Lincolnshire COUNTY COUNCIL
Working for a better future

Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 April 2019**
Subject:	**Integrated Community Care Portfolio**

Summary:

The Lincolnshire health and care community have all committed to working in partnership to realise the ambition that 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.

Neighbourhood working is the foundation for making this happen. Across Lincolnshire we have identified twelve neighbourhoods. These neighbourhoods are used to define the area where colleagues from all agencies, statutory and voluntary, will come together to support the needs of the local population. We used the term Neighbourhood team to describe how professionals work together to support the needs of an individual. It is a way of working that is similar to the 'team around the child' framework, that is there is not a single team rather that teams of professionals come together to provide co-ordinated, person centred care to an adult with complex needs.

Whilst all twelve neighbourhoods are supported by a neighbourhood lead, the maturity of their service delivery arrangements varies as the leads came into post at different times.

From the work that has been completed to date there are great examples and good evidence that an integrated approach to care delivery not only improves patient experience and outcomes but supports best use of resource.

Our current focus is on pulling together the learning from the different areas in order to develop an understanding of the core elements that support the effective delivery of local services.

Alongside the development of Neighbourhood working colleagues there are other programmes of work that will support the shift of care and treatment from hospital settings into the community.

This report updates the Adult and Community Wellbeing Scrutiny Committee on the implementation of the Integrated Community Care portfolio and the progress that has been made in Neighbourhood Working; the Integrated Accelerator programme; and the KPMG and Optum commissioned work.

Actions Required:

To consider and comment on the information presented on the Lincolnshire Sustainability and Transformation Partnership's 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. The recently published NHS Long Term Plan, framework for delivering universal personalised care and the new GP contract all describe:

- The changing needs of the population are putting pressure on the health and social care system in England.
- Ageing population – between 2017 and 2017 there will be 2 million more people aged over 75.
- Chronic conditions – increased focus on helping people manage long term conditions.
- New Treatments – steady expansion of new treatments gives rise to demand for an increasing range of services.

In addition they all reference the fact that:

- Service provision is fragmented in multiple different types of organisations.
- Too often these services do not communicate effectively with each other.
- The totality of patients' needs is not always understood by those serving them.
- Care is not always delivered in a person centred way.

Nationally and across Lincolnshire it is understood that 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 health and social care will work together to develop integrated service delivery that optimises the skills and expertise of key partners to support improved outcomes and best value.

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.

Currently 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.

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.

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.

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.

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.

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 are, 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.

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 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 are 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, social 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.*

Across Lincolnshire there are twelve Neighbourhood areas support by ten Neighbourhood leads. A map of these is attached at Appendix 1.

3.1 The Operating Framework for Neighbourhood Working

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 Primary Care Networks

The NHS Long Term Plan introduces Primary Care networks as the foundation for Integrated care Systems

The core principles of Primary Care Networks are consistent with those of Neighbourhood working. A National defintion of Primary Care Networks have been developed and funding has been made available to facilitate the develop of local structures that will enable the delivery of the intended outcome.

- Primary care networks enable the provision of **proactive, accessible, co-ordinated and more integrated primary and community care** improving outcomes for patients.

- They are likely to be formed around natural communities based on GP registered lists, often serving populations of around 30,000 to 50,000.

- Networks will be small enough to still provide the personal care valued by both patients and GPs but large enough to have impact through deeper **collaboration between practices and others in the local health (community and primary care) and social care system.**

- They will provide a platform for providers of care being sustainable into the longer term.

It is anticipated that across Lincolnshire there will be more PCNs than Neighbourhoods but that PCNs will be developed so that they align with the current Neighbourhood areas and support local communities.

3.3 Neighbourhood Working Progress

Outlined below are some case studies describing how neighbourhood working has supported individuals.

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 provided a much better experience for the individual concerned and meant that the ambulance that would have been called was available for someone else and that there was one less person attending A & E.

Introduction of Primary Care Coordination.

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 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

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.

The following key pieces of work have been progressed and compliment neighbourhood working :

Library of Information and Services – has been developed in partnership with Lincolnshire County Council 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.

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.

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.

3.4 Information and Technology

IM&T and the use of digital technology to support local care delivery is vitally important to delivery of integrated care and treament.

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.

- There are currently 1,300 active users on the Lincolnshire Care portal
- Providers with access enabled are United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and 25 GP Practices across Lincolnshire
- ULHT information available on the portal includes the patient administration system, radiology reports, lab results, estimated dates of deliveries and outpatient letters.
- Also available from the spine is the patient's summary care record, patient demographic service and child protection information sharing
- Next phases of roll out are: Lincolnshire County Council Adult Social Care Q1 in 2019/20, ULHT Maternity Services Q1 2019/20, East Midlands Ambulance Service Q3 2019/20
- Timescales for roll out to St Barnabas, care homes and other secondary care NHS trusts are yet to be identified
- Feedback from portal users has been very positive, particularly in relation to ULHT - to understand progress of referrals, the patient journey in secondary care, radiology results and electronic discharge summary.

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.

4. Integrated Accelerator Programme

On 20 March 2018, the Secretary of State for Health and Social Care announced three pilots integrating health and social care assessments, to take place over two years in Gloucestershire, Nottinghamshire and Lincolnshire.

4.1 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.

