NHS
Lancashire and South Cumbria
Integrated Care Board

Integrated Care Board

Date of meeting	3 May 2023
Title of paper	Implementation of Fuller Stocktake Report – developing Integrated Neighbourhood Teams (INTs) to improve population health
Presented by	Dr David Levy, Medical Director
Authors	Dr Peter Gregory, Dr Lindsey Dickinson, Dr Andy Knox, Peter Tinson, Andrew Bennett and Jonathan Bridge
Agenda item	9
Confidential	No

Purpose of the paper

The paper provides an update on the development and delivery of a clear plan for transforming the provision of care for the Lancashire and South Cumbria population in response to the Fuller Stocktake Report recommendations.

Executive summary

Since July 2022 the ICB has undertaken extensive engagement with stakeholders, who have co-produced an Integrated Neighbourhood Care Delivery Framework.

The Framework was launched at a Lancashire and South Cumbria wide event on 19 April 2023 attended by over 200 colleagues from a wide range of partner organisations.

In response to the Fuller Stocktake Report recommendations, the ICB's approach to the phased development of INTs is based on a Core20PLUS5 analysis of the most deprived neighbourhoods.

This paper, developed jointly between primary care and population health teams, describes the ambition and expected outcomes of the delivery of INTs.

Recommendations

The Board is asked to receive this update on the delivery of the Fuller Stocktake Report recommendations and support the phased plan to develop INTs.

Governance and reporting (list other forums that have discussed this paper)

Meeting	Date	Outcomes
The Framework and products have been subject to extensive engagement since July 2022.	Various	A summary of engagement feedback and responses is available.

Conflicts of interest identified				
Not applicable.				
Implications				
(If yes, please provide a brief risk description and reference number)	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed			N/A	
Equality impact assessment completed			N/A	
Data privacy impact assessment completed			N/A	
Financial impact assessment completed			N/A	Informs wider discussions about investment in primary and community services.
Associated risks	X			Risks are detailed in programme risk register, especially workforce.
Are associated risks detailed on the ICB Risk Register?	X			

Report authorised by:	Dr David Levy, Medical Director

Integrated Care Board – 3 May 2023

Implementation of Fuller Stocktake Report – developing Integrated Neighbourhood Teams (INTs) to improve population health

1. Introduction

1.1 The Fuller Stocktake report was published in May 2022 and identified a 'moment of real opportunity' to streamline access to care and advice, provide more proactive, personalised care with support from a multi-disciplinary team of professionals to people with more complex needs and to help people stay well for longer as part of a more ambitious and joined-up approach to prevention.

1.2 In July 2022, the ICB Board agreed a process for primary and community health and care partners across Lancashire and South Cumbria to come together and build on their existing progress, to develop and deliver a clear plan for transforming the provision of care for the Lancashire and South Cumbria population in response to the Fuller Stocktake report recommendations.

1.3 At the heart of these recommendations was enabling all Primary Care Networks (PCNs) to evolve into Integrated Neighbourhood Teams (INTs).

1.4 This paper provides both an update on the progress to further develop INTs and also outlines the potential impact of INTs on improving the health and wellbeing of local populations.

2. Development Journey

2.1 Since July 2022 extensive engagement has taken place with stakeholders, who building on local and national best practice have co-produced an Integrated Neighbourhood Care Delivery Framework and several associated products such as a PCN/Neighbourhood self-assessment and planning tools.

2.2 The framework describes what good looks like for the following seven delivery themes:

1. Integrated Neighbourhood Teams
2. Integrated Urgent Same Day Care
3. Working with People and Communities
4. Digital, Data & Intelligence
5. Workforce
6. Estates
7. Support

2.3 For each of the themes it also sets out the steps to get to a good at Neighbourhood, Place and System.

2.4 Based on feedback received additional products are being developed, including an outcomes framework.

2.5 Together the framework and associated products will enable and support partners to deliver the Fuller recommendations within defined milestones. The launch of the framework and products took place on 19 April 2023 following two postponements due to winter and strike pressures.

2.6 Each PCNs/Neighbourhoods will undertake the self-assessment and develop a delivery plan no later than the end of June 2023.

2.7 The delivery of INTs and associated improvements in population health will be significantly led by place partnerships.

2.8 This work forms part of the ICBs wider Transforming Community Care Programme and will be overseen by a newly established INT Oversight Group.

