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:	**18 April 2018**
Subject:	**Integrated Neighbourhood Working**

Summary:

To update the Health Scrutiny Committee for Lincolnshire on the progress that has been made in the collaborative design and implementation of Integrated Neighbourhood Working – identifying the key successes and issues and the links to the GP Forward View programme.

Integrated Neighbourhood Working is one of the four priorities in the Lincolnshire Sustainability and Transformation Partnership, which the Committee decided in October 2017 to consider in greater detail.

Actions Required:

To provide feedback on the progress on the delivery of the Lincolnshire Integrated Neighbourhood Working programme.

1. Background

1.1 National Context

The Five Year Forward View (FYFV) published by the Department of Health in 2014 identified a number of interventions to support the sustainability and transformation of the NHS.

Specifically relevant to the Integrated Neighbourhood Working programme is the focus on *Integrated Health and Care services - Helping frail and older people stay*

healthy and independent, avoiding hospital stays where possible and the principles that are identified to support this way of working;

- Increasingly we need to manage across systems – networks of care- not just organisations. Out of Hospital care needs to become a much larger part of what the NHS does
- Services need to be integrated around the individual not a GP or a particular organisation.
- Integrated care locally through service improvement and outcomes
- Co-production with people, voluntary groups, staff and other key stakeholders
- Recognition that 'one size does not fit all' – localisation and understanding population.
- Evolution not 'big bang' – focus on continuous improvement, adaptive change and learning.
- Back energy and leadership where we find it

5 Year Forward View Department of Health 2014

The Primary Care Home Model, which includes a focus on health population management has been developed by the National Association of Primary Care (NAPC) and is seen as a key component part of the GP Five Year Forward View. (GP FYFV)

There are four key characteristics that make up a Primary Care Home:

1. An integrated workforce with a strong focus on collaboration and partnership working – spanning Primary, Secondary and community services (physical and mental health, social care, independent providers & third sector).
2. A combined focus on personalisation of care with improvements in population health outcomes – with a focus on prevention, self-care and self-management.
3. Aligned clinical and financial drivers with shared risks and rewards.
4. Provision of care to a defined, registered population of between 30,000 – 50,000.

Both these national drivers along with the GP FYFV have helped to shape the Integrated Neighbourhood Working programme in Lincolnshire over the last 18 months.

1.2 Lincolnshire Context

In 2013 Neighbourhood Teams was one of the key priorities for the Lincolnshire Health and Care (LHaC) programme to develop integrated services that supported individuals to remain at home or 'closer; to home and avoid unnecessary hospital attendances or admissions.

The programme led to some excellent multi professional working between the main statutory services with Multi-Disciplinary Team meetings being held regularly in parts of the County to identify and support individuals with the most complex or complicated situations.

However the challenge for Lincolnshire and the rest of the Country is not necessarily the individuals who have the most complex or complicated level of need because as a system we know who they are, but we do not coordinate or join up their care very well and this must improve as part of the work programme.

True transformational change will only start to happen when as a community, we start to tackle population health needs as a local system, as a continuum of advice, guidance, coordination, support and care through prevention, self-care, self-management, peer support, case management and or complex case management.

As LHaC became the STP for Lincolnshire it was agreed that a new approach was needed to help drive through real transformational change, learning from national programmes such as the Vanguard sites and the Primary Care Home (PCH)model, Neighbourhood Teams needed to expand to deliver Integrated Neighbourhood Working based on whole populations not just on those individuals with the highest level of need.

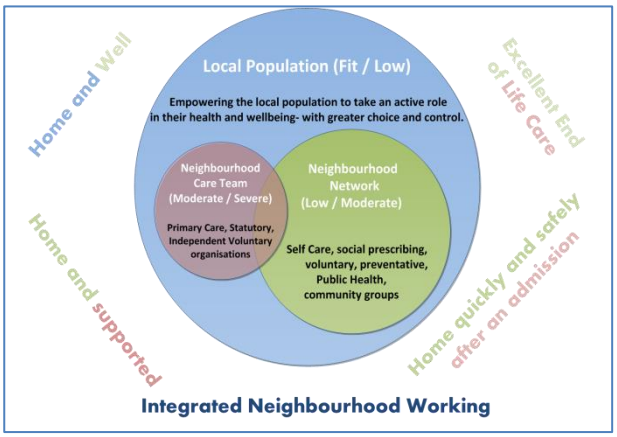
Integrated Neighbourhood Working - 2017 onwards

This large programme of work is the 'flagship' development for the STP. It is a complex, multi stranded development, which is aimed at transforming the way in which people are identified and supported with their local communities, utilising all of the community capacity within each Neighbourhood area.

