Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire's Clinical Commissioning Groups and the Sustainability and Transformation Partnership

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**26 March 2019**
Subject:	**Neighbourhood Working**

Summary:
This report provides an update to the Board on the development of neighbourhood working in Lincolnshire.

Actions Required:
The Board is asked to consider the information in the report and the future plans to further develop neighbourhood working in Lincolnshire.

1. Background

1.1 Introduction

Stakeholders across Lincolnshire have all agreed that the default location for providing care and treatment should be the community unless there is a clinical need or an economic case for it to be delivered in an acute hospital setting.

The core principles that will influence the design and development of Integrated Community Care (ICC) are:

- Home first & digital by default
- Truly integrated workforce
- Proactive population management
- Tackling the root cause of poor health
- Prevention and early intervention
- Resilient communities
- Personal responsibility and empowerment

The anticipated benefits of ICC include:

- Ensuring that people are treated and supported at the right time and in the most appropriate setting
- Ensuring an increased focus on prevention, encouraging individuals and mobilising the population to take personal responsibility for their own health and wellbeing
- Greater use of community assets to support wider individual wellbeing
- Focus on self-care / support for local people and their carers
- Embedding person centred care and shared decision making
- Providing more care close to home
- Better care planning / risk stratification across the health and social care system
- Reduced clinical variation
- More efficient services with less waste
- Positive patient experience

This will translate to:

- Reductions in attendance and use of hospitals, reducing unplanned admissions, length of stay and transfers across the system
- Reductions in the use of residential and nursing area, aiming to reduce admissions and overall length of stay
- Increase in people receiving rehabilitation and reablement at home to maximise independence
- Increased numbers of people being able to die in their own home rather than in hospital
- Increases in people being able to take control of their own health and care by use of expert patient programmes, digital access, telehealth and telecare
- Increased engagement of local organisations such as schools, employers, third sector groups in promoting health choices.

Neighbourhood working is the foundation for delivering effective integrated community care. The primary aim of Neighbourhood working is to bring services together to use their collective skills and expertise to support people living in a defined geographical location.

