Integrated care close to home: Creating healthy communities in Lincolnshire






Lincolnshire
COUNTY COUNCIL
Working for a better future

Contents

Foreword

Welcome to my sixth Annual Report as Director of Public Health for Lincolnshire.

In this Annual Report, I focus on community and primary health and care services, which are essential to the public's health. They support our wellbeing and enable us to access help with our everyday health and care needs. The report draws on learning from some aspects of the previous two, bringing them together in a case for changing how we work together to integrate care closer to our homes.

My fourth Annual Report set out clearly how diverse Lincolnshire is, from our urban centres like Lincoln to our long beautiful, isolated coastline. My fifth Annual Report provided an insight into the challenges and opportunities to add more health to the older age of the people of Lincolnshire as they become a larger part of our population.

Primary care services, which provide almost 90% of the total NHS contacts each year in England, are often overshadowed by discussions about emergency departments and hospital care. Given there are more than six and a half thousand general practices in England, compared to 200 emergency departments, the debate needs to be rebalanced so that our primary and community care services receive the same attention as other services.

Demand in general practice and the rest of primary care is rising, partly due to an ageing population, partly because of improvements in what is possible in primary care, and partly because of additional hospital asks for primary care and delays in hospital-based delivery. These changes in what we need and what can be provided by general practice are reflected in other primary and community health and care services and will continue with our ageing population.

Increased demand and pressures on primary and community health and care services are already creating problems with timely access to services, with both those seeking care and those providing it less satisfied with the way services work than they have ever been. These pressures can also be expected to widen existing health inequalities, as people with the greatest health needs but poorest access are likely to be most impacted.

The increasing demand and pressures can't be met by solely increasing spending. We must explore and develop new ways of working. We need to do this through creating new relationships between services and the communities and people they serve, redesigning services to be person-centered, whilst maximizing the effect of all our community assets.

This report presents a vision for reimagined primary and community health and care services, a vision which supports people to live life to the full for as long as possible through preventative care whilst helping people to effectively manage their health. It proposes some approaches to overcome the challenges we face. Welcome to my Annual Report; I look forward to discussing it with you over the coming months.

Executive Summary

In Lincolnshire, people are living longer but are doing so in poorer health. Around a quarter of Lincolnshire's residents are aged 65 and older, and this number is expected to rise by 41% by 2043.

Our over 85 population is projected to almost double over the same period. Lincolnshire residents have increasing long-term health needs, with more than half classified as having high needs or long-term conditions that require comprehensive support.

The diverse geography of the county, comprised of large rural and coastal areas with a wide spread of small communities, creates challenges for health and wellbeing. In addition, some communities in the north and east of the county experience high levels of deprivation, a significant driver of poor health.

Lincolnshire's health system must respond to these challenges and meet the growing health needs of our population. However, the current picture is one of an overburdened hospital system as pressures on A&E and waiting lists continue to mount. At the same time, demand for primary and community care services is ever increasing, without the investment to match.

While responsive and well-resourced hospital care is critical, a health system that is weighted towards treating ill health rather than preventing it is both unsustainable and ineffective. We face significant challenges, but we also have an opportunity to innovate and deliver care differently for our population. By prioritising prevention, not just treatment, providing people with the knowledge and skills they need to stay well for as long as possible and manage their conditions whilst moving care out of hospitals and into communities, we can make meaningful and sustainable improvements to health and wellbeing.

So, how do we redesign our health and care services to build a stronger relationship with the public, boost satisfaction, improve health outcomes, and reduce health inequalities?

While there is no shortage of examples of service models that try new ways to meet the growing health needs of populations, there is limited evidence on their effectiveness, and there is no one-size-fits-all solution. However, common promising practices emerge from the evidence that provide a set of priorities and principles for moving forward.

Prioritising prevention and supporting people to take the lead in their own care

Why treat people for illness if we can stop them from becoming unwell in the first place? By supporting people to live healthily and empowering them to take a lead in their own care, we have an opportunity to make drastic improvements to health and wellbeing. This is particularly important in Lincolnshire, with our ageing population, rising rates of long-term health conditions and significant health disparities. A focus on prevention means making it easy for people to adopt and sustain healthy habits, whilst giving them the skills and confidence they need to manage existing health conditions.

Streamlined access and a shift towards technology

Any redesign of primary and community health and care must make access to services easier and create more pathways to care, especially for those facing barriers. For the public, this means having more choice and flexibility in how they interact with the system based on their individual needs and preferences. Utilizing data and harnessing digital technology can help us to make the best use of the available resources, prioritise services, and streamline access. Digital inclusion must be at the backbone of these efforts to address barriers to the use of digital technology to ensure that no one is left behind.

Multidisciplinary teams (MDTs) bringing personalised care closer to home

Working together in MDTs at a neighbourhood level, professionals across the health and care system must provide joined-up and personalised care for patients. Patients with long-term health conditions are most likely to benefit from this approach. A focus on the person and not the service will require a change in culture but is essential for patients to receive care tailored to their needs. People must also play a key role in decision-making about their care to ensure that what matters to them is at the heart of their treatment plan.

What could this look like in Lincolnshire?

Changes to how we structure and provide health and care services will improve patient satisfaction and health and wellbeing, lead to efficiency gains for the system, and improve workforce retention. It is difficult to quantify what these impacts will be, but we can make estimates using data from existing models as a benchmark, to illustrate what we could achieve.

By deploying our workforce to support people to live healthy lives and equip them with the skills they need to better manage long-term health conditions, an estimated 723 deaths from cardiovascular disease could be prevented each year. Similarly, by encouraging people to take up recommended health and screening checks, we can identify health concerns early and achieve substantial increases in our cancer screening rates for early diagnosis and treatment, resulting in better survival rates.

Using Population Health Management approaches tested by the Foundry Healthcare Model; we can better prioritise resources and ensure appropriate pathways to care. In doing so, more than half a million unnecessary GP encounters could be avoided each year in Lincolnshire, resulting in a potential cost saving of over £4m annually. This would support our GPs by freeing up resources, allowing them to focus on patients with more complex needs.

Finally, by embracing MDT working and creating a culture of person-centred care, we can improve the patient experience, particularly for people living with long-term conditions. Using strategies similar to those used by the Jonkoping Model in Sweden, if we provide elderly residents with a package of comprehensive support at home and in the community when leaving hospital care, we estimate that nearly 600 people aged over 75 could avoid being readmitted to hospital within 30 days of discharge annually.

Recommendations

1. Develop new relationships with the public where they are supported to take the lead for their health and care.
2. Develop a renewed focus on prevention.
3. Harness digital technology to innovate the delivery of care and use digital inclusion to avoid leaving people behind.
4. Deliver person-centred care in neighbourhoods through integrated multidisciplinary teams.
5. Support and invest in our workforce to co-produce and embrace new models of care.

1 | Introduction

What is primary and community care?

General practitioners (GPs) have been key to the delivery of health and care services since the inception of the NHS, helping people address health needs that could not be fulfilled by informal caregiving.

The arrangement of general practice has changed greatly over the last 70 years. In its early stages, community nursing teams led by community doctors were vital to the delivery of primary and community care. As time passed and more diverse professions and disciplines joined these teams, single community nursing teams split into several smaller teams accountable to various clinical and managerial leaders. As hospital capacity and specialism under the NHS grew, the important role of general practice, which offers free care at point of delivery throughout a person's life, became overshadowed by hospital care. It was not until 1967 that the 'GP Charter' formally recognised general practice as a specialty.

Today, demand for care is at an all-time high due to increases in life expectancy and technical advances in the types of treatments NHS services can provide to people. While improvements in life expectancy allow people to enjoy extra years, as people live longer, they do so in poorer health and with greater dependency on health and care systems. Because of the significant increase in demand, support for managing individual health and care needs has shifted from hospital settings to primary and community care services, particularly for those with complex health issues.

