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:	**16 October 2018**
Subject:	**Integrated Community Care**

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
- Introduction of Primary Care Networks
- Use of Technology
- Development of Specialist Community Services.

Actions Required:

The Committee is requested to note and consider the information presented on Integrated Community Care, and to decide whether any feedback should be submitted to the Lincolnshire Sustainability and Transformation Partnership, as part of the *Healthy Conversation 2019* engagement exercise.

1. Background

The NHS nationally and locally faces significant challenges. We all acknowledge the pressures of an aging population, increasing need and cost with an overstretched workforce. These issues seem more acute in our county, particularly with a dispersed semi-rural population with pockets of high deprivation. However, our response to this challenge has not changed since the creation of the NHS over seventy years ago. We are over reliant on a reactive, hospital based, paternalistic model of health care with different sectors of our health and care system working in splendid isolation.

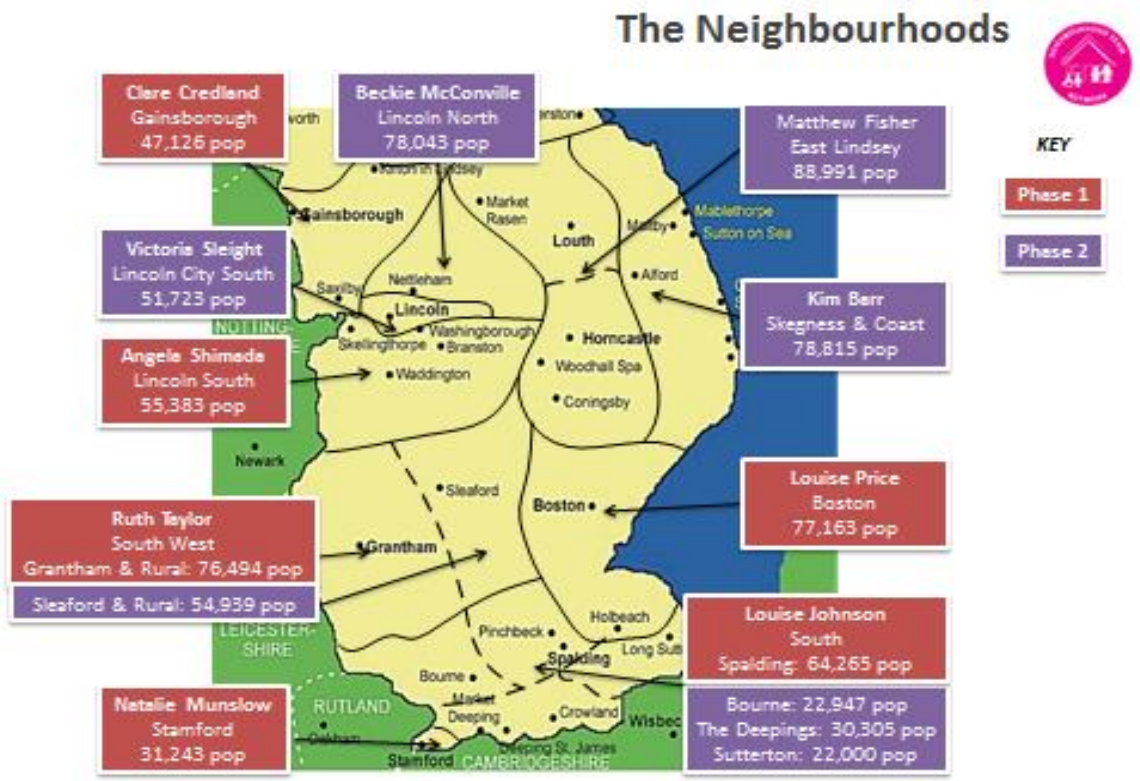
The feedback from the *Healthy Conversation* has confirmed that local people are asking for care close to home, a holistic approach that helps them remain in the bed they bought, to make access a simple process and a high standard of care delivered by compassionate professionals who they trust.

In responding to this, we understand the need to change the way care is delivered in the community, where the majority of care takes place and move away from the hospital focus. The Integrated Community Care portfolio is our proposal to realign care across the county.