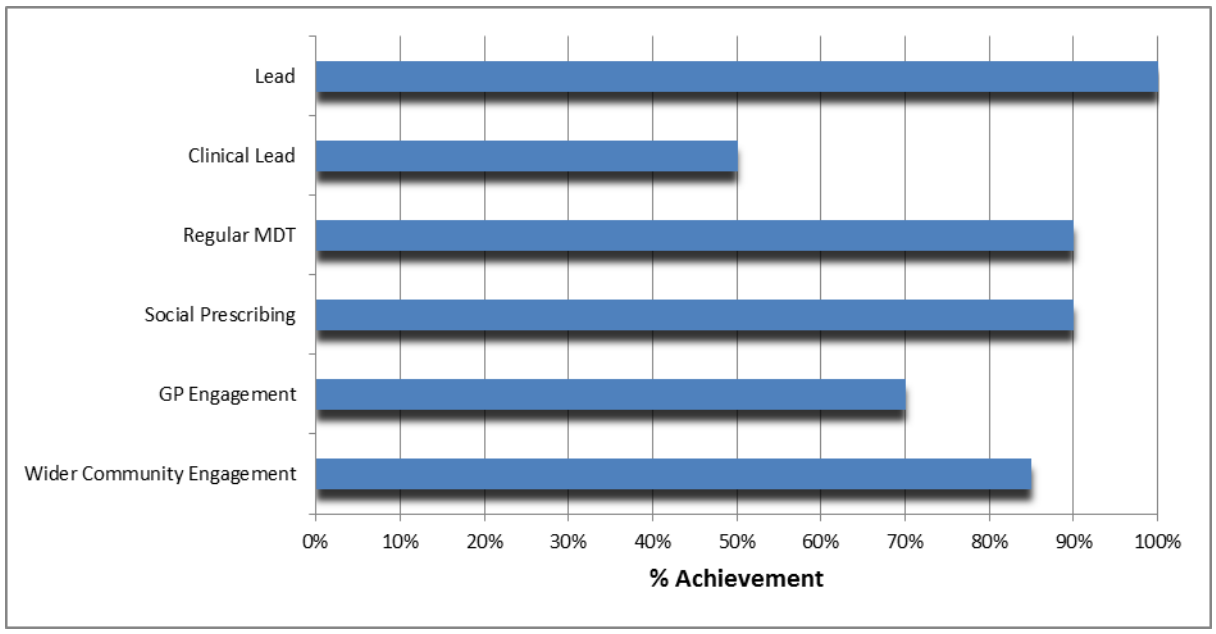
1.2 Progress

There are 12 designated neighbourhoods across Lincolnshire, as shown in Appendix A.

Funding made available through the BCF was used to support the development of neighbourhood working and specifically the appointment of Neighbourhood and Clinical leads. This investment was a key enabler in supporting the establishment of the local infrastructure that is vital to providing the design and development of local services that will facilitate population health management.

Chart 1 shows the progress to date in establishing the infrastructure to support neighbourhood working.

Chart 1



The development of Neighbourhood working has been influenced by the following:

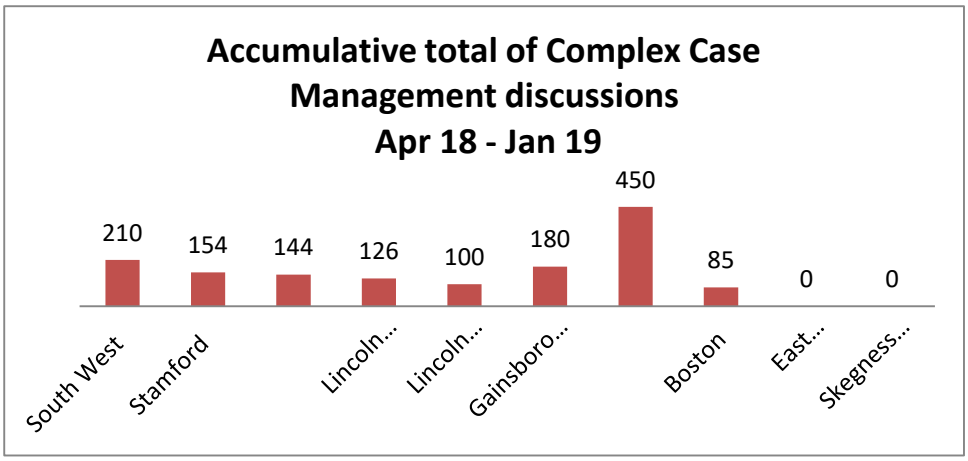
- Establishing arrangements to support patients with complex needs.
- Introducing social prescribing.
- Encouraging local teams to identify initiatives that are meaningful to local stakeholders.

1.3 Establishing arrangements to support patients with complex needs

In the majority of Neighbourhoods colleagues from across the various agencies come together as a multi-disciplinary team to review the needs of patients referred to them. The focus is to provide co-ordinated person centred care and treatment that addresses the complex needs of the individual. These MDT discussions are happening on a regular basis with the exception of Skegness and Coastal and East Lindsey where the recently appointed leads are working to introduce local arrangements.

Chart 2 shows the number of complex cases that have been reviewed and case management by the Neighbourhood MDT.

Chart 2



These numbers only represent a small amount of the joined up working and activity that is now starting to embed in Neighbourhoods. For example; in Boston 271 patients have been reviewed by their newly formed primary care MDT's since November.

Stamford have identified 400 severely frail patients and have been cross referencing with adult care and health providers to understand where the gaps are, and agreeing the key worker.

Whilst the numbers may appear low, the impact for individuals is significant.