Primary and community care services within our health and care system are as depicted in Figure 1, the services of focus in this report are outlined in red.

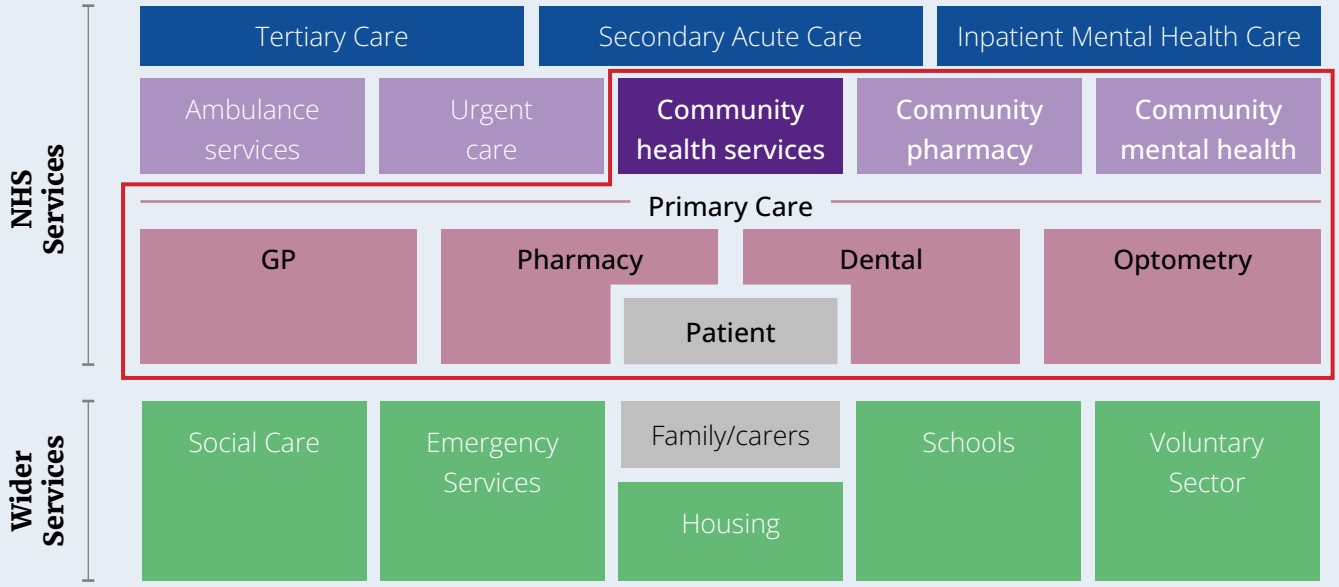
Primary and community care services are generally offered in smaller local facilities close to people's homes. These services include GPs, dentists, opticians, pharmacies and community clinics. Primary and community care also refers to home based services delivered by nurses, physios, occupational therapists and a range of other professions.

Community pharmacies are typically located on high streets or in neighbourhoods and provide easily accessible medical advice and support for a range of minor illnesses, often on a walk-in basis. Community mental health services provide care and support for people with severe mental health needs as close to home as possible, including access to psychological therapies.

This report focuses on primary and community services. However, we acknowledge their connections to the wider system, in particular to adult social care which ties in closely with community care.

The increase in health needs and the improvements in the capabilities of primary care settings are not the only reasons for the increasingly stretched primary and community care sector. In some areas of the county it is harder to recruit people to the health and care jobs which need filling. For many of us the way our families work has changed rapidly, with more members of the family needing to do paid work and sometimes living long distances apart. These challenges and changes have resulted in more of us needing support more frequently from caregivers outside our family and friend groups.

Figure 1: Primary and community services within the wider health and care system



Source: The Kings Fund, 2024[1]

The state of primary and community care, now and into the future

A recent investigation found that the NHS in England is in critical condition[2]. Our healthcare systems face the challenges of an ageing population and an increasing number of people with preventable diseases. We need a new approach central to which is the redesign of our primary and community care sector.

In Lincolnshire, our primary and community care sector is under-resourced at an Integrated Care System (ICS) level. Even with enough funding our services would struggle to meet the high demand due to difficulties in recruitment and retention. The allocation of resources does not meet the overall demand for services. This is felt most in the areas of our county with the highest need, the fewest personal and family resources, and the worst access to services.

Primary and community care is a cost-effective way to meet the needs of our population and alleviate pressures on an already strained hospital system. However, our current provision is at its breaking point. Something needs to change. Otherwise, we risk worsening inequalities, with communities facing the highest need and poorest access suffering the most.

This report makes the case for ongoing changes needed to tackle challenges in primary and community care. It presents evidence to indicate some general and specific approaches that could help bring about this change. Importantly, this report does not suggest a one-size-fits-all solution to the challenges we discuss. Instead, it highlights the common themes that are necessary for meaningful change.

These are:

1. A new relationship with the public where they are supported to take the lead for their care.
2. A renewed focus on prevention.
3. Harnessing digital technology to innovate the delivery of care and promoting digital inclusion to avoid leaving people behind.
4. Delivering person-centred care closer to home through integrated multidicisplinary teams.
5. Supporting and investing in our workforce and embracing new models of care.

References

Introduction

[1] The Kings Fund, 2024, Community health services explained.
Community Health Services Explained | The King's Fund (kingsfund.org.uk)

[2] Department of Health and Social Care, 2024. Independent investigation of the NHS in England.
https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

2 | Lincolnshire's Population

A diverse geography

Lincolnshire is the fourth largest county in England, with a diverse geography and population. The county has large rural areas, over 50 miles of coastline, and an urban centre in Lincoln which is the county's only city. Beyond Lincoln, the population centres around market towns of various sizes. Most areas are populated, which makes Lincolnshire different from other rural areas that have large areas of land with few people. This wide spread of small communities across the county adds complexity and additional costs to providing care locally. Lincolnshire's geography creates unique challenges for health and wellbeing, influenced by individual factors and broader structural conditions.

In urban areas, there are health risks linked to housing conditions and living arrangements. Vulnerable groups are often concentrated in small areas with an inadequate supply of suitable housing, overcrowded homes, and homelessness. These conditions can make people more vulnerable to health problems and increase the risk of poor health outcomes.

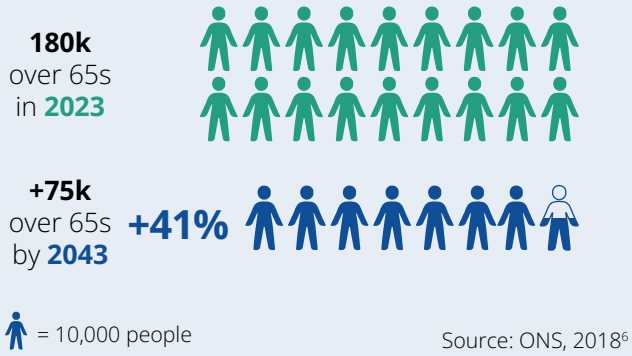
Coastal communities in Lincolnshire, like many others across the country, face a number of ongoing health challenges. Lower levels of education can limit life chances and health literacy. The high number of fast-food outlets and alcohol-based entertainment options increases exposure to unhealthy behaviours. Older adults from other parts of England moving to the coast is part of the reason why there are more older people in these areas than the average. A higher proportion of these older people have poor health than the Lincolnshire average, too. This higher need, which is coupled with difficulties in recruiting and retaining skilled health workers, multiplies the challenge of meeting the additional needs of older people. These factors are hindered further by the seasonal nature of employment and the extra strain on the health system during holiday periods due to the influx of tourists.

