Provider Collaboration Review

Lincolnshire STP

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Provider Collaboration Reviews

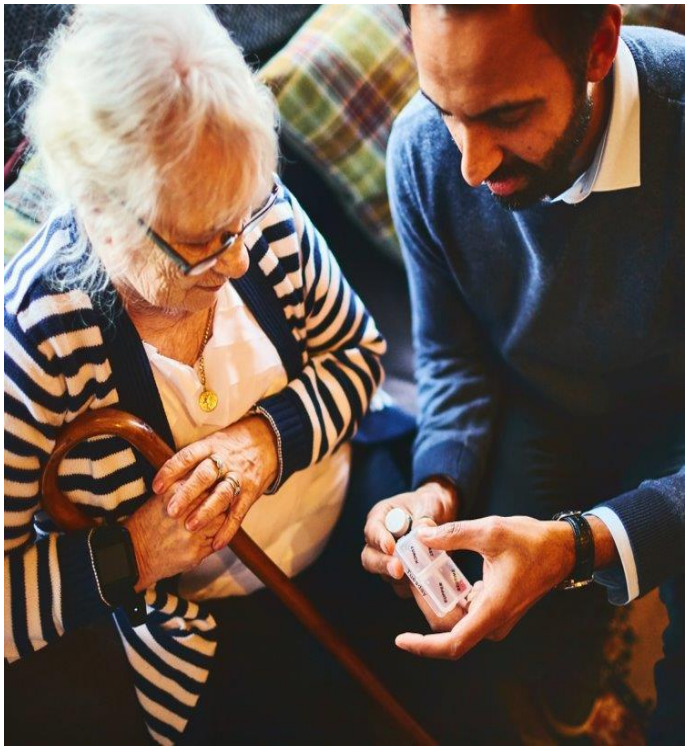
How have providers worked collaboratively in a system in response to the COVID-19 pandemic?

The Scope

- The journey for people over the age of 65 with/without COVID-19 across health and social care providers, including the independent sector, local authorities and NHS providers.

- The objective is to support providers across systems by sharing learning on the COVID 19 period and on how providers are preparing to re-establish services and pathways in local areas.

The outputs



- Feedback for each local System
- Insight report – September
- Final report – Chapter in state of care report October 2020.

Key Lines of Enquiry

- How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?
- Was there a shared plan and system wide governance and leadership during the COVID -19 period?
- Was there a plan for ensuring the safety of staff, and sufficient health and care skills across the health and care interface during the COVID -19 period?
- What impact have digital solutions and technology had on providers and services during the COVID -19 period?

How we carried out this Review

- We carried out this review at pace during the week of 27 July 2020.
- We spoke with a range of health and social care staff, senior managers and executive leaders.
- We carried out 26 interviews with groups of people such as Primary Care Networks, providers of adult social care and providers of NHS funded care.
- This review focused on the Local Authority area of Lincolnshire, the geographical footprint of which, is consistent with the Lincolnshire sustainability and transformation partnership (STP).
- The review did not assess the role that commissioning plays within the system as we do not have the legal powers to comment on the commissioning of services.

Lincolnshire in Context

The following organisations are part of Lincolnshire STP:

- NHS Lincolnshire CCG
- Lincolnshire County Council
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust
- LinCA
- Lincolnshire VET

Lincolnshire in Context

- Lincolnshire STP has many areas with a medium or high proportion of older people. This is the case for most of the system, with the exception of Lincoln which has some of the lowest proportions of people aged over 65.
- There is big variation in the deprivation of areas across Lincolnshire STP. There are areas of very high deprivation on the coastline around Skegness and further north towards North East Lincolnshire LA. The further west in the STP the lower the levels of deprivation with the exception of small pockets of high deprivation in Gainsborough, Lincoln, Grantham and Sleaford.
- There are low numbers of BAME populations across the whole of the system.
- Lincolnshire's age standardised rate of Covid 19 diagnosis was less than half the national rate. The area has the 12th lowest rate of all the local authorities in England.
- The number of lab confirmed cases in Lincolnshire peaked during week ending 11 April at 176.
- Lincolnshire had a fairly late peak compared to other areas, in Weeks 21 and 22 (late May).

Key Findings – How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?

What we heard went well:

- **Joint working across the STP** was led and coordinated through a local resilience forum (LRF) and comprehensive cell structure, which included representation from a broad range of stakeholders.
- The Lincolnshire system made a joint **decision to only discharge patients to care homes once a COVID-19 status was known.** System leaders believed this significantly contributed to COVID mortality being lower in Lincolnshire than the England average.
- Lincolnshire had a large problem with PPE during early April. A 'PPE cell' quickly resolved this, enabling a single approach and ensuring PPE supplies could be accessed by all providers. **Mutual aid across the system also ensured PPE availability** where it was needed most.
- The **Lincolnshire Care** Association (LinCA) was an active part of the STP and played a vital role during the pandemic by representing and supporting providers within the independent and voluntary sector.
- There was **good oversight of the needs of the population** with recognition of health inequalities in those areas of deprivation across Lincolnshire STP. **Partnership working** across the health and social care footprint connected residents with local support networks and mechanisms.