One 91 year old gentleman, who lives alone, went to his GP after a number of falls in his own home. He asked the GP to support him to get a place in a residential setting. After discussion the gentleman agreed to a referral to the MDT. He was seen by a member of the team who completed a personal assessment. This highlighted that the gentleman was isolated, had a visual impairment and was very lonely. The team referred the gentleman to the visual impairment team. They arranged for the gentleman to receive large print newspapers and other aids. In addition they found out that there was a local history group. The gentleman now attends this having bought himself a new mobility scooter with lights so that he could go out in the early evening

The Living With and Beyond Cancer team have worked with the local neighbourhood teams to support proactive referral to services in the community for a patient with lung cancer. They compared the time taken by the MDT to review the case and make all the referrals to various agencies required to support this patient with the time taken by the Clinical Nurse Specialists in the hospital.

The results were as follows:

- A referral to the MDT took the CNS five minutes. The MDT reviewed the case – 2 hours and took 40 minutes to make all the referrals. Total 2 hours 45 mins
- The CNS took 4 hours to make the referrals to the various agencies. Because of other responsibilities these referrals were made over a period of 13 days. Total time 13 days 4 hours.
- Impact the patient had all care and support they required in the hospital and the probability of a crisis occurring was significantly reduced.

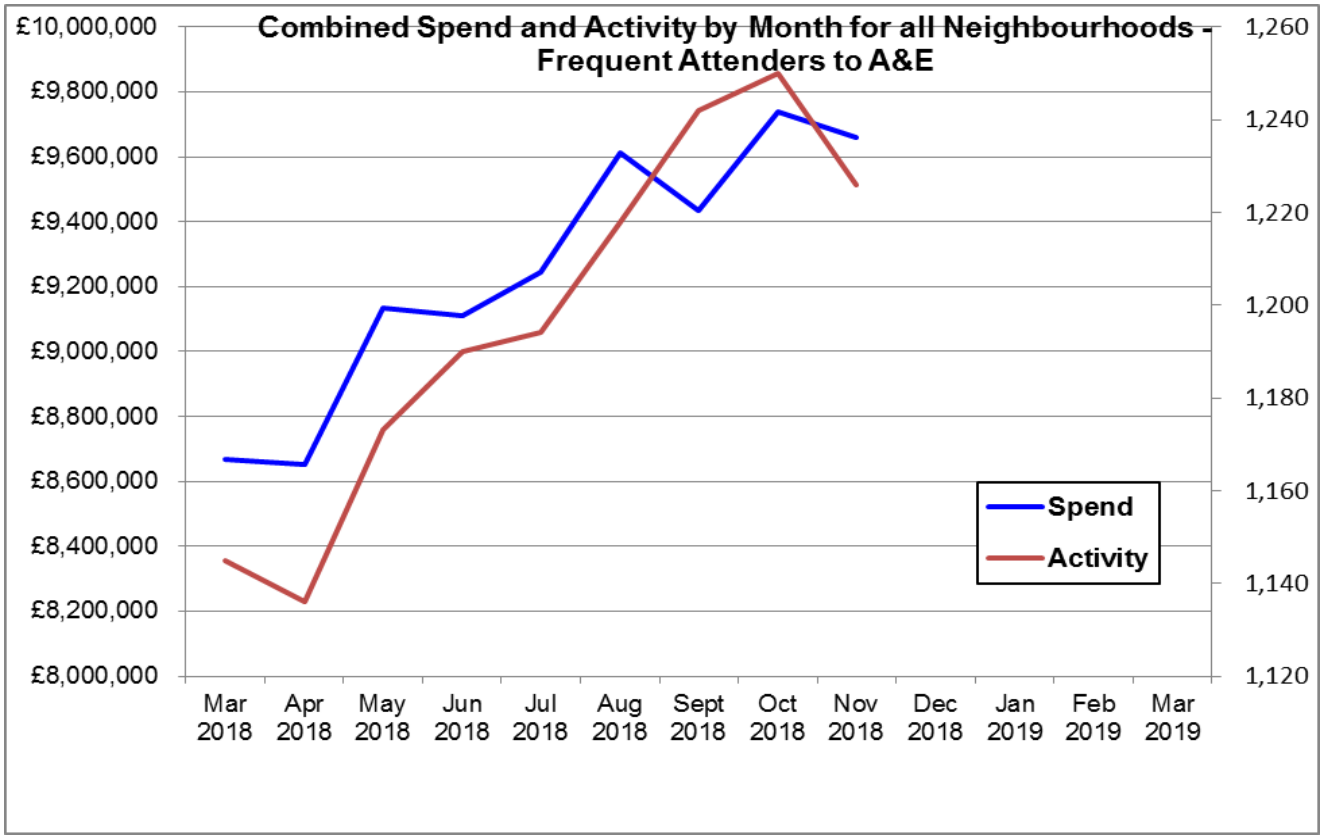
MDTs have been reviewing cases highlighted to them either by GPs or through local data as frequent A & E attenders. Each of these patients will be offered a comprehensive personalised assessment and a care plan will be developed to ensure that the individual has access to the appropriate support, including advanced care plans or plans to enable the patient / carer to manage acute episodes of a long term condition