The vision for Integrated Neighbourhood Working is simple;

'Empowering the local population to take an active role in their health and wellbeing, with greater control and choice.'

Taking the learning from the national programmes it has been agreed to adopt the four key characteristics of the Primary Care Home model for Lincolnshire – with an agreement that the population size would increase to 75,000 and to connect the clear interdependencies between the Integrated Neighbourhood Working and the Primary Care Programmes.



This graphic illustrates the shift to whole population health management in the Integrated Neighbourhood Working programme and the interdependencies between the core team, the network and the wider health determinants.

2. Better Care Funding

A System agreement was reached in the summer 2017 that £4m of the Better Care Funding over the next 2 years should be invested in Integrated Neighbourhood Working to help to increase the scale, pace, leadership and clinical oversight into the programme of work.

CCGs and Primary Care were asked to develop plans with key partners and stakeholders for a decision to be made about the next localities to be supported.

Three key roles were identified as a must have for each agreed neighbourhood;

- Neighbourhood Team Lead
- GP Lead
- Project Manager

2.1 Phase 1 Sites (June 17 onwards)

a. Gainsborough – population 45k – Went live in June 2017
b. Lincoln South – population 55k, phase 1 – Care Homes went live December 2017
c. Stamford – population 30k– Joined the National PCH model in Nov 2016
d. Boston – population 75k
e. South West - Grantham town and rural – Population 77k
f. South - Spalding – Population 78k

2.2 Phase 2 Sites (April 18 onwards)

a. Lincoln North
b. Lincoln City South
c. East Lindsey North – Louth and surrounding villages
d. East Lindsey Middle – Skegness, Horncastle, Woodhall Spa
e. South West – Spalding
f. South – Holbeach, Market Deeping, Little Sutton

3. Integrated Neighbourhood Working Programme

3.1 Leadership, the 'Core' Team and the Network.

Neighbourhood Team Lead

- Responsible for leading the development and implementation of Integrated Neighbourhood Working.
- Cultural and behavioural role model
- Organisationally agnostic
- Mentor / support to the GP Lead
- Developing the team / network through coaching and mentoring
- Accountable to the local Steering Group for the performance of the team and network against the agreed outcomes and the governance framework.
- Updates to partner organisations on performance and progress.

GP Lead

- Clinical lead and advisory lead for the local Neighbourhood.
- GP expert / advisor on the clinical redesign pathways
- Advocate and peer champion for Integrated Neighbourhood Working.
- Ambassador for 'new ways of working'.
- Unblocking and challenging current practice with peers and wider system.
- Recognising and making system connections
- Mentor / support to the NHT Lead

Core Team – (Example of Gainsborough's Members)

- Voluntary Sector infrastructure
- Health Providers (Lincolnshire Community Health Services NHS Trust and Lincolnshire Partnership NHS Foundation Trust)
- Lincolnshire County Council Adult Care
- Carers First
- Alzheimer's Society
- Fire and Rescue
- West Lindsey District Council – Housing
- The Managed Care Network
- Wellbeing Service

The Network - (Example of Gainsborough Network)

- Job Centre Plus
- Domiciliary Care provider
- Care Homes
- Frailty Unit at Lincoln County
- Third sector and voluntary sector

3.2 The Importance of Organisational Development

One of the most critical elements to the success of Integrated Neighbourhood working is the recognition of the level of cultural and behavioural change that is required by the workforce to be able to have a 'different conversation' between themselves, users of services and the public.

The focus of the conversation is 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.

With this in mind we have been developing a comprehensive Organisational Development programme with funding support from the Integrated Personal Commissioning Programme and Lincolnshire Workforce Advisory Board and has personalisation at the heart of it – this has been and is being made available to all sites.

The programme incorporates following elements;

- Diagnostics, team building and individual OD support
- Service Improvement
- Personalised Care and Support Planning working with Helen Sanderson and Associates
- Integrated Assessment – developing trust and understanding roles and responsibilities.
- Enhanced Make Every Contact Count training, to include personalisation and care navigation competencies.