We have been working together for some years to develop services that will support and enable us to achieve the task of people from across Lincolnshire. Our local plans will be supported and facilitated by the key actions outlined in the *NHS Long Term Plan*. This national programme sets out the expectation of modern, resilient primary care supported by excellent community care including mental health and an integrated service model which ultimately stops our reliance on hospital based services.

This report describes the progress to date and the work we are doing to maintain the development of Integrated Community Care across the county.

2. Neighbourhood Working



The neighbourhood teams continue to work closely with partners in their local communities. There have been some excellent examples of local initiatives that are supporting the development of holistic care, which reflects patient need and is delivered by a team of professionals from different organisations working as one. Some of these examples include:

- Using IT generated alerts to ensure that patients with complex need who had been discharged from hospital were contacted by the Neighbourhood team on discharge. The team were then able to complete a full assessment in the patient's own home and develop a proactive care plan that reduced the risk of further admissions to hospital.
- Introduction of advance practitioners across the Lincolnshire East teams to support management of complex patients identified by GPs.
- Linking with partner agencies to build a multi-agency team to support patients who are homeless. This has evolved to become 'team around the adult' .
- Ongoing development of a dedicated care home liaison service that has reduced the number of attendances at A & E, reduced the number of emergency admissions, increased the number of patients dying in their preferred place of death and reduced the number of GP visits to care homes.

Neighbourhood working is the foundation of the Integrated Community Care programme. Over the last two years the teams have focused on building the links with partners in their local communities. There is now strong evidence that this joined us working is having a positive impact on the outcome for patients but that there are also some key constraints that are stopping us realising the full benefits.

To ensure that we continue to drive the development of Neighbourhood working, Carolyn Nice, Assistant Director, Adult Frailty and Long Term Conditions, Lincolnshire County Council, has agreed to lead the next phase of development. The key objective of this work will be to address the barriers that prevent fully integrated patient care. Early priorities include :

- reviewing the work done to date to identify which core roles should be included in the Neighbourhood team;
- improving access, for all members of the core team, to information that enables them to identify patients that would benefit from holistic interventions;
- identifying bases in local communities where colleagues from different organisations can be collocated; and
- identifying key individuals in each organisation who will support the neighbourhood team to resolve issues that are currently preventing a patient from receiving the care they need.

Alongside this work there is a dedicated programme of work to support the integration of services for patients who are frail. The key priorities for this team are:

- developing the acute frailty unit;
- extending responsive community provision to enable patients taken to hospital to go home as soon as possible;
- developing guidelines to support the review of medications for patients on multiple treatments;

- standardising the assessment tools that will be used in Lincolnshire; and
- reviewing the service provision, systems and processes to support patients who are approaching the end of their life. The aim of this programme of work will be to map the current arrangements in order to reduce duplication and additional administrative processes that can lead to delays in patients receiving the care they need.

3. Introduction of Primary Care Networks

One of the key initiatives of the NHS long term plan is the development of Primary Care Networks. (Appendix A).

Primary Care Networks (PCNs) will create the framework to facilitate greater integration and joint working both across General Practice and with other agencies. Across Lincolnshire there are 13 PCNs. A map showing the boundaries of these is currently in development.

A Clinical Director has been appointed from the practices that are part of the PCN. In some instances this role is shared by two people.

PCNs across Lincolnshire are at different places in their development. Over the next few months the key priorities for the PCNs are:

- Introducing new roles within the PCN :

    - **Clinical Pharmacists:** highly trained health professionals who are specialists in medicines. If you have a long-term condition such as asthma or diabetes, the clinical pharmacist can talk to you about the medicines you are taking to make sure they are working for you.
    - **First Contact Physiotherapists:** are advanced practitioners with extensive expertise in the clinical assessment, diagnosis and management of musculoskeletal (MSK) conditions. They can also refer patients for a course of physiotherapy treatment, order investigations or make referrals into secondary care services,
    - **Social Prescribers:** supporting patients with one or more long-term conditions, who need support with their mental health, who are lonely or isolated, or who have complex social needs which affect their wellbeing. They spend time with patients, focusing on ‘what matters to me’ and taking a holistic approach to people’s health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.