Key Findings – How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?

- **There was a well-established third/voluntary sector, providing support services.** The wellbeing service identified those people who were vulnerable. Over three months, 17,000 people who were shielding were contacted. The wellbeing service also coordinated the volunteer service, these efforts resulted in; 1000 requests dealt with over the phone, 17000 contacts made, dealt with 936 requests for support, and more than 300 referrals to the British Red cross for urgent support for example, food parcels.
- **Urgent dental centres worked closely with community dental services** to ensure where someone was over 65 and required a site visit they were directed to the right service and seen at the start or end of the day to reduce contact as much as possible.
- **Support during COVID-19 was focussed on two groups** within the population; clinically vulnerable (shielding) and vulnerable. Through a process of RAG rating, the system were able to identify the most vulnerable from these two groups and prioritise care accordingly.
- **Pathways and services were redesigned** to manage people with COVID and non-COVID illness. These included for example, implementation of blue (COVID) and green (non-COVID) sites across the acute and primary care sectors.

Key Findings – How have providers collaborated to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?

- **There was an overwhelming commitment across the system to reduce the burden on urgent and emergency services within the acute trust.** The Clinical Assessment Service (CAS) was instrumental in preventing hospital admissions and/or arranging additional home care support, with 70% of NHS111 calls transferred to the CAS. In addition, the care home sector were given direct access to CAS.
- **Advice and guidance was available 24/7 for those staff caring for people who were palliative and/or end of life.** In addition, seven day working, integrated pathways for COVID-19 patients at end of life and improved demand monitoring enabled fast-track access to domiciliary care and other care networks.
- **Medicines arrangements were in place to support vulnerable people**. For example, close working with primary care colleagues to help identify an accurate list of patients who needed to shield and remote prescribing clinics which helped avoid the need for patients to access their GPs for certain medicines during the pandemic.
- **A weekly survey** was carried out for 10 weeks during the COVID-19 lockdown period to understand how people had accessed health and social care services during this time.

Key Findings – Was there a shared plan and system wide governance and leadership during the COVID -19 period?

What we heard went well:

- In the early phase there was a **rapid development of command and control** and strategic cell structure with the focus very much on finding solutions at pace.
- There was **daily situation reporting** (SITREP) on staff and patient incidents and disease prevalence. In addition, an Early Warning Dashboard monitored a range of COVID-19 indicators as potential early warning triggers, including for example, NHS Pathways triages through NHS 111 and 111 online, staff sickness, patients admitted or newly diagnosed with COVID-19 to United Lincolnshire Hospitals NHS Trust (ULHT), confirmed COVID-19 patients occupying beds at ULHT hospitals and oversight of PPE stock levels and availability.
- Across the system **there was good support from local dental councils (LDC) and networks (LDN)** to set up urgent dental centres. The geographical location of an urgent dental centre was taken in to account and factors such as age, deprivation and rurality were considered. The locations chosen prevented as much travel as possible. One site was established specifically for shielding, vulnerable and people over 65.
- **Providers were involved in systemwide and national discussions about stocks of medicines**, so that they would be able to help with supplies both locally and to other systems if it were required.

Key Findings – Was there a shared plan and system wide governance and leadership during the COVID -19 period?

- All cells had **empowered representation** from every organisation. Agreements and learning from cells was escalated up and down through the command structure to ensure rapid learning at the height of the crisis. A revised strategic cell structure incorporating the new ways of system working was to continue as the system moved into the recovery and restoration phase.
- **Monthly slide decks on learning** was compiled and presented to the board of directors, governors, system CEOs, regional alliance and health scrutiny committee for Lincolnshire.
- **Quality Impact Assessments** were consistently used across services where changes to service delivery had taken place and to inform services restarting.
- The system had taken the lessons of the more **flexible, agile and responsive** working during COVID and was redesigning its governance structures to emulate this good practice going forward. For example, the use of digital technology, home working, flexible working arrangements and quick decision making.
- As services were to reopen as part of the recovery and restoration phase, the system encouraged people to access help and advice needed in a simple, safe and convenient way in order to provide an alternative to accessing urgent and emergency services. The **'talk before you walk'** initiative offered four different ways for the public to access medical services they required.

Key Findings – Was there a strategy for ensuring the safety of staff and sufficient health and care skills across the health and care interface?

What we heard went well:

- **Oversight of staffing across health and social care** was managed through a 'workforce' cell with outputs for example, sickness absence, shielding, testing and staff relocation discussed at a daily chief executive call.
- Wherever possible, staff were redeployed to enable them to continue working despite shielding. For example, staff were able to provide virtual clinical triage services.
- Staff had access to a 24/7 **mental health hotline** to receive support and advice for the pressures they had faced.
- **Staff testing was described as an "easy process"** and staff were able to book their own tests.
- **Support across adult social care through weekly registered manager meetings** gave staff the opportunity to share best practice and any concerns. Outputs from these meetings enabled information to be shared with commissioners.
- **Additional training for staff across the STP** was provided and was instrumental in ensuring for example, where staff had been redeployed they had the necessary skills to equip them for their alternative role.