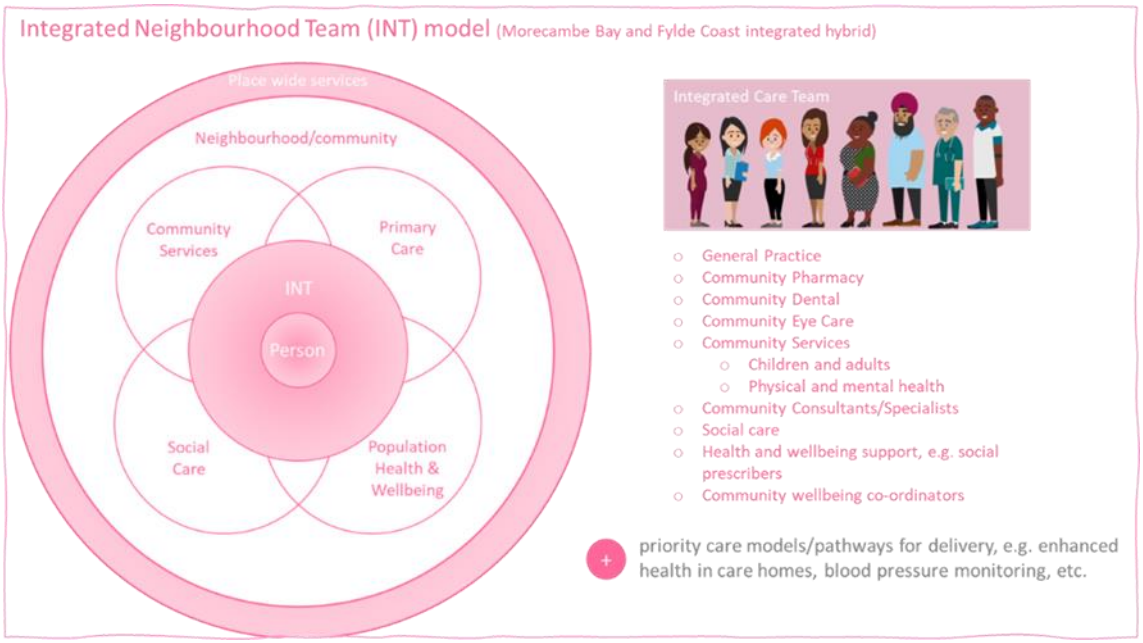
3. Integrated Neighbourhood Teams

3.1 Much of the development work has rightly focused on the development of Integrated Neighbourhood Teams. Early in the development process it became clear that partners were primarily viewing neighbourhoods through three different lenses:

3.2 Whilst this work focuses on the third lens (INTs), it is recognised that all three lenses are fundamental to the development of vibrant neighbourhoods that improve the health and wellbeing of their populations.

3.3 The ongoing involvement of voluntary sector partners in the development and delivery of INTs will be critical to ensure a holistic approach is taken to population and individual person needs.

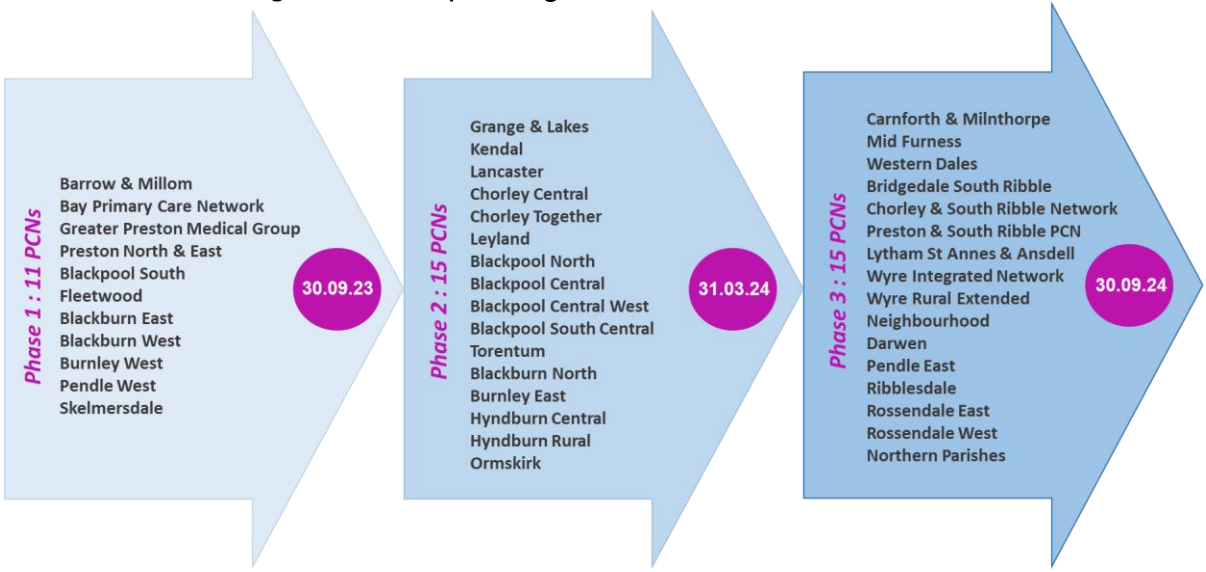
3.4 There was much consistency of thought to what constitutes a fully evolved INT model, which is illustrated below:



3.5 The Fuller Stocktake Report recommended that systems should first aim to have INTs up and running in Core20PLUS5 most deprived areas. ICB population health colleagues supported the identification of the INT phasing which was also reviewed by place colleagues.

3.6 Locally partners explored different approaches to the 'build' of INTs and considered that the 'core service build' should initially include General Practice, community services (physical, adults) and social care. They also considered that there should be local flexibility to determine the development journey to the 'full service build' based on local population needs. This journey will be identified through the delivery planning process mentioned earlier.

3.7 The PCN/Neighbourhood phasing for the 'core service build' is identified below:



3.8 The above represents a minimum expectation and it is recognised that some places and PCNs/Neighbourhoods may wish to go further faster. It is expected that the 'full service build' will be completed by no later than September 2025.

3.9 Relatedly a proposal for an INT Accelerator Programme is currently being finalised which would select and support a few PCNs/Neighbourhoods to rapidly complete their 'full service build' and relatedly develop integrated organisational delivery arrangements, for example an Alliance, which would be underpinned by an integrated and incentivised outcomes framework.

3.10 It is critically important that all INT organisational partners are fully committed to this INT build programme and ambitions. The early support of local authority partners to the 'core service build' is essential.

4. The impact of Integrated Neighbourhood Teams on population health

4.1 The Fuller Stocktake report states that "primary care must be at the heart of each of our new systems – all of which face different challenges and will require the freedom and support to find different solutions." Indeed, if primary care is to be at the heart of our integrated care system, then we should expect that the advent of integrated neighbourhood teams to drive improvements in the overall health of our populations. This must be supported by high quality data to help drive the design and implementation of new proactive models of care that improve health and wellbeing, reduce health inequalities and identify interventions which could improve outcomes, as well as reduce demand.

4.2 This section of the paper sets out how our approach to the development of Integrated Neighbourhood Teams will enable the ICS to improve the health of our population and tackle the obvious inequalities in health which exist between our communities. We illustrate this with reference to:

- A Case study of Frailty
- The developing approach to inequalities in our so-called "priority wards"
- Enhanced health checks to support integrated neighbourhood delivery
- Working effectively with people and communities
- Clinical leadership supporting integrated neighbourhood teams

Case study - Frailty

4.2.1 One example which has been identified in Lancashire and South Cumbria is the proactive identification and management of individuals with assessed frailty. Whilst frailty is a complex, multi-faceted area of health, there is a well-recognised approach to identification, particularly in over 65s.

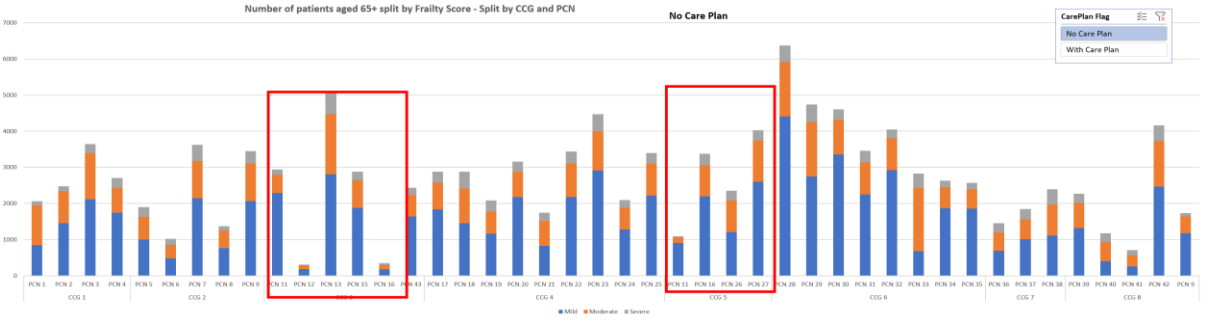
4.2.2 Frailty identification focuses on a small number of key interventions (falls assessment, medicines review and promotion of the additional information in the summary care record) for those most at risk of adverse events including hospitalisation, nursing home admission and death. Early identification coupled with targeted support can help people living with frailty to stay well and live