Rural communities in Lincolnshire share similar challenges. Like coastal communities, it is hard to recruit and keep skilled health workers, plus there is some inward migration of older people with more complex health needs. The spread-out nature of rural populations means that accessing healthcare can be difficult and expensive, often requiring people to own a car or to have a higher income to travel to care providers, which can mask pockets of deprivation. Additionally, fewer than 1 in 10 homes in rural areas are considered affordable. Many homes in rural areas are older, less energy-efficient, and lack access to mains gas, the cheapest form of heating. These factors significantly increase exposure to drivers of ill health[1].

An ageing population

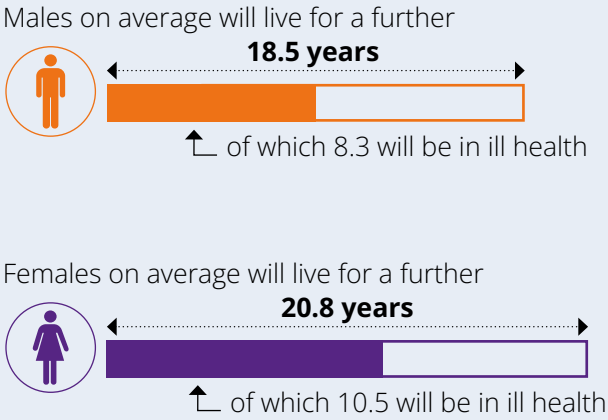
Lincolnshire has a resident population of nearly 770,000 people[2], with about 816,000[3] people registered with local medical practices. Around a quarter (23%, or 180,157) of Lincolnshire's residents are aged 65 and older, and this number is expected to rise by 41% to 255,000 people by 2043. The number of people aged 85 and over is also projected to double[4] in this period. People living longer than ever is a major achievement, and an active older population brings many benefits. Older people make significant contributions to their communities through work, volunteering, and caregiving. However, while people are living longer, they are also experiencing more ill health and complex needs. Roughly a quarter (27%) of those aged 65 or over struggle with everyday activities due to long-term illness[5] and live with two or more long-term conditions[1]. Health outcomes and life expectancy vary across the county. Differences in levels of deprivation result in the unequal distribution of ill health, driving health inequalities.

Figure 2: Lincolnshire's over 65 population



Source: ONS, 2018[6]

Figure 3: Life expectancy and healthy life expectancy at 65 in Lincolnshire



Source: OHID, 2023[7]

The effects of deprivation

At a county level, deprivation rates in Lincolnshire are similar to the national average, but this broad view hides the significant deprivation faced by many communities, particularly in the north and east of the county. For example, on the East Coast around 85% of the population of the First Coastal Primary Care Network (PCN), including Mablethorpe and Skegness, reside in areas in the most deprived fifth of the Index of Multiple Deprivation[8]. Deprivation is a key driver of health inequalities. Those living in the most deprived areas are more likely to experience poor health across a range of conditions and are more likely to develop multimorbidity earlier in life[1] and die young[7]. While national statistics provide an overall picture of deprivation, it is important to note that small pockets of deprivation can exist close to or within more affluent areas, which can sometimes mask the true scale of need. Therefore, an individualised approach must be taken in designing and delivering health and care services, regardless of location, with efforts to address inequalities embedded throughout.

Figure 4: Deprivation* as a driver of inequalities in Lincolnshire

30% more
likely to suffer from depression and 22% more likely to be obese

↓-7 years less**
of life expectancy for females in the most deprived areas

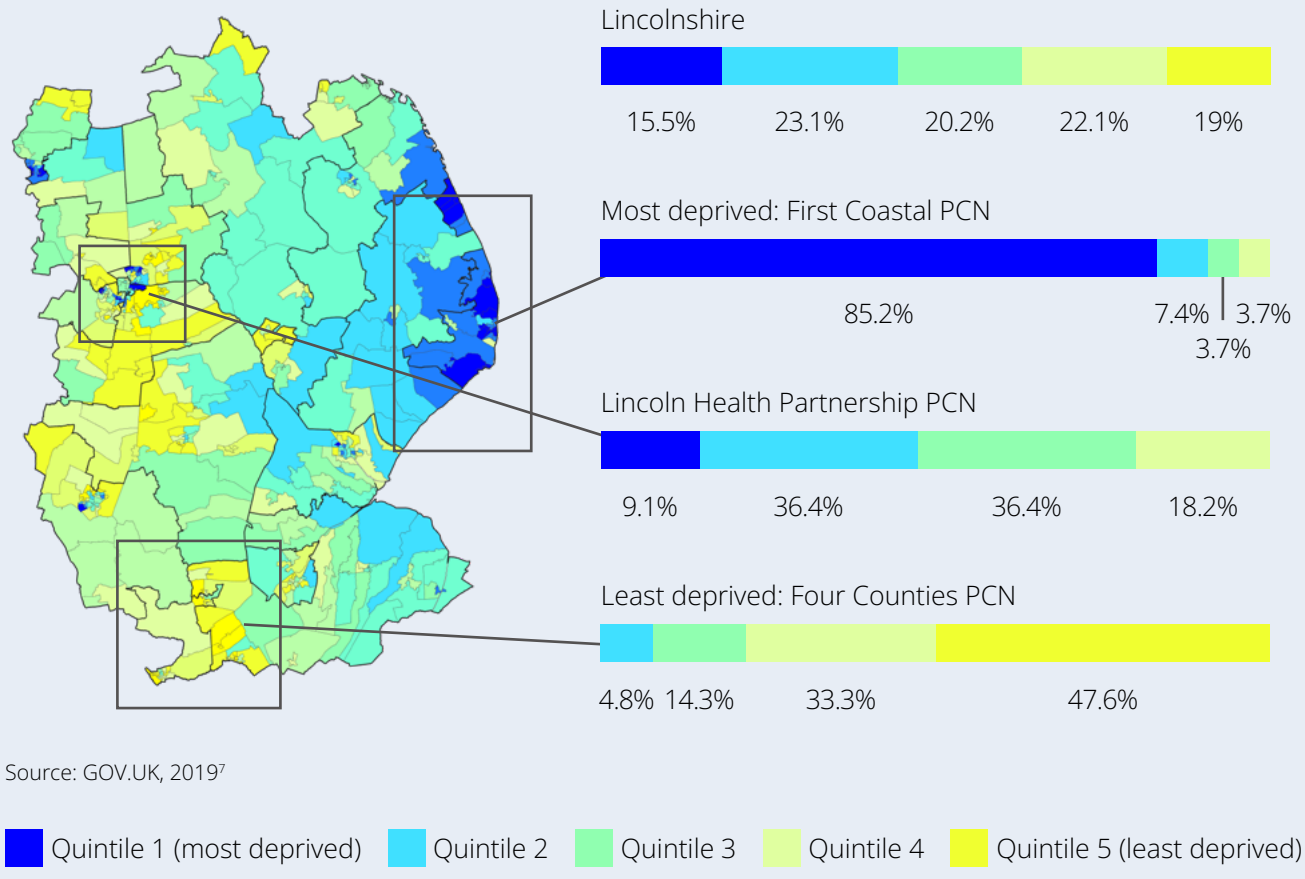
25-35% greater likelihood
of developing multimorbidity earlier in life

↓-9 years less
of life expectancy for males in the most deprived areas

*Life expectancy at birth 2018-2020. Index of Multiple Deprivation (2019) used to define deprivation deciles.
**Least deprived decile compared to most deprived decile.

