pilots delivered in partnership with colleagues in the neighbourhood including Care home support , ECP home visiting schemes
- Being selected as one of only two pilots to establish a practice nurse programme that will enable newly qualified nurses to take their first jobs in GP
- Extending the GP team to include other professionals such as Clinical Pharmacists, First contact physios.
- Neighbourhood leads and GPs working together to identify patients who would benefit from a personalised care package which includes support from other agencies
- Roll out of extended access across Lincolnshire – enabling everyone to have the opportunity to see a GP in an evening during the week and on both Saturday and Sunday.

The strength of GP is the links it has with its local community and as such as the ICC programme develops GP will be central to ensuring that services are delivered in a way that reflects the needs of local residents.

4.1 Workforce

One of the key areas of concern with regards providing a resilient GP service for the local community is workforce availability.

Our aim is that by September 2020 we will have 2,020 patient facing staff in primary care. The trajectory for September 2018 was 1,983, and we are slightly ahead of this with 1,985 people in post. In addition to this, Lincolnshire has been successful in bidding for £225k to support 10 nursing posts new to general practice in a new approach to nursing education, working with BGU.

There is a supporting programme to increase both retention and recruitment. These include national support to repeat our international recruitment initiatives and initiatives to encourage registrars who have trained in Lincolnshire to remain here when they qualify. Practices throughout the county are keen to support the new medical school and have already signed up to provide placements for medical students

Focused projects are being supported with two of the Federations. These programmes will facilitate practices to understand the skills and competences required to best meet the needs of local people and then look to extend the GP team to include other professional groups thus allowing GPs to focus specifically on those patients with complex needs. In addition to the examples referred to earlier models to provide improved access to mental health support in primary care are being developed.

Our aim is to ensure that we develop a rolling workforce plan that reflects the changing demands and needs highlighted through the development of our ICC programme.

4.2 Working differently

A number of practices are due to commence a pilot to test out on-line consultation. Two different approaches to on-line consultation will be tested out across a number of practices covering both urban and rural areas.

A number of events are planned to support practices in gaining understanding and experience of how to use quality improvement methodology to support continuous improvement of local services.

4.3 Primary Care at Scale

Primary care at scale describes the opportunity for GPs to work together to support the needs of people living in a neighbourhood. There are different arrangements across Lincolnshire but in essence they are all working to deliver the same objectives. Namely :

- Provide increased resilience to GP.
- Provide improved access to specific services that would be unaffordable if delivered by a single practice.
- Provide 100% coverage of extended services.
- Build opportunities for GP to work in partnership with other agencies to enhance Integrated community care e.g. specialists working in GP for example a pilot is being arranged in one Neighbourhood that will provide patients with ongoing mental illness direct access to a CPN who works across the practices in a Federation.

As the range of services available in GP increases then it is important that patients can be supported to get an appointment with the right person first time. In the coming months, receptions will be provided with enhanced training to enable them to gather

some basic information from patients so that they can book them an appointment with the right person. The infrastructure to enable patients to be booked into GP practices other than their own have been tested through the introduction of extended access and are working well.

Extended access has been rolled out across Lincolnshire since the 1st October although some services were operational from September. The models and delivery arrangements have been developed locally. Although it is early days there is good usage of the service and patients have been happy to travel to other places to be seen.

4.4 Building practice resilience

Additional funding has been provided to support practices develop greater resilience by working together to provide care for their patients. Both of these programmes were developed by groups of practices to mitigate their specific risks but will provide valuable learning which can be shared across the county.

One programme is focussing on releasing time for patient care by developing people and changing processes that are more efficient. Processes will be standardised, as a precursor to sharing these tasks between practices. In this way, processes will be done once for multiple practices rather than multiple times in each practice, there are added benefits of this programme as it creates the opportunity for staff to cover for gaps or even develop rotational posts across a number of practices.

The second programme covers 5 east coast practices and is to develop an acute care home visiting service utilising specialist paramedics. Cases will be triaged by the practice with specialist paramedics actually carrying out visits following medical triage.

The specialist paramedic programme follows on from work currently underway in partnership with Health Education England as part of a national pilot evaluating the benefit of keeping patients differently and keeping them in their community.

Both programmes are being run for 12 months and involve end of programme evaluation.

5. Integrated Accelerator Programme

On 20 March 2018, Jeremy Hunt announced three pilots integrating health and social care assessments, to take place over two years in Gloucestershire, Nottinghamshire and Lincolnshire.

5.1 Purpose and scope

NHS England will support the sites to implement a pro-active and joined-up approach to needs assessment, personalised care and support planning, and (where beneficial) integrated personal budgets. This builds on the work already underway as part of the Integrated Personal Commissioning and the personalised care demonstrator programmes.

The objectives of the pilots are:

- better health and wellbeing outcomes
- reduced demand on health and care services
- better experience for people and their families.

The scope of the pilots includes anyone who receives a needs assessment under the Care Act 2014 from the local authority, including carers and regardless of financial circumstances. The initial focus will be decided with each site based on local priorities.

5.2 Local Response

In Lincolnshire this programme is being embedded into Neighbourhood Working and is building on the progress that has already been made.

NHS England are specifically working in three Neighbourhoods;

- Grantham (South West)
- Boston
- Gainsborough

The initial phase of the project commenced in October, and will focus on using the skills and expertise learnt through the Helen Sanderson and Associates project and test out a co-produced and designed care and support plan template.