independently for as long as possible. We also know that in parts of our area, given the significant health inequalities which exist, there are frail individuals from age 40 and above who would benefit from earlier intervention to prevent further deterioration and help mitigate future demand on services.

4.2.3 Current analysis of frailty data across the ICB (see Chart 1 below) suggests there is significant variation in primary care when looking at the number of eligible patients assessed for frailty with a recognised score indicated on the care record. Without an assessed score and subsequent care plan in place, there is increased risk that people will need to access urgent care services.

4.2.4 We believe that through the continued development of Integrated Neighbourhood Teams (INTs), we have the opportunity to increase the focus on frailty, with increased attention paid to assessing suitable patients, developing care plans and proactively managing individuals to stay well and reduce demand on services. As a result of the engagement with multiple partners and the data-driven focus, INTs will be better equipped to undertake targeted risk stratification work through an MDT approach utilising community services, primary care and VCFSE to segment the population and target people at risk of hospitalisation from exacerbations of long-term conditions – particularly those with recognised frailty amongst our elderly population. To this end in our phase one INT areas by the end of March 2024, we intend to reduce the variation across primary care and ensure that where patients have been diagnosed as frail in the last 12 months, that at least 50% will have an updated score and care plan developed.

Chart 1: Number of frail patients aged 65+ without a care plan (shown by PCN) – Feb 2023



Priority Wards

4.2.5 NHS England/Improvement's Equity and Health Inequality Team (EHIT) together with NHS Right Care previously produced a Health Inequalities Pack for each of the CCGs in Lancashire and South Cumbria. One of the outputs in each pack was an analysis of Unplanned Hospitalisations (sensitive to ambulatory or urgent care interventions) per 100,000 population by Local Authority ward (KPI 106a), plotted against a national Index of Multiple Deprivation (IMD) scale. This enabled a calculation of difference in life expectancy between the most and least deprived sections of the local

population and also identified the more deprived wards in Lancashire and South Cumbria with greater than expected non-elective admissions.

4.2.6 This analysis found that for many of the most deprived wards, the excessive admissions were not restricted to a few disease areas but were high across a broad range of common conditions. These included, for example, chest pain, heart failure, COPD, cellulitis and asthma.

4.2.7 Further analysis identified outliers which were designated as 'priority wards' with significantly more admissions even than might be expected for their deprivation score. This is suggestive of local areas offering less preventive support or proactive management of health risks, leading to people presenting with urgent or emergency care needs.

4.2.8 The following visual provides insight into the impact the admissions have on

Unplanned Hospitalisations (ACS) at BTH from Blackpool Priority Wards (December 2021 to November 2022)

	ACS Emergency Admissions				ACS Emergency Bed Days			
	Total	Paediatric	Adult	Geriatric	Total	Paediatric	Adult	Geriatric
Tyldesley Ward	114	9	42	63	645	6	217	422
Talbot Ward	120	8	44	68	989	14	284	691
Bloomfield Ward	151	4	93	54	1,010	5	594	411
Claremont Ward	147	8	82	57	736	2	273	461
Park Ward BLP	98	9	52	37	611	14	320	277
Total	630	38	313	279	3,991	41	1,688	2,262
Total %		6%	50%	44%		1%	42%	57%

Blackpool Priority Wards account for 630 ambulatory care sensitive condition emergency admissions and 3,991 bed days. This is 11% of all unplanned hospitalisations

This is the equivalent of 11 beds occupied over the 12 months December 2021 to November 2022. This is 13% of all unplanned hospitalisations from Blackpool Priority Wards.

the Acute sector from five priority wards in Blackpool.