Source: ICS Joined Intelligence dataset, 2024[3], OHID, 2023[7]

Figure 5: Deprivation across Lincolnshire



Source: GOV.UK, 2019[7]

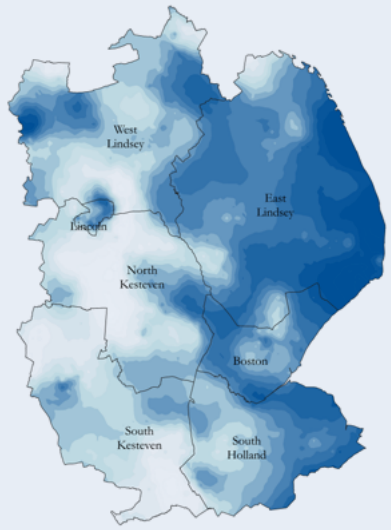
Where you live matters

Where people live has a significant influence on health outcomes, influenced by the unique challenges of each location and access to health and care services. A map of healthcare access in Lincolnshire shows a gap between need and access. For example, some of the most deprived communities are located in coastal and rural areas where access to healthcare is poorest.

A key measure of healthcare access is how long it takes people to reach their nearest GP. In West Lindsey, a rural area, only a third of people can get to a GP within 15 minutes by public transport or walking[9]. One promising tool to improve accessibility in rural and coastal areas is the expansion of digital platforms, like the NHS App. However, an assessment of digital exclusion shows a link between poor physical access and poor access to digital services[10],[11],[12]. In our most deprived coastal areas, technology-enabled care may not always be a feasible solution*.

Figure 6: Where you live matters

Deprivation

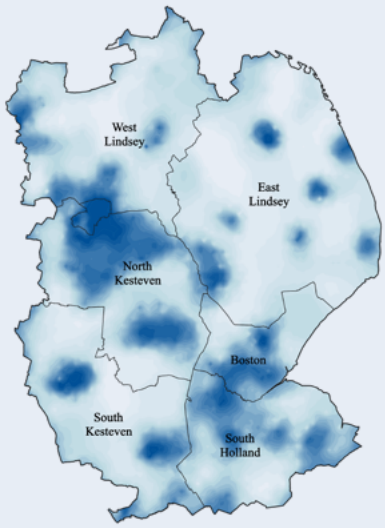


Lower deprivation

Higher deprivation

Source: GOV.UK, 2019[8], English Indices of Deprivation

Access to healthcare

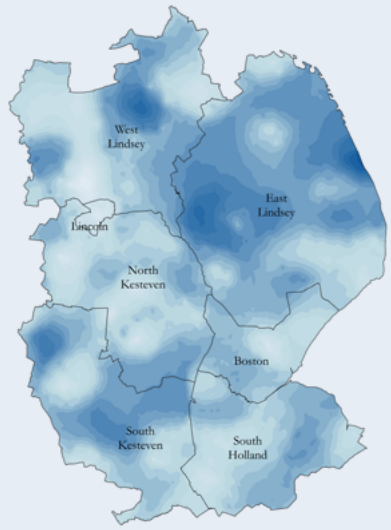


Poor access

Good access

Source: Department for Transport, 2019[9], Journey Time Statistics

Population aged over 65



Low proportion

High proportion

Source: ONS, 2021[2], Population and Household Estimates

The ability of Lincolnshire's health and care system to meet the increased needs of an ageing population, close the gap between health needs and access, and reduce health inequalities presents a critical challenge but also an opportunity to bring care closer to the individuals and communities that need it the most.

*Digital exclusion measured using the Lincolnshire Digital Health Toolkit. This tool uses 3 data sources NOMIS, Experian Mosaic and ONS. 8 Themed areas are ranked and scored from most digitally excluded to least.

References

Lincolnshire's Population

[1] Lincolnshire Director of Public Health (DPH) *Annual Report, 2022, DPH Annual Report 2022 – The Diverse Communities of Greater Lincolnshire.* https://lhih.org.uk/wp-content/uploads/2023/04/Director-of-Public-Health-Annual-Report-2022.pdf

[2] Office for National Statistics (ONS), 2021, *Population and household estimates, England and Wales.* Population and household estimates, England and Wales: Census 2021 - Office for National Statistics (ons.gov.uk) Contains OS Survey Data ©.

[3] Integrated Care System (ICS) Joint Intelligence dataset, 2024, *Lincolnshire ICS Joined Intelligence Dataset.*

[4] Office for National Statistics (ONS), 2018, *2018 based subnational principal population projections for local authorities and higher administrative areas in England.* Subnational population projections for England - Office for National Statistics

[5] Projecting Older People Population Information (POPPI), 2024, *People aged 65 and over with a limiting long term illness.* Projecting Older People Population Information System (poppi.org.uk)

[6] Office for National Statistics (ONS), 2018, *Population age structure and density for local authority areas.*

[7] Office for Health Improvement and Disabilities (OHID), 2023, Inequality in life expectancy at 65. Health Inequalities Dashboard (phe.gov.uk).

[8] UK Government (GOV.UK), 2019, *English Indices of Deprivation*. English indices of deprivation - GOV.UK (www.gov.uk) Contains OS Survey Data ©.

[9] Department for Transport, 2019, *Journey Time Statistics.* https://www.gov.uk/government/collections/journey-time-statistics Contains OS Survey Data ©.

[10] Office for National Statistics (ONS), 2018, *Journey Time Statistics.* https://www.gov.uk/government/statistical-data-sets/journey-time-statistics-data-tables-jts

[11] Experian Mosaic, 2024, *Segmentation portal.* https://www.segmentationportal.com/Mosaic7/us

[12] Digital Exclusion Risk Index (DERI), 2024, *DERI Version 1.6.* https://www.gmtableau.nhs.uk/t/GMCA/views/DigitalExclusionRiskIndexv1_6/DERIhomepage?%3Aembed=y&%3AisGuestRedirectFromVizportal=y

3 | Health and care in Lincolnshire

Investment in primary and community care

Nationally and locally, primary care and community care are how most individuals interact with the health system. The demand on primary care is increasing, with an average of 876,000 GP appointments taking place every day. This is an increase of 34,000 appointments a day since 2018[1]. Despite this increase, the Department of Health and Social Care's total spending on primary care between 2015 and 2021 fell[1]. Conversely, between 2020 and 2021, spending on acute healthcare grew faster than other forms of NHS spending[2]. Nevertheless, the pressures on A&E, beds and discharges continue to mount, presenting a significant challenge for healthcare[3].

In Lincolnshire the figures tell a similar story. Spending on acute care significantly outweighs spending on primary care and community care combined.

Figure 7: Lincolnshire's healthcare expenditure

Every year in Lincolnshire, we spend...

£785m on **acute care**
£302m on **primary care**
£117m on **community care**

Source ICS Joined Intelligence dataset, 2024[4]

Figure 8: Interactions with Lincolnshire's Health System

Acute care staff managed

420,139 **emergency** activity
123,366 **elective** admissions

between 2023-2024

GPs handle

21m

patient encounters per year

Source ICS Joined Intelligence dataset, 2024[4]

Investment in community care can lead to lower hospital elective and non-elective admission rates, reduced ambulance conveyances, and decreased A&E attendance, therefore reducing pressure on secondary care services[2]. Additionally, the estimated cost-saving potential from preventing hospital care through community care for a typical-sized Integrated Care System (ICS) is £25 million per year[2].

Long-term and complex health needs

More than half of Lincolnshire's population are classified as high need or have long-term conditions that require comprehensive support[4]. Over the last five years the number of patients presenting to care with long-term conditions increased by 11%, while the number of patients with high-complexity conditions nearly doubled (91%). Providing care to these groups cost over £1 billion in Lincolnshire over the last year alone[4]. This dramatic increase is not evenly distributed across the county, with 17 out of 81 GPs in Lincolnshire reporting having more patients with high needs than the average in Lincolnshire[4]. As life expectancy increases and the number of people with multiple long-term conditions rise, the need for a shift towards prevention rather than cure is more pressing than ever.