Key Findings – Was there a strategy for ensuring the safety of staff and sufficient health and care skills across the health and care interface?

- **Risk assessments were undertaken in response to specific staff groups**. For example, BAME staff, pregnant women and people with long term health conditions.
- Providers acknowledged the lack of national guidance around the return to work of shielded staff. At the time of our review discussions remained ongoing with no set strategy for this group of staff.

Key Findings – What impact have digital solutions and technology had on providers and services during the COVID -19 period?

What we heard went well:

- **The digital agenda advanced at pace** with virtual GP and outpatient consultations and advice through the use of electronic applications such as Q health, askmyGP and Project ECHO.
- Video conferencing worked well to **establish local relationships** and ensure any problems could be raised and addressed quickly and learning could be shared across the system. This was also used to provide training to staff in for example, infection prevention and control including donning and doffing of PPE and oral health.
- **Multidisciplinary and multi-agency meetings were facilitated rapidly** through the use of Microsoft TEAMs.
- **Whzan Digital Health technology had been introduced to a number of care homes** during the COVID pandemic with a full roll out to all care homes expected by the end of August 2020. Care homes were supplied with a digital health kit, including blood pressure monitor, pulse oximeter, and a thermometer enabling vulnerable residents to be closely monitored and give staff the reassurance to act on situations quickly if symptoms changed. Findings were shared with other professionals such as paramedics or GPs when needed.

Key Findings – What impact have digital solutions and technology had on providers and services during the COVID -19 period?

- **Wider sharing of access to SystemOne** enabled providers across sectors to view individual patient records and share treatment plans.
- Use of social media and public broadcasting enabled the system to inform the public of critical information. Besides **informing the public** about COVID-19 and where to seek help, they were also able to keep the public updated on any changes to service delivery.
- In appreciation of those **vulnerable people** where access to digital technology was limited and/or areas of deprivation, offices were provided where people could access IT equipment to enable virtual appointments.
- The digital work was considered to be a **great success in mental health**. There was previously a reluctance to move to digital consultations for mental health patients as it was believed that seeing someone in person was part of the therapy, but since COVID-19 this has been well received. In some cases it had helped those with social anxiety, i.e. being able to see someone from the comfort of their own home.

Future Focus

- It was recognised across the system that the volume and frequency of guidance from national government was challenging to manage and adapt to at times.
- Relationships with some third sector organisations, fostered pre-COVID through the STP, had not been used to their advantage during the pandemic.
- There appeared to be more than one part of the system identifying those shielding and vulnerable adults which suggested the system may not have had complete oversight. There were small numbers of individuals who felt they had not been identified as either clinically vulnerable or vulnerable and some providers felt shielding information had not always been shared across the system as a whole.
- A small number of people felt, in the early stages of the pandemic, access to primary medical services (GPs) “seemed like it had shut down”.
- One stakeholder told us they were not aware of a shared strategic approach and did not feel that all services met the needs of the population during the COVID-19 pandemic.
- Some staff were unaware of mobile testing sites.
- In the first 10-week COVID-19 survey many comments revealed patients feeling left in the dark with regards to their non COVID-19 related treatment and appointments.

Integrated Working

"We were in this together"

"LinCA, the voice of social care"

"The care workforce has been excellent and invaluable in their response"

Integrated Working

"Key workers going the extra mile to keep people safe and well"

"Talk before you walk!"

"We all knew what our job was; to protect people from harm and save lives"

Reflections

- Lincolnshire was later than a lot of the country to register diagnoses (both in the community and in care homes). This extra time allowed the system to focus on national messages, monitor activity elsewhere and apply learning to their own system.

- Most people we spoke with commented on the overwhelming support provided across the LRF with regards to mutual aid. We heard many examples where resources and services had been shared. For example, PPE, IT equipment, staff and clinical areas.

- Honorary contracts and MoU enabled staff to move between organisations seamlessly where required.

Reflections

- Restoration of essential NHS non-COVID services brought about a green (COVID-free) site at Grantham Hospital. The conversion of Grantham ED to an UTC afforded the option of having completely green diagnostics and inpatient services on the rest of the site to deal with elective activity.

- There was a shared sense and ownership of risk across the system; the patient belonged to everyone not just one part of the system.

- Providers worked closely with third sector organisations to provide community support. For example, with meal provision, meal preparation and shopping.

Reflections

- There was an overwhelming sense of satisfaction across the STP, with high levels of support and low bureaucracy across the system enabling changes to be implemented at pace.

- Pre-COVID, Lincolnshire STP had already re-established collaborative working across health and social care. The COVID-19 period accelerated this partnership working with effective communication across all sectors and agreed STP priorities for both during and post-COVID.

- Outputs from this review suggest the STP has an effective platform to progress to ICS status from 2021.

Your questions please