4.2.9 The focus of the Priority Wards programme being led by the Population Health team is to work with individuals and communities, identifying actions to mitigate key aspects of disadvantage and strengthen the benefits of local assets to improve outcomes.

4.2.10 Whilst the programme is not stating that it will directly reduce admissions, it provides insight into a place-based conversation about how Primary and Community health and care services integrate to meet the needs of the residents who live with multiple vulnerabilities in these areas. At a high-level the actions that are anticipated to impact on unplanned hospitalisations are:

- Tackling unwarranted variation in community-based services, including but not limited to NHS primary care and community services, with a focus on outcomes
- Strengthening community leadership and cohesiveness, empowering people within the Priority Ward communities to take action and influence

decisions that affect their lives *(see working with people and communities section below)*

- Increase targeted support and awareness of this support for wider issues that affect peoples' health but are not health care services, for example income and debt, and housing security.

4.2.11 Integrated Neighbourhood Teams will be a fundamental component part of how we address the issues identified in the priority wards from a health perspective and become the main delivery vehicle for the appropriate healthcare interventions. They will also remain a critical stakeholder locally for all other partners engaged in the priority ward – the lens through which we will begin to shape more and more of our population health programme in subsequent years.

4.2.12 Phase one of the priority wards approach began in 2022/23 and is continuing this year. This first phase consisted of using ward data, local intelligence and existing and new engagement to undertake a deeper dive into each of the priority wards to understand the underlying factors driving demand and identify potential responses. This work was commissioned from local VCFSE partners in each of the priority wards, thereby ensuring genuine insight and engagement.

4.2.13 Plans for phase two of the programme will intend to evidence impact of:

- Prevention of avoidable hospital admissions and readmissions.
- Look to narrow the gap in emergency admission rates between deprivation quartiles, demonstrating outcomes improved.
- Deepen understanding at a place level to the underlying problems with care delivery and the barriers to better prevention and pro-active management of health risks in priority wards, which then present as crisis and emergencies.
- Increase levels of patient activation and personalised care.
- Deepen the local (ward level) network for integrated care co-ordination
- Plans would be expected to demonstrate what other resource & focus could be drawn in to optimise the impact of existing funded services in the priority wards.

4.2.14 It is fundamental to this approach that the actions are coproduced and/or agreed with people who live in the Priority Wards. For this reason, a significant amount of community engagement and co-production has taken place in phase one and generated huge energy and aspiration from communities and VCFSE partners to take action on the issues that have been identified.

4.2.15 A system wide approach across out of hospital community services, primary care, local authorities and the VCFSE sectors are essential to addressing the health inequalities which we know exist and are exacerbated within our priority wards. Deloitte (2019) provides a series of detailed examples of where integrated care has delivered tangible outcomes including savings and improved health outcomes for large populations (available deloitte-uk-public-sector-population-health-management.pdf)

4.2.16 The table below outlines the potential benefits of our in-depth work in these priority wards.

Impact of reduction in Health Inequalities for 10 Conditions in all Priority Wards by CCG area impact on NEL inpatient activity

Unplanned Hosp Adm	Blackpool	Blackburn	WL	CSR	GP	EL	F&W	MB	Total	NEL inp £4,842*
Saved Admission if NO inequalities exist	390	177	174	155	336	405	222	718	2,577	12,477,834
1% reduction	3.9	1.77	1.74	1.55	3.36	4.05	2.22	7.18	26	125,892
3% reduction	11.7	5.31	5.22	4.64	10.08	12.15	6.66	21.54	77	372,834
5% reduction	19.5	8.85	8.7	7.75	16.8	20.25	11.1	35.9	129	624,618
10% reduction	39	17.7	17.4	15.5	33.6	40.5	22.2	71.8	258	1,249,236

Sources:

- Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.
- NHS England » Equality and Health Inequalities packs 2018 – North
- Cost taken from the: NHS England » National Cost Collection for the NHS – assumption that admission if for longer than two days based on the length of stay data for the cohorts identified in the Priority Wards work in Blackpool.