Only 4 in 10 people registered with a GP are considered generally healthy or in need of occasional acute illness care. 12% of these individuals are children, young people and maternal health cases[5]. It is important to ensure accessible and timely care is provided to this population, including follow-up and continuity of care when needed.

Geography also has an impact on the use of healthcare services in Lincolnshire. People who live in urban areas are more likely to attend A&E, while those who live in rural and coastal regions are more likely to use elective admissions, outpatient appointments and GP services. On average, the healthcare system spends £125 more per person per year in rural areas compared to urban areas[4]. This difference in the use of healthcare services across the county highlights how the needs of the population vary depending on where they live.

Figure 9: Geographic patterns of healthcare usage across Lincolnshire

People who live in **urban** areas are most likely to

- Attend A&E
- Have lower healthcare expenditure

People who live in **rural** areas are most likely to

- Schedule appointments
- More frequently visit the GP
- Have higher expenditure by £125 per person per year

Source ICS Joined Intelligence dataset, 2024[5]

Pressures on the workforce

Approximately 90% of NHS contact with the public in England takes place through primary care. Improvements in what services primary care can provide, demographic change, and delays in secondary care delivery have caused the demand on primary care to increase over the past decade. While the workforce has also grown over this time, it has not kept pace with demand.

Several factors contribute to this, including long training times, insufficient staff in training, and a trend towards partial or full-time retirement among existing staff.

The national shortage of GPs is particularly acute in Lincolnshire. GPs make up a smaller proportion of the workforce in the county than any other health and care system in the Midlands.

The reduction in new GPs entering the workforce has placed pressures on GP access as well as reducing satisfaction among both patients and the workforce. A recent national survey found that over half (51%) of the public expect access to GP services to worsen in the year ahead, and more than 1 in 3 (38%) anticipate a decline in the standard of care[7]. These figures signal low patient expectations.

Figure 10: Lincolnshire's healthcare workforce

Pillars of service delivery

- **1** Acute Trust
- **60** Dental Practices
- **14** Primary Care Networks
- **112** Community Pharmacies
- **4** Hospitals
- **73** Optometry Practices
- **81** General Practices

Source: Primary Care People Group, 2024[5]

Total primary care workforce

- **458** GPs
- **755** Other patient roles*
- **349** Nurses
- **1,252** Administrative/ non-clinical

*Other patient roles: physiotherapists, paramedics, etc.

Prevention and early intervention

Figure 11: Levels of prevention

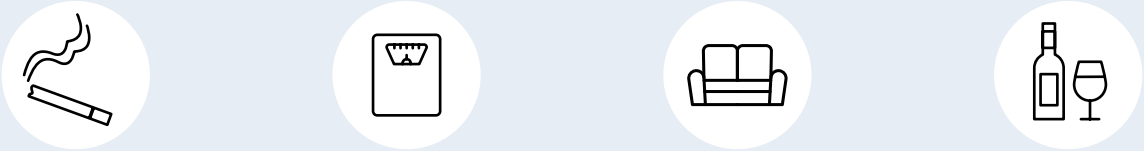
Source: Public Health Lincolnshire County Council, 2024

Primary prevention is key to addressing drivers of ill health and disease that are prevalent in Lincolnshire. Interventions such as vaccination campaigns and health education programmes, along with behavioural inteventions such as those to help people stop smoking, are critical to reducing the risk of individuals developing long-term, high-need conditions

Secondary prevention is crucial to improving health outcomes. Screening and regular health checks enable early diagnosis when treatment is most effective. In Lincolnshire, screening rates for both bowel and cervical cancer are above average for England, while breast cancer screening rates are slightly worse than the national average, highlighting some room for improvement[8].

Finally, tertiary prevention is critical to support people to live as healthily as possible with conditions which are no longer suitable for curative treatment and care. Patients should be empowered to take a leading role in their own care and provided with the confidence and skills needed to ease symptoms and help them to live life to the fullest. Given the burden of long-term health conditions, these interventions are essential for improving the health outcomes of a significant number of people in Lincolnshire.

Figure 12: Preventable unhealthy behaviours across Lincolnshire



15%

of adults currently smoke

Source: GPPS, 2021[9]

68%

of adults are overweight or obese

OHID, 2021[10]

37%

of adults are physically inactive

OHID 2021[11]

20%

of adults drink over 14 units of alcohol a week

OHID, 2021[12]

While Lincolnshire faces many challenges, these challenges also provide opportunities to deliver care differently for our population. As we strive towards transforming our health and care services, we must focus on improving the quality of life and health for all our residents for the full span of their life. In the words of Ashley Montagu, "the idea is to die young as late as possible".

References

Health and Care in Lincolnshire

[1] The Kings Fund, 2024a. *Call for radical refocusing of health and care system to put primary and community services at its core.* Primary And Community Care Needs To Be At The Core Of Health And Care | The King's Fund (kingsfund.org.uk)

[2] National Health Service Confederation (NHSC), 2023, *Unlocking the power of health beyond the hospital: Supporting Communities to prosper.* Unlocking-the-power-of-health-beyond-the-hospital.pdf (nhsconfed.org)

[3] The Health Foundation, 2022, *Projections: General and acute hospital beds in England (2018–2030).* How many hospital beds will the NHS need over the coming decade? - The Health Foundation

[4] Integrated Care System (ICS) Joint Intelligence dataset, 2024, *Lincolnshire ICS Joined Intelligence Dataset*

[5] Primary Care People Group, 2024, Lincolnshire Primary Care People Plan 2023-2026. Lincolnshire-Primary-Care-People-Plan-2023-2026-v2.0.pdf

[6] Integrated Care System (ICS), 2024, *One Workforce Presentation – Operational Planning June 2024.* https://lincolnshirecc.sharepoint.com/sites/PublicHealthHubSite/Shared%20Documents/Work%20Programme%20Areas/DPH%20Annual%20Report%202024/05_Data/ICS%20One%20Workforce%20Presentation%20-%20Operational%20Planning%20June%202024.pptx?web=1

[7] Ipsos & The Health Foundation, 2024, *Public Perceptions of health and social care: five findings the new government should know.* Public perceptions of health and social care: five findings the new government should know

[8] Office for Health Improvement and Disabilities (OHID), 2023, *Cancer screening coverage: bowel cancer. Fingertips* | Department of Health and Social Care (phe.org.uk)

[9] GPP Patient Survey (GPPS), 2021, *Smoking prevalence in adults.* https://gp-patient.co.uk/

[10] Office for Health Improvement and Disabilities (OHID), 2021, *Overweight (Including obesity) prevalence in adults. Fingertips* | Department of Health and Social Care (phe.org.uk)

[11] Office for Health Improvement and Disabilities (OHID), 2021, *Percentage of Physically active adults.* Fingertips | Department of Health and Social Care (phe.org.uk)

[12] Office for Health Improvement and Disabilities (OHID), 2021, *Percentage of adults drinking over 14 units of alcohol a week.* Fingertips | Department of Health and Social Care (phe.org.uk)

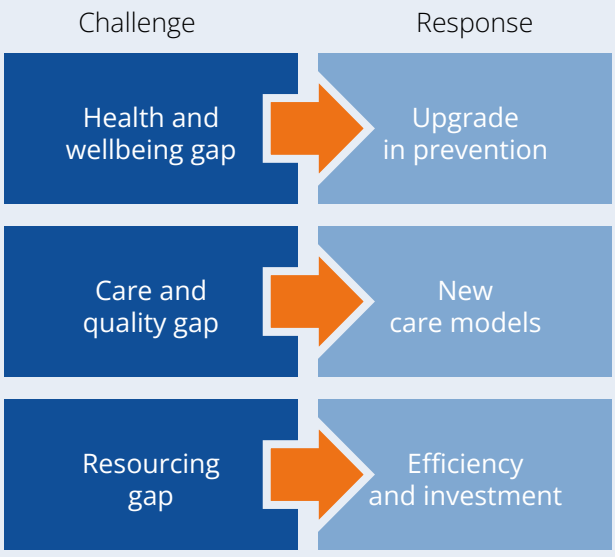
4 | An opportunity to do differently and do better

As we have outlined, Lincolnshire's health system faces many challenges. However, these challenges offer a prime opportunity to redesign health and care services to build a stronger relationship with the public, boost satisfaction, improve health outcomes, and reduce health inequalities.