Each Neighbourhood will use rapid testing / plan, do, study, act (PDSA) models to test out the template in their area with different cohorts of individuals to get a really good cross section of the population.

The next steps will be to develop an electronic solution to enable individuals and workforce the appropriate visibility of their plans, including emergency services.

From a governance perspective the programme will have its own Board and will report directly into the Integrated Community Care Board.

6. Building the infrastructure to support ICC

The Lincolnshire Health and Care system is working with two nationally renowned organisations (KPMG & Optum) to develop a model of an Integrated Care System, through using data analytics, designing an operating model and building on the work of neighbourhood programme.

This programme consists of a number of separate but related initiatives:

a. **Modelling and data analytics** – looking at data across the STP including adult care to understand where best to put resources, and how many and which services will be needed in the near future

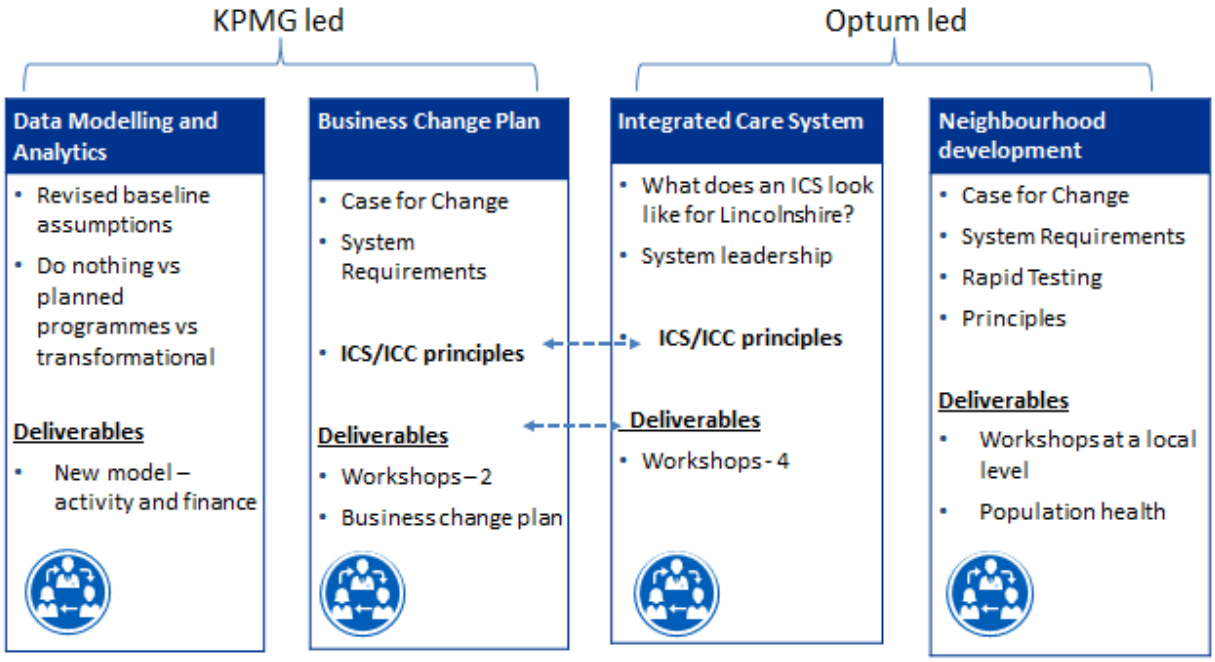
b. **Whole system engagement** – leaders from all organisations in the STP including Lincolnshire County Council are working together to develop a shared vision and model for integrated care in Lincolnshire. The current system is no longer fit for purpose and a radical redesign is needed that focuses on prevention, self-care and ensuring care is closer to home.

c. **Locality activities** – neighbourhood working is a step in the right direction. Now, the focus is to ensure that it is working well and focusing their efforts and prioritising as well as they can.

   It is important to ensure that the neighbourhoods understand the system changes that will be determined by system leaders and have a say in those changes, based on their local knowledge.

   Optum are working with East Lindsey, Lincoln South and South Lincolnshire Neighbourhoods.

The illustration below outlines the high level plan and deliverables and demonstrates how the two business are working together to meet the objectives set.



6.1 Progress to date

The first ICS workshop has been held and has started to identify some of the key principles that the system leaders want to focus on in the development and design of an ICS.

A number of workshops are being held over the next 3 months which will focus on the ICS model and being clear about the operating model for such a transformational change.

Data modelling is underway with the Optum assumptions of 3 years ago being reworked with current and future planning activity being fed in. This will then be revalidated and utilised as part of the whole system modelling piece KPMG are leading on which will include local, national and international data and evidence.

Key Milestones

- End Oct – second ICS workshop
- During Nov – stakeholder engagement and task and finish groups
- Mid Nov – Data Modelling piece complete
- Nov & Dec – Neighbourhood testing
- Mid Dec – Operating model workshop – including data piece
- End Jan – Development of business case for an Integrated Care System for Lincolnshire

7. Conclusion

This report outlines the background to the evolution of the Integrated Community Care portfolio and its links to both national and local priorities. It describes the four main programmes and their progress to date including the ongoing requirement for Organisational Development and behaviour change.

It is presented to inform the Health Scrutiny Committee of the current progress in development of the Integrated Community Care Portfolio for Lincolnshire.

8. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report

Document title	Where the document can be viewed
GP Forward View 2016	https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

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