Enhanced health checks to support integrated neighbourhood delivery

4.2.17 In 2022/23, the ICB launched the enhanced health check (EHC) programme across Lancashire and South Cumbria. A report carried out by Public Health England in 2020, Preventing illness and improving health for all: a review of the NHS Health Check programme and recommendations - GOV.UK (www.gov.uk) shows the benefits of the health check - even just a few years after an NHS Health Check, attendees tend to show better health outcomes, including lower levels of hospital admissions and death from heart attacks and strokes - but also makes recommendation for some ways that the health check could be expanded to provide even greater benefit to our populations

4.2.18 Ordinarily cohorts for standard checks would be identified through age profiling (targeting the over 40s) however, through our implantation of EHCs in Lancashire and South Cumbria we have purposefully taken the opportunity to target those in our population who experience the lowest health outcomes using the Core20plus approach (using the 20% most deprived IMD score and mental health conditions as the common identifiers system wide) for an EHC and further support. The EHC uses the standard NHS health check questions

plus additional questions rooted in a health coaching approach to support the identification of social vulnerability, and other clinical vulnerabilities beyond CVD to enable us to identify people within our communities who are at greater risk of preventable disease and those who require additional support.

4.2.19 The main point is to improve health and wellbeing outcomes for all, particularly those who are at risk of experiencing lower than average outcomes. To achieve this local health and care partners, including INTs, need to be able to identify what is making people experience lower than average outcomes

4.2.20 Implementing the Fuller Stocktake and the further development of Integrated Neighbourhood Teams provide the opportunity to deliver health checks differently, taking time to build a positive longitudinal relationship between individuals and health and care providers. Outreach models for health checks and other case finding and preventative interventions will be better informed and enabled by the richness of the working with people and communities workstream in neighbourhoods too. We are already starting to see the early fruits of this with examples of EHCs being delivered in community centres, warm spaces and faith settings. This approach will also provide an opportunity to ensure that there are appropriate intervention(s) available, considering not just physical support but ways to increase community connections and ultimately the engagement with INTs from their local population.

4.2.21 In summary, EHC focusses on vulnerable people in our communities who are at the highest risk of experiencing the worst health and wellbeing outcomes. It considers the wider determinants of health that impact their health and wellbeing (financial hardship, isolation, poor mental health and wellbeing), and preventative screening that vulnerable people may not take up. This case finding approach will sit at the heart of the INT development and be a fundamental part of how local neighbourhood teams understand, manage and improve population health in their area, focusing specifically on those parts of our communities which experience the worst inequalities and inequity.

Working effectively with People and Communities

4.2.22 Working with people and communities is a key priority theme within our implementation of the Fuller Framework because we recognise the huge dividends to be gained by developing relationships with our communities founded on deep listening, identifying local assets and supporting communities to identify their own health and wellbeing priorities.

4.2.23 There is a need for a community development presence, where possible led by members of the community, in every one of our neighbourhoods. Where this is already happening and there are trusted relationships between community members, we will encourage our Integrated Neighbourhood Teams to engage with and support these activities. Where more development work is required, we will support INTs to maximise the expertise available to them from the VCFSE sector, local authorities and the ICB to begin this movement and consider where best to concentrate their efforts.

4.2.24 We know there are already numerous best practice examples across Lancashire and South Cumbria of effective work with local communities. Some areas such as Fleetwood have received national recognition for the energy and dedication which has been placed on this way of working differently with people in the local community.

4.2.25 We are confident as our Integrated Neighbourhood Teams increase in maturity that this direct approach to working with and listening to our communities will enable previously under-served communities to take control, become active participants in their health and wellbeing and actively shape services that properly meet their needs and aspirations.

Clinical leadership for health inequality

4.2.26 Given the expectations of the Fuller Stocktake and the level of health inequalities in Lancashire and South Cumbria, we believe that Integrated Neighbourhood Teams will require strong clinical leadership and expert guidance. Through the Population Health programme, we have appointed a health inequality clinical lead (HICL) for every PCN across Lancashire and South Cumbria. During 2022/23, these individuals have undertaken significant professional development through our leading Population Health Academy. Working closely with the PCN Clinical Directors and other professionals in the INTs, the skills and knowledge of these Clinical Leads will be available to support INTs in understanding the issues creating health inequalities within their local populations and will help to co-design the targeted interventions required to improve the health of local communities.

5. Recommendations

5.1 The Board is asked to receive this update on the delivery of the Fuller Stocktake Report recommendations and support the phased plan to develop INTs.

Dr Peter Gregory
Dr Lindsey Dickinson
Dr Andy Knox
Peter Tinson
Andrew Bennett
Jonathan Bridge

20 April 2023