So, how should we redesign our services? What benefits may we derive? And how can we address any risks that come with new ways of working?

Primary care should be central to service redesign. Investing in primary and community care is a cost-effective way to meet the diverse needs of individuals. The World Health Organisation (WHO) states that primary care is essential for achieving Universal Health Coverage[1]. In the UK, politicians, health experts, and organisations are calling for a shift away from a hospital-centric system to community-based services designed to improve health and wellbeing closer to home.

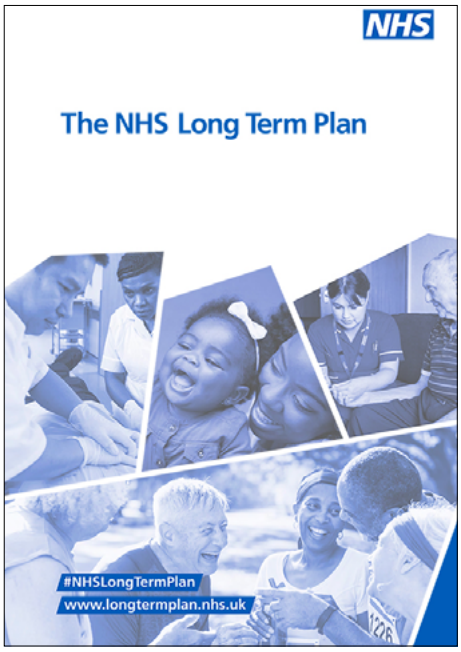
Figure 13: Transforming challenges into actions for positive change



Public Health Lincolnshire County Council, 2024

National guidance and recommendations

The national **NHS Long-Term Plan** sets out a vision for more coordinated, proactive and personalised care offered to individuals by the NHS[2]. A key goal of the plan is to boost out-of-hospital primary and community care. **The Health and Care Act (2022)** builds on the Long-Term Plan by promoting cooperation between care organisations to deliver more joined-up care[3]. A main element of the Act is the formation of Integrated Care Systems, which bring together partners as a system-wide team to coordinate services.



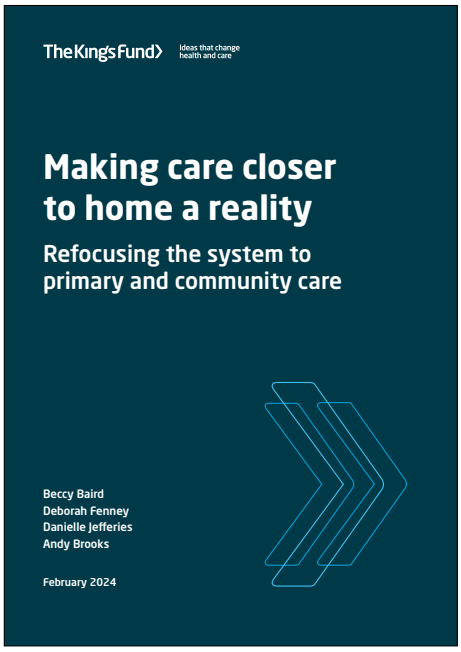
The Fuller Stocktake Report Next Steps for Integrating Primary Care (2022) is a review of ongoing integrated primary care projects commissioned by NHS England[4]. It has support from the leaders of 42 Integrated Care Systems, including Lincolnshire, and recommends that healthcare delivery should centre on three main principles[5]:

1. Streamlined access and providing choices about how to access care
2. Providing personalised care through multidisciplinary team working
3. Helping people to stay well for longer with a focus on prevention

The report recommends implementing these principles using integrated neighbourhood teams and fostering a culture of shared ownership to find new ways to improve the health and wellbeing of communities.

The recent Kings Fund Report, **Making Care Closer to Home a Reality (2024)**, identifies a lack of progress in moving health and care services from hospital to community settings. The report marked this as a critical failure caused by urgent problems taking priority over long-term issues that could be addressed by primary or community care services[6]. The Kings Fund recommends speeding up the implementation of integrated primary and community care through:

- Developing a skilled workforce of multidisciplinary teams
- Engaging with people and communities, understanding what matters most to them
- Ensuring flexibility to enable change to be made based on local needs



More recently, **the Darzi investigation into the state of the NHS** stressed that too much of the NHS budget is spent on hospitals, with too many people ending up in hospitals because not enough money is spent in the community[7]. The report identifies seven key themes central to reforming our NHS:

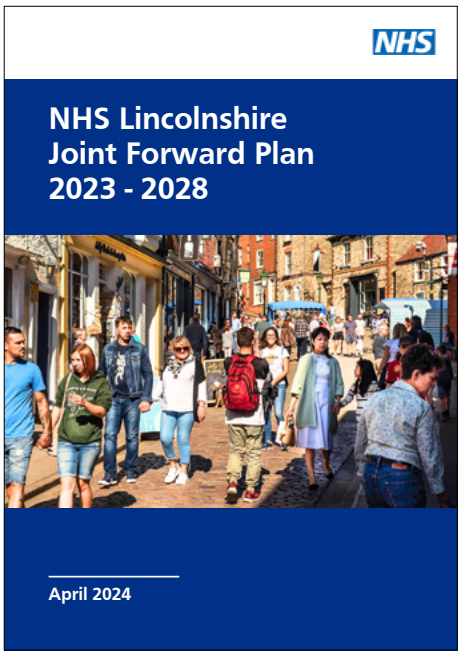
1. Re-engage staff and empower patients to take a leading role in their care
2. Shift care closer to home, with investment to make this happen
3. Embrace new neighbourhood models of care through multidisciplinary teams
4. Improve hospital productivity by improving patient flow out of hospital and into the community
5. Tilt towards technology to transform care
6. Ensure the NHS contributes to prosperity, getting more people off waiting lists and back into work
7. Reform to make the structure of healthcare deliver

Priorities for health and care in Lincolnshire

In Lincolnshire, our health strategies align with the national recommendations, and we have a significant focus on delivering effective primary and community care.

Our NHS Lincolnshire **Joint Forward Plan** focuses on increasing integrated care services that are designed around the person[8]. The plan sets several priorities to ensure that people are at the heart of care:

- Focusing on preventing ill health so people live and stay well
- Improving access and timely delivery of care, ensuring people receive the right care at the right time
- Fostering deeper relations with the public through integrated community-based care
- Building a happy and valued workforce



Building on the Joint Forward Plan, **Our Shared Agreement** is a commitment from the Lincolnshire Integrated Care Board to prioritise what matters most to the person receiving care instead of only discussing issues among healthcare professionals[9]. Our Shared Agreement commits us to work together, leverage patients' strengths and assets, and put people at the centre of care. Our Shared Agreement represents a fundamental change in how primary and community health and care services are provided in Lincolnshire.