3.3 The Operating Framework (see Appendix A)

The 5 key functions of the operating framework are now clearly identified and defined.

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.

3.4 The System Metrics and Integrated Neighbourhood Working Outcomes

The key system metrics are clear for the Out of Hospital programmes of work of which Integrated Neighbourhood Working is one; the others are Urgent Care (Clinical Assessment Service, Urgent Care Streaming, Out of Hours services) and Transitional Care

1. A reduction in avoidable non elective admissions
2. A reduction in A&E attendances
3. A reduction in Delayed Transfers of Care
4. A reduction in Readmissions within 30 days

The trajectory for the Out of Hospital portfolio is based on the original calculations of a 13.9% shift over 5 years from secondary care to community including a 2.5% increase / year in activity.

To be able to demonstrate the impact and outcomes of the Integrated Neighbourhood Working programme on people, workforce and ultimately the system, The Integrated Neighbourhood Working Outcome framework is focusing on 2 key areas;

1. People are better able to manage their health and lifestyle (Care Navigation / social prescribing)
2. People are supported to have a different conversation to develop a personalised care and support plan with individual outcomes and ways of delivery.

4. Progress to date

4.1 Neighbourhood Team Lead – Assessment Centre

A two day assessment centre has just been completed by a number of candidates – supported by over 25 partner and stakeholder organisations including GPs, CCGs, Lincolnshire Care Association, Lincolnshire County Council, Healthwatch, patient expert and health providers.

The focus of the recruitment process was to really understand the individual's behaviours and values as these are seen has critical to the success of the role.

6 NHT Lead posts have been appointed to (1 interim) and have been operational from 1 February 2018.

There are 4 posts outstanding, with a second assessment centre is being held on the 19th and 20th April.

4.2 GP Lead

Each Neighbourhood has identified a GP lead to support their local programme.

4.3 Prevention, Care Navigation and Self Care

These are critical projects for the Primary Care and Integrated Neighbourhood Working programmes, as the focus is helping the System, workforce and the public to make the shift from a medicalised approach to health and wellbeing to an individual strength and asset based approach.

This is being delivered through collaboration between Public Health, the Voluntary sector, Integrated Neighbourhood Working and the Primary Care programmes.

There are four key work streams;

a. Advice and Guidance – working with Lincolnshire County Council in the procurement of a Library of Information for Lincolnshire – go live date 1 August 2018.
b. Health Literacy – training being offered and taken up by a wide range of partner organisations.
c. Care Navigation – Enabling the individual to access the right level of support, at the right time, first time, to help manage a wide range of needs. Working closely with the Voluntary sector infrastructure organisations and the newly recommissioned Wellbeing Service in developing a sustainable model for Lincolnshire. The Make Every Contact Count (MECC) training has been developed to include the bronze competency level of care navigation framework in the GP FYFV and Lincolnshire's Home First principles. This is being offered to all emerging sites.
d. Social Prescribing – is a means of enabling primary care services to refer individuals with social, emotional or practical needs to a range of local, non-clinical services, when a medical intervention or just treating clinical origins is not getting to the root of the individual's problem. The work programme is part of the Care Navigation development.

4.4 Gainsborough

Gainsborough has just reached completed its quarterly review the following outcomes:

a. Introduced personalised care and support planning with the core team
b. Organised and led 4 really well attended stakeholder engagement events which has led to an increase in members of the core team
c. Invested in the local Voluntary Centre Services to develop a referral route into the social prescribing offer from the third sector
d. 150 individuals in a number of settings have been supported with a variety of solutions from advice and guidance, social prescribing, care navigation, case management and advanced care planning.
e. Colocation offer at John Coupland Hospital for the Core team and the wider network.

Lessons Learnt So Far

a. Key enablers need to actively participate in the programme- IM&T / Estates
b. Communication, communication, communication
c. GP engagement is crucial
d. Supporting 3rd sector infrastructure and sustainability.
e. Time is required to develop relationships
f. Contract and commissioning management

4.5 Lincoln South

Lincoln South has just started phase 1 of their programme, with an emphasis on the 17 Care Homes in their Neighbourhood. The Core Team are working with the staff to identify the residents level of frailty and then put in place the appropriate care and support planning, including advanced care plans. They are also supporting the Homes with any identified training needs, advice or guidance. The Core Team are working very closely with the GP Federation who have started to see a reduction in GP call outs due to the responsiveness and skill set of the team.