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

NHS England is 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.

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

5. 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.

A Case for change which will bring together the feedback and outcomes of the data modelling will be published shortly. For the first time this will bring together the whole picture for the Lincolnshire system.

The case for change will create the opportunity for the Lincolnshire system to come together to support co-design and development of the delivery plan.

7. Conclusion

This report outlines the background to the evolution of the Integrated Community Care portfolio, its links to both national and local priorities and the outline with regards future building a shared strategic delivery plan.

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

8. Consultation

a) Have risks and Impact analysis been carried out?

b) Risks and Impact and Analysis

9. Background Papers

The following background papers were used in the preparation of this report: -

Document title	Where the document can be viewed
NHS Long Term Plan 2019	https://www.england.nhs.uk/long-term-plan/
Universal Personalised 2019	https://www.england.nhs.uk/personalisedcare/
GP Forward View 2016	https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
GP contract 2019	https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

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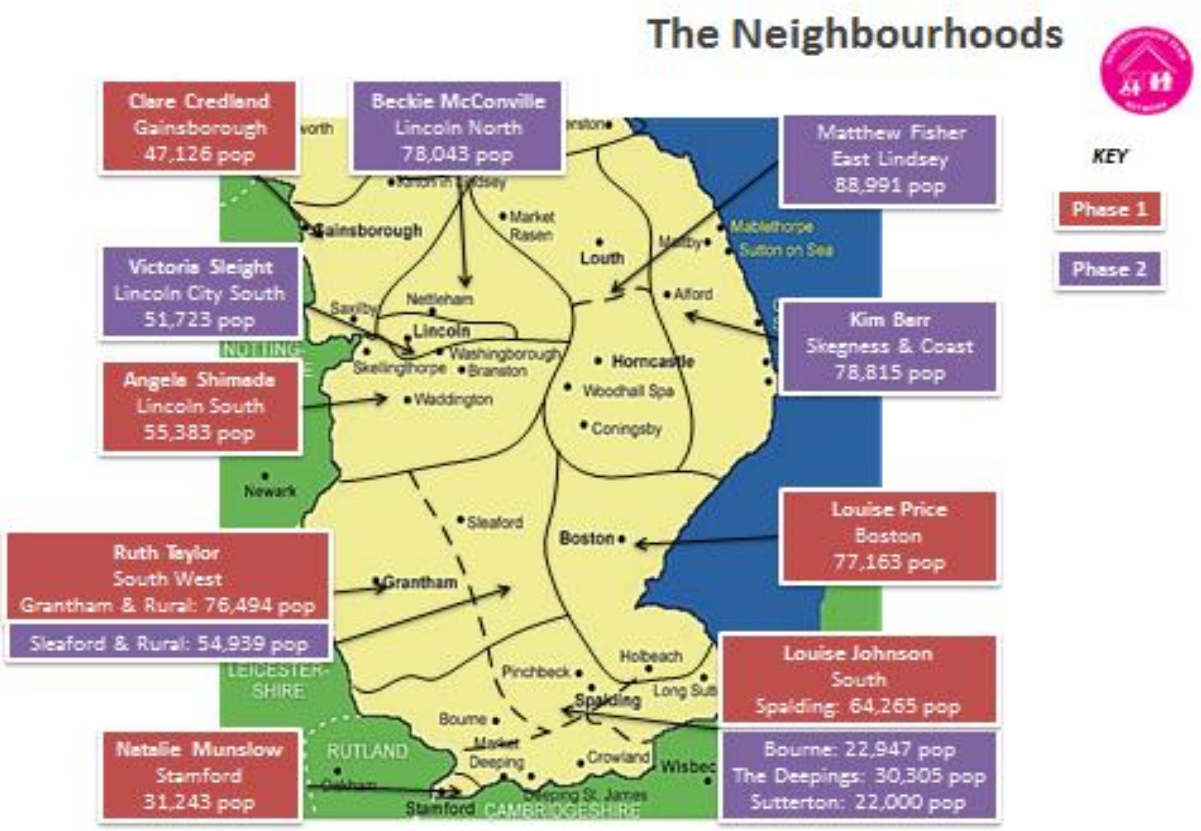
The Neighbourhoods
Clare Credland
Gainsborough
47,126 pop
Beckie McConville
Lincoln North
78,043 pop
Matthew Fisher
East Lindsey
88,991 pop
KEY
Phase 1
Phase 2
Victoria Sleight
Lincoln City South
51,723 pop
Kim Barr
Skegness & Coast
78,815 pop
Angela Shimada
Lincoln South
55,383 pop
Louise Price
Boston
77,163 pop
Ruth Taylor
South West
Grantham & Rural: 76,494 pop
Sleaford & Rural: 54,939 pop
Louise Johnson
South
Spalding: 64,265 pop
Netelie Munslow
Stamford
31,243 pop
Bourne: 22,947 pop
The Deepings: 30,305 pop
Sutterton: 22,000 pop
Gainsborough
Market Rasen
Louth
Mablethorpe
Sutton on Sea
Alford
Nettleham
Lincoln
Skellingthorpe
Washingborough
Branston
Horncastle
Woodhall Spa
Coningsby
Waddington
Newark
Sleaford
Boston
Grantham
Holbeach
Pinchbeck
Spalding
Bourne
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