An example of the personal impact :

A patient was identified who had multiple admissions in the past year for catheter related problems. The individual visited A & E 31 times in the previous 12 months.
Working with the MDT a review was completed to understand the nature of the catheter issues. An advanced care plan was put in place and care home advised of the steps being taken. Close monitoring is ongoing to prevent further admissions, but after 1 month the patient had not had an admission to A & E since the intervention

Graph 1 shows both activity and financial costs for all Neighbourhoods for this cohort of patients.

Graph 1



1.4 Introducing Social Prescribing

The Social Prescribing project is being delivered as a 'proof of concept' across the County. It is an integral part of Neighbourhood working and personalised care. The project is being led by Lincolnshire Community and Voluntary Services (LCVS) and Voluntary Centre Services (CVS). They are working with Rose Generation to develop the social and financial return on investment of social prescribing that will support evaluation of the methodology.

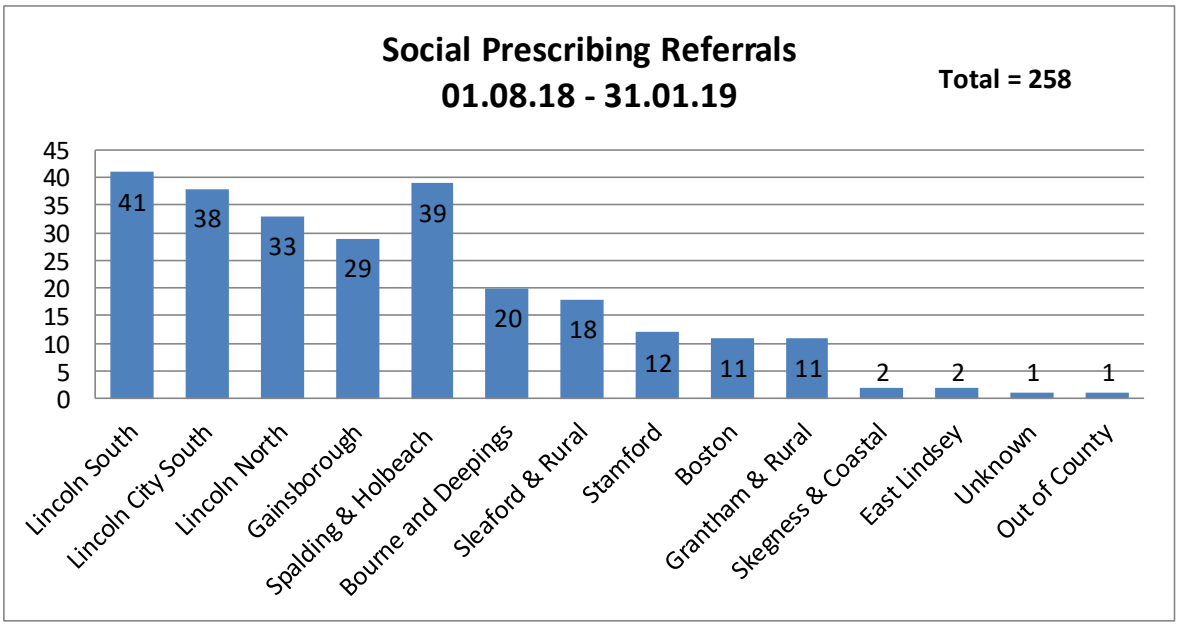
Social Prescribing Care Study

Mrs Y

Mrs Y completely lost her confidence since being hospitalised for falling. She was referred to the programme by the community Occupational Therapist. The patient said:

"The SP link worker has been invaluable in helping me see that I didn't have to accept my current situation as final. She has supported me and at the same time challenged me to think and act differently. I would not have had the confidence without this support and would have probably been unable to leave the house and become more frail and socially isolated. I have had small successes along the way such as being able to use my hoover and start cooking again. My physical strength and mood have improved significantly. I am regularly practising exercises at home and have been motivated to do so because I can see the difference it has made."

Chart 3



1.5 Encouraging local teams to identify initiatives that are meaningful to local stakeholders.

To encourage the development of neighbourhood working local teams have identified areas of development that are meaningful to their local population. Examples include:

- Establishing practice care co-ordinators
- Introducing care home liaison service
- Establishing home visiting service
- Message in a bottle
- Citizens Advice and Work & Pensions operating from GP practices

1.6 Constraints

Whilst there has been good progress with regards developing the infrastructure to support Neighbourhood working there are a number of identified constraints that currently limit the scale and pace of impact. These include:

- Organisational versus population alignment of resource management
- Information Governance
- IT infrastructure

2 Conclusion

Neighbourhood working is the foundation of effective Integrated Community Care that enables population health management. Good progress has been made and there are excellent examples of the impact this is having on people's lives. The focus for the coming twelve months is to accelerate the further development of local arrangements so that the pace and scale of impact can be increased. The development of Neighbourhood working is central to the Integrated Community Care programme.

The framework that has been adopted across Lincolnshire aligns with the recently published The NHS Long Term plan and Universal Personalised Care Offer.

Over the next twelve months our Lincolnshire development programme of neighbourhood working includes:

- Establishing Primary Care Networks that align and complement the neighbourhood structure.
- Population Health Management – develop the arrangements for integrated population health management by supporting resource alignment and local co-ordination of resources to reflect patient need.
- Personalisation – development of joined up assessments, Personal care and support plans and facilitation of increased utilisation of Personal Health Budgets.
- Home First – Using service improvement methodology to test clinically developed initiatives to support patients who are assessed as frail. This is a precursor to enhancing the interpretation and co-ordinated frailty services within the community.
- Agree the core features e.g. method of referral etc. that support neighbourhood working
- Support the transformation of specialist service provision for diabetes, respiratory and CVD so that it is provided as an integral element of community services.
- Developing the social prescribing offer for Lincolnshire.
- Develop the digital offer for patients
- Addressing constraints that limit the ability for clinicians to work together to serve patient need e.g. IT governance and IT infrastructure.

3 Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Evidence from the Joint Strategic Needs Assessment has been used to inform the development of neighbourhood working. The development of neighbourhood working supports the JHWS themes of 'Embedding prevention into all pathways across health and care included integrated locality teams' and 'Developing joined up intelligence and research to identify needs, target and evidence outcomes prevention.'