- Preparing for the five new service specifications that will become operational from April 2020 :

    - Medicine reviews
    - Enhanced health in care homes
    - Anticipatory care
    - Personalised care
    - Supporting early cancer diagnosis

4. Use of Technology

Some of the key concerns highlighted as part of the *Healthy Conversation* were in relation to access to GP appointments and the difficulties of travel in rural communities. A recent event celebrated the progress in developing the digital platforms to support health and care across all sectors and throughout Lincolnshire.

One option is to add digital appointments in addition to the traditional face to face appointments provided by GP. By using this approach; people can be seen by a doctor via their smart-phone, tablet or computer.

The use of technology to support General Practice is currently being piloted in 8 practices across Lincolnshire. The use of technology may be described as an e-consultation or by the name of the produce that is being used, for example *Ask My GP* or *Q Doctor*.

E-consultations are also being used by the Clinical Assessment Service as part of the wider development of the counties integrated urgent care service provision.

Our plan is that, by April 2020, 75% of practices will be using this technology and by April 2021 all our GPs will be using e-consultation to support improved access.

The feedback both from patients and clinicians is very positive and has highlighted the following.

- More choice and flexibility when you need it
- The right clinician, first time
- Greater convenience when you need a doctor's advice
- Save unnecessary journeys to your GP practice
- A highly skilled medical team who can provide innovative care via an effective and proven digital consultation service.

5. Specialist Community Services

Alongside the development of existing community based services work has begun to reduce the need for patients to attend an acute hospital. Current initiatives include:

- Diabetes: To introduce a single team approach to support the management of patients with diabetes. The aim being that by April 2021 90% of all diabetes care will be delivered in the community.

- Stroke Rehabilitation: To establish a single team approach to support the management of patients who have had a stroke. The single team will support patients to receive access to acute interventions and facilitate discharge within ten days so that the person may continue their rehabilitation in their own homes

- Dermatology spot clinics: The Spot Clinics are face to face triage clinics, delivered in a community setting, for single lesions. They are 2 hour consultant led clinics that will run out of Lincolnshire GP Practices which also offer Community Surgical Scheme, to allow the clinics to develop into one-stop clinics where lesions can be removed following triage by the consultant.

6. Ongoing Development

The Integrated Community Care programme is the key enabler to delivering sustainable modern health care. The core elements of the programme are the development of Neighbourhoods and PCNs. This work has begun as has the review of current service models these two transformation programmes will support the development of arrangements to enable us to realise the ambitions of both the Lincolnshire and NHS Long Term plans.

At the heart of the Integrated Community Care programme is the ambition to build services that will improve the healthy life expectancy of people living in local communities. In the coming months alongside the development of PCNs, Neighbourhood working and refresh of service models we will increasingly be exploring how technology can help us to enhance local service provision and give us access to data that will enable clinicians to better identify patients who would benefit from proactive interventions.

Underpinning the Integrated Community Care programme is the need to change the relationship between local residents and the NHS. The aim is to ensure that patients, carers and professionals worked together to develop care and treatment plans that are right for the individual. We will need support from local people to help us design services that will achieve this goal.

Whilst the development of Integrated Community Care is consistent with the feedback from our *Healthy Conversation* events, and national best practice we understand that new ways of working are often frightening and confusing. We are keen to support residents and professionals as we develop the Integrated Community Care portfolio and would welcome the opportunity to provide regular updates to the Health Scrutiny Committee.

7. Consultation

This is not a direct consultation item, but the Committee may wish to submit comments to the Lincolnshire Sustainability and Transformation Partnership as part of *Healthy Conversation 2019* engagement exercise.

8. Conclusion

The Committee is requested to note and consider the information presented on Integrated Community Care, and to decide whether any feedback should be submitted to the Lincolnshire Sustainability and Transformation Partnership, as part of the *Healthy Conversation 2019* engagement exercise.

9. Appendices – These are listed below and attached to the report

Appendix A	Briefing: Understanding Primary Care Networks – Context, Benefits and Risks *(The Health Foundation – July 2019)*

10. Background Papers – No background papers within the meaning of Part VA of the Local Government Act 1972 were used in the preparation of this report.

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