Approaches to transform primary and community care

There is a broad consensus that we need new and innovative approaches to integrated primary and community care to meet the needs of our populations. However, the evidence base for implementing such integrated services is still developing, and there is no one-size-fits-all solution, especially for a diverse area like Lincolnshire.

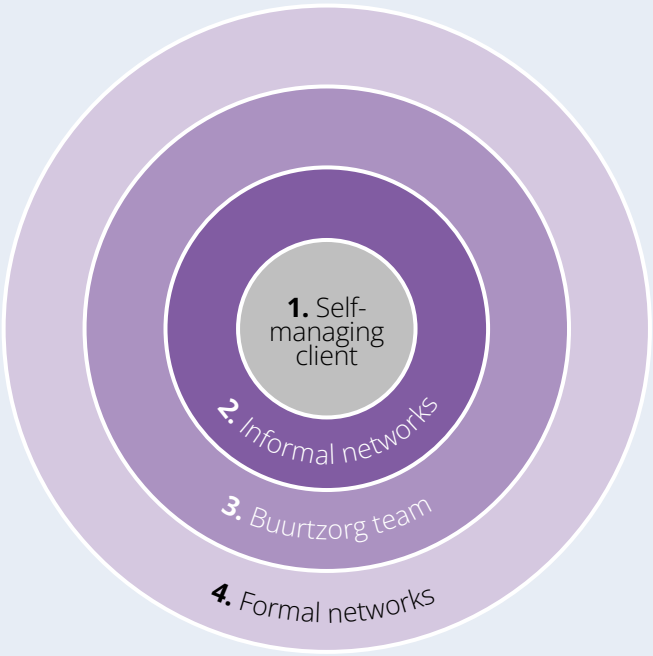
Despite countless examples of new models of primary care, a more substantial evidence base is needed[10]. While many new models have been evaluated and documented in case study reports, proof of their effectiveness is limited. Still, several new primary and community care models have gained traction and have been widely documented and replicated.

For example, in the Netherlands, the Buurtzorg home-care organisation has created self-managed neighbourhood nursing teams. These teams support patients to live independently at home and connect them with support networks within their communities. This innovative model provides both social and clinical care at home and has inspired similar approaches in 24 countries due to its adaptability[11]. In Jonkoping, Sweden, the Esther model has set up multidisciplinary teams of health and care workers. These teams use a person-centred approach to improve the quality of life of their patients. This model has similarly been replicated beyond Sweden (see Chapter 7 for more information).

Closer to home in England, The Wigan Deal is a partnership-based model working across all public services to address wider determinants of health and improve health and wellbeing (see Chapter 5 for more information)[13]. Other models in England, such as the Modern General Practice Model, focus on reorganising services, prioritising needs and gathering important information to more efficiently allocate resources based on what people want and need[14].

Figure 14: The Buurtzorg model of care

The Buurtzorg model of care starts with understanding the person and works outwards



Source: Buurtzorg, 2015[12]

After reviewing a wide range of models, evidence and guidance, several common themes appear in the literature. These themes inform criteria for initiatives that could significantly improve the delivery of primary and community care. Services should be:

- Locally driven, designed to meet the needs of local communities
- Person-centred, empowering patients to take a leading role in their care
- Built on the strengths and assets of individuals and communities.
- Designed through co-production with partners and service users
- Ensure whole system integration
- Commit to an integrated workforce and multidisciplinary team approach
- Reduce health inequalities, closing the gap between most and least deprived.

An opportunity to innovate

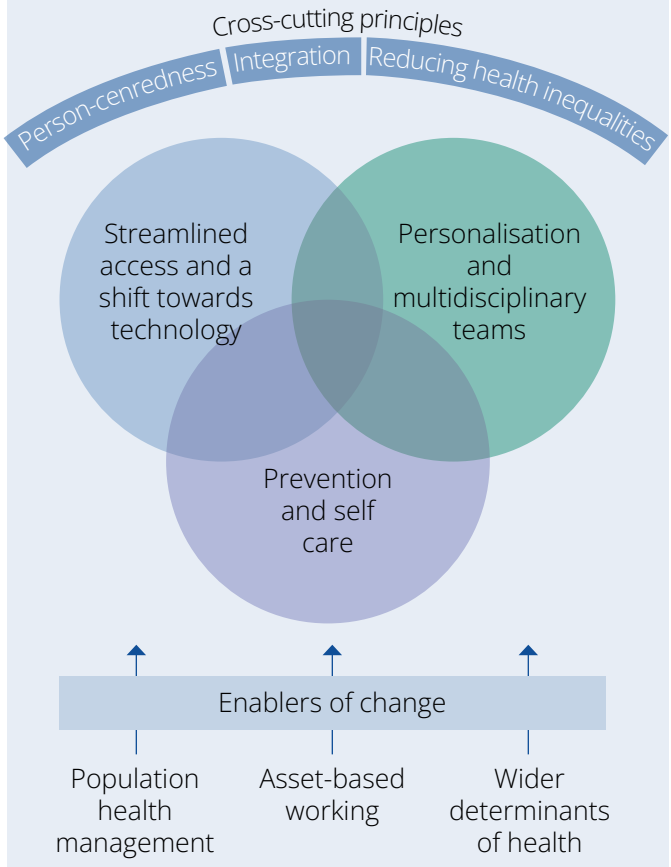
In the following chapters of this report, we will outline various models and initiatives that fit with our criteria. While many of these models are not new, they have yet to be widely implemented in Lincolnshire. These examples demonstrate what a transformed offering of community and primary care could look like for Lincolnshire.

We present different models drawn from the evidence base, organised according to the themes identified in The Fuller Stocktake Report (2022)[15]:

- Helping people to stay well for longer with a focus on prevention and self-care
- Streamlined access and a shift towards technology
- Providing personalised care through multidisciplinary team working

Cutting across these themes are the principles of person-centredness, integration and reducing health inequalities, which should be woven throughout new approaches to care. Promising practices and ways of working underpin these themes as enablers of change.

Figure 15: A framework for reformed models of primary and community care



Source: Public Health, Lincolnshire County Council, 2024

References

An opportunity to do differently and do better

[1] World Health Organisation (WHO), 2023, *Universal health coverage.* https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

[2] National Health Service (NHS), 2019, *The NHS Long Term Plan.* https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/

[3] UK Government (GOV.UK), 2022, *Health and Care Act 2022.* https://www.legislation.gov.uk/ukpga/2022/31/contents

[4] National Health Service England (NHSE), 2022, *Next steps for integrating primary care: Fuller Stocktake Report*. https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

[5] The Kings Fund, 2022, *Levers for change in primary care: a review of the literature.* https://assets.kingsfund.org.uk/f/256914/x/382aff840f/levers_for_change_primary_care_literature_review_2022.pdf

[6] The Kings Fund, 2024, *Making care closer to home a reality.* https://assets.kingsfund.org.uk/f/256914/x/ab65341d7a/making_care_closer_home_reality_report_2024.pdf

[7] Department of Health and Social Care (DHSC), 2024, *Independent investigation of the NHS in England.* https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

[8] Lincolnshire Integrated Care Board (ICB), 2023, *Joint Forward Plan.* https://lincolnshire.icb.nhs.uk/about-us/strategies-and-plans/joint-forward-plan/

[9] It's all about people, 2024, *Our Shared Agreement.* Our Shared Agreement :: Lincolnshire STP

[10] Henderson et al., 2023, *Understanding primary care transformation and implications for ageing populations and health inequalities: a systematic scoping review of new models of primary health care in OECD countries and China. BMC Medicine, 21(1). doi:* https://doi.org/10.1186/s12916-023-03033-z

[11] Buurtzorg International, 2020, Collaboration. https://www.buurtzorg.com/collaboration/

[12] Buurtzorg International, 2015, *The Buurtzorg Model.* The Buurtzorg Model - Buurtzorg International

[13] The Kings Fund, 2019, *A citizen-led approach to health and care: Lessons from the Wigan Deal.* A Citizen-Led Approach To Health And Care: Lessons From The Wigan Deal | The King's Fund

[14] National Health Service England (NHSE), 2024, *Modern General Practice Model*. https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/

[15] National Health Service England (NHSE), 2022, *Next steps for integrating primary care: Fuller stocktake report.* NHS England » Next steps for integrating primary care: Fuller stocktake report

5 | Prevention and self-care, helping people to stay well for longer

Taking proactive steps to stay healthy and practising self-care can help people stay well for longer and avoid health problems. This is particularly important in Lincolnshire, with our ageing population, rising rates of long-term health conditions, and significant health disparities. Focusing on prevention and self-care offers a huge chance to improve health and wellbeing, reducing the strain on health and care services.