4 Consultation

Not applicable

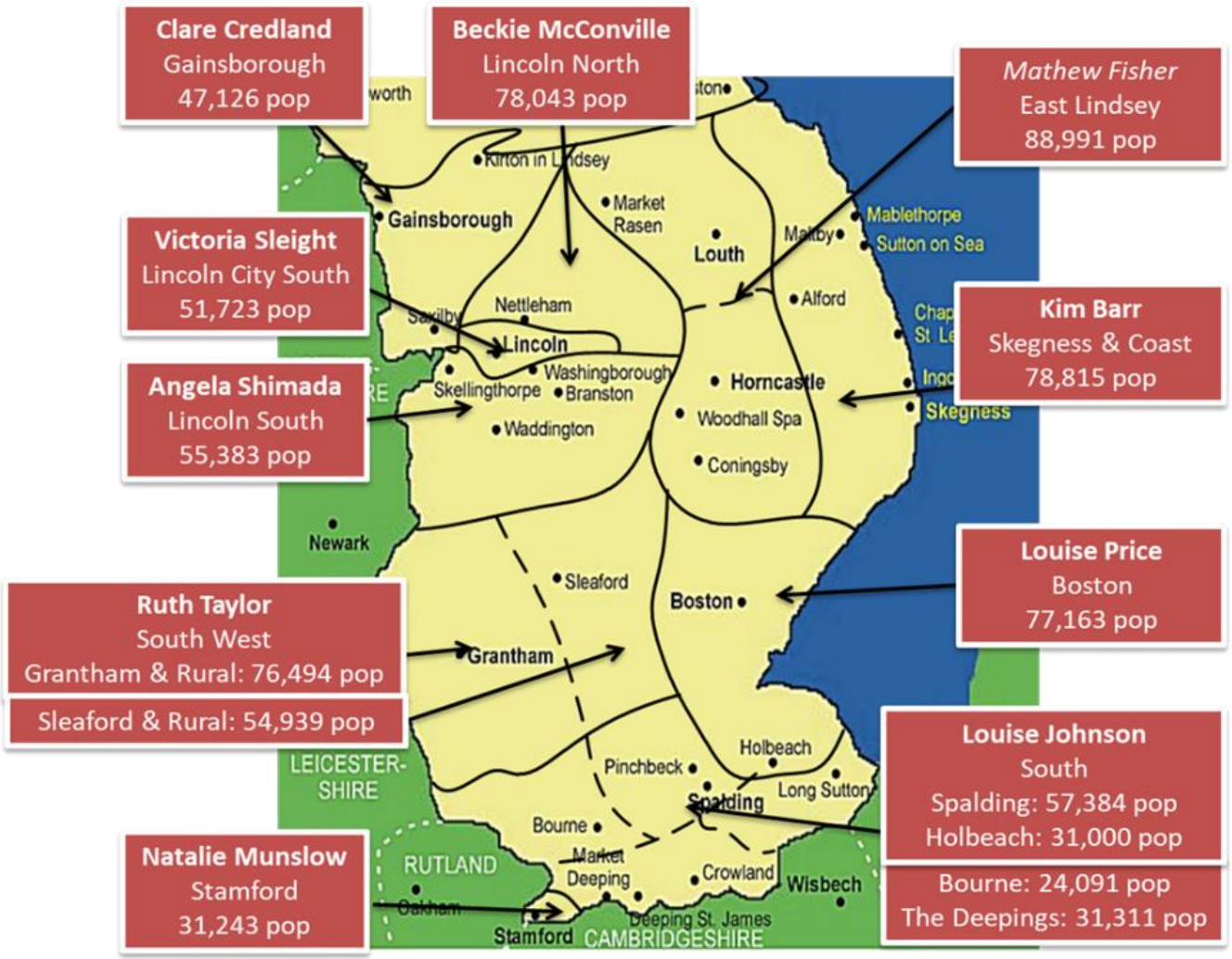
5 Appendices

These are listed below and attached at the back of the report	
Appendix A	Map of the 12 designated neighbourhoods

6 Background Papers

This report was written by Sarah-Jane Mills who can be contacted on 01522 515381 or sarah-jane.mills@lincolnshirewestccg.nhs.uk

The Neighbourhoods



Neighbourhood	Population
Lincoln City South	51,723
Lincoln South	55,383
Grantham & Rural	76,494
Sleaford & Rural	54,939
Stamford	31,243
Bourne & Deeping	55,408
Spalding & Holbeach	88,384
Boston	77,163
Skegness & Coastal	78,815
East Lindsey	88,991
Gainsborough	47,126
Lincoln North	78,043
Total	783,712