4.6 Grantham and Spalding

The two GP Federations in the South of the County are working together to implement the GP FYFV and Integrated Neighbourhood Working – recognising that some of the component parts of the operating framework can be done once over a larger population such as the approach to Care Navigation and the voluntary sector infrastructure behind access into local social prescribing offers.

Grantham and Spalding have been identified as their initial sites but they are looking to start to implement the approach much wider over the next 6 months, with a more hub and spoke model, which will include 1 NHT lead each for South and South West with an appropriate infrastructure in place to support smaller Neighbourhoods. The model includes a complex case manager role as a key link between GP practices and the 'core' team and the wider network. They have a clear remit around identifying and proactively working with the older population.

4.7 Boston

Boston have identified their core team and are setting up a Boston Steering Group. They have agreed to focus on Delayed Transfers of Care initially with an agreement that as the pathway is developed, that individuals who are discharged will receive responsive and proactive support around personalised acre and support planning to help reduce the possibility of readmission.

The planning group have shown a really keen interest in Care Navigation and Social Prescribing and the impact this could have on Primary Care workload. They are currently training up the Primary Care workforce and offering this out to the wider community and are in discussion with the Voluntary sector infrastructure about delivering a similar model to Gainsborough.

4.8 Stamford

Stamford are part of the Primary Care Home model and have developed a very clear vision and strategy for the area, they have had a core team operating for some time now with a focus on individuals with a high level of need and complexity but recognise the requirement for extending their scope. The team are starting to collocate in Stamford Hospital.

Stamford are focusing on population identification and segmentation – working with National Association Primary Care, Lincolnshire Public Health and the STP.

The team in Stamford have excellent GP leadership and engagement, plus real support from Peterborough Hospital in the programme of work.

4.9 Next Steps

Phase 1 sites have plans in place and have identified their next steps to ensure that by the 1st April 2018 they **all** will be able to start to demonstrate Integrated Neighbourhood working in their area. This will be through a more targeted approach than was originally used in the first site.

Phase 2 sites will start to implement planning and delivery of Integrated Neighbourhood Working from 1st April 2018.

The progress of each Neighbourhood is being managed through the Countywide Learning and Development forum and each area is accountable to the Integrated Neighbourhood Working Strategic group.

Recruitment to the remaining 5 NHT Lead posts and to start to build up the work programme in the areas which have not been involved so far. This will mainly be in the east of the County.

Work is ongoing on the outcome metrics and framework and how this could be used to shape a different approach to commissioning and contracting for 'place based' care.

Lincolnshire has also been recognised by the Rt. Hon. Jeremy Hunt, the Secretary of State for Health and Social Care, in a speech he made on the 20 March 2018 as one of 3 pilot areas over the next two year that will ensure '*that every single person accessing adult social care will be given a joint health and social care assessment and - critically - a joint health and care and support plan, where needed' and will be 'offered an integrated health and care personal budget.'*

Being able to deliver the above promise will need to happen through the Integrated Neighbourhood Working programme fortunately we are best placed and geared up to start to deliver that new way of working.

4.10 Links to the GP Five Year Forward View

Out of the 10 high impact actions – Integrated Neighbourhood Working will be integral or contribute to the success of the following

a. Active Sign Posting
b. Develop the practice team
c. Productive work flows
d. Partnership working
e. Social prescribing
f. Self-care support

5. Consultation

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide health overview and scrutiny committees with a specific statutory role in relation to consultations on substantial variations or developments in NHS services, where there is an obligation on the responsible commissioner to consult.

This report is not a statutory consultation item within the scope of the 2013 Regulations. This is because the direct service impacts on patients, for example in terms of accessibility of services, are not substantial. However, the Health Scrutiny Committee has an opportunity to provide feedback on the progress of Integrated Neighbourhood Working as part of its consideration of this report.

6. Conclusion

The report outlines the background to the evolution of the Integrated Neighbourhood Working programme and its links to both national and local priorities. It describes the need for OD support and the role of leaders, the operating framework, and the progress being made in the emerging localities.

It is presented to inform the Health Scrutiny Committee of current progress in delivering Integrated Neighbourhood Working

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

Appendix A	The Neighbourhood House

8. Background Papers

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

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