Prevention and self-care involve taking care of our wellbeing, managing symptoms, and preventing health conditions from getting worse. By spotting and addressing health risks early on and encouraging healthy habits, we can prevent illness before it happens and save money on expensive treatments.

For individuals, this means learning the skills and gaining the confidence to take charge of their own health, better manage long-term conditions, and live healthier lives. For health professionals, this means building a deeper relationship with the public, moving from just treating and controlling conditions to working with patients, supporting and empowering them to take an active role in their own care. We should also work with communities to promote prevention efforts.

A joined-up approach to prevention

That prevention is better than cure is a long-accepted mantra in healthcare. In England, over 2,000 people aged over 65 are admitted to hospital each day for conditions that could have been treated earlier in the community or prevented altogether[1]. Primary and community services play an essential role in preventing ill health. By working in partnership with communities, local authorities and the voluntary, community, faith and social enterprise sector (VCFSE) in a joined-up approach, we can focus on helping communities that need it most.

Communities are key in prevention efforts. They provide social connections, play a valuable support role, and can encourage good mental and physical health. Working with communities to design and implement prevention efforts can help provide more appropriate and effective ways of engaging people to improve their health and wellbeing. This includes finding ways to work in partnership with individuals and groups at most risk of poor health and utilising local community assets to develop and deliver interventions.

Enabler of change: Addressing wider determinants of health

A holistic approach to prevention targets the root causes of poor health, including social and environmental factors. To create healthy communities, we need the right building blocks to be in place, which include quality housing, good education and stable jobs. These wider determinants of health are often the main drivers of health inequalities. We can't expect to make any significant improvements to the health and wellbeing of our population without tackling these factors, and doing so requires close working relationships between the health and care sectors, local authorities, and public services.

For example, in Wigan, public services have been transformed in an approach known as the 'Wigan Deal'[2], which has built a shared way of working across all services in the area. Multi-agency work is led by the local authority, which works closely with the NHS, VCSE organisations, the police, housing, employment, and welfare services. Working together flexibly across organisations within local neighbourhoods has created opportunities to tackle the wider determinants of health and wellbeing in a coordinated way.

Case study: Community Health and Wellbeing Workers (CHWWs)

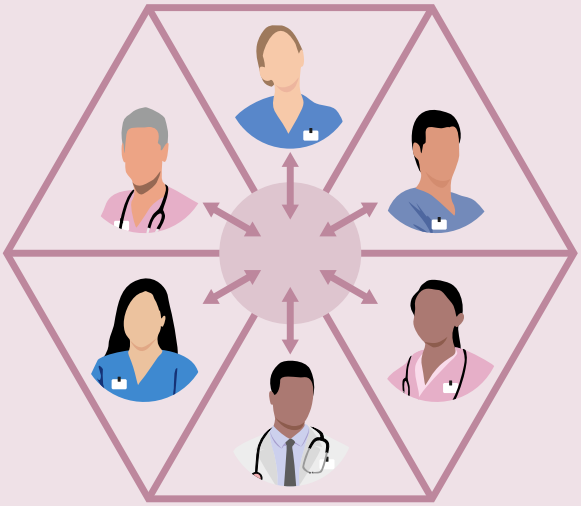
Developed in Brazil, the Community Health and Wellbeing Worker (CHWW) model is a household-level approach to preventative care. CHWWs are paid or voluntary members of the local primary care team. They are lay health workers recruited and trained to provide basic health and social care support to a defined area of up to 200 households[3].

Figure 16: What are CHWWs?

Brazilian CHWW model

Each CHWW supports:

- Promotion of healthy lifestyles
- Public health campaigns
- Antenatal and postnatal care
- Reminders for vaccination schedules
- Screening services
- Disease management
- Adolescent and sexual health
- Social care support
- Appointment keeping
- Medication compliance
- Triaging and referrals
- Service navigation
- Community engagement



Primary care clinic

- GP
- Nurse
- Nurse auxiliary

Catchment area

- 1,000 households

Micro area

- 150-200 households
- CHWW lives in micro area
- Full time role
- Every household visited once a month

Source: Macinko and Harris, 2015[4]

As members of their communities, CHWWs are sensitive to local conditions and wider determinants of health, enabling them to build trust and improve access in hard-to-reach areas[5]. CHWWs visit each household once a month to assess needs, conduct health promotion, aid with navigation of support services, triage, and make referrals.

Figure 17: Barriers and facilitators to community health working

Source: Public Health Lincolnshire County Council, 2024

CHWWs is a World Health Organisation endorsed approach that has proven highly successful in relieving pressure on health systems[6]. In Brazil, the support provided by CHWWs to help people improve their health was associated with reductions in death from cardiovascular disease (34% decrease) and from heart disease (21% decrease)[7]. Pilots of the model are ongoing in cities across the UK, with early indicators suggesting increases in cancer screenings[8], immunisation uptake[6], and improvements in self-management for type 2 diabetes[9] among visited households.

Self-care and self-management for health and wellbeing

Self-care refers to everything we do to take care of our own health and wellbeing, whether we are generally well or living with a health condition. This includes practising healthy behaviours to maintain good physical and mental health and self-management interventions to help manage and ease the symptoms of long-term conditions. Self-care approaches must be person-centred, providing options relevant to individual needs, preferences, and lived experience.

The promotion of self-care is not intended to remove responsibility or duty of care away from health professionals but rather should be incorporated as a complementary approach within a supportive health and care system. Primary and community care can play a role in enabling and facilitating self-care in the following ways:

- **Accessible information and education:** Providing easy-to-access and understandable information and education about healthy practices tailored to those who need it the most. Digital approaches such as mobile apps and websites offer an opportunity to reach large audiences alongside traditional methods such as print media and in-person education sessions.
- **Health coaching:** Supporting people to make more informed choices about their health and increase their ability and confidence to become active participants in their care, for example, by working with them to make plans and break down goals into manageable steps.
- **Peer support:** Bringing people together with similar long-term conditions to support each other either on a one-to-one or group basis. Peer support can enable people to share their experiences and provide mutual support and advice for living life to the fullest with a long-term condition.

Case study: myCOPD Digital App

myCOPD is a digital application downloadable on any device designed to support people with chronic obstructive pulmonary disease (COPD) with the skills, confidence and knowledge to take the lead in their own care and self-manage their condition[10].

Figure 18: MyCOPD app compared to standard COPD care

Source: Public Health Lincolnshire County Council, 2024

Due to limited resources and the nature of hospital care for acute COPD crises that prioritises the return of patients to home, many patients feel they need more support and advice to practice self-care effectively. myCOPD is intended to reduce face-to-face contact for patients who are comfortable receiving online or hybrid care delivery, alleviating demand while providing a quality alternative form of support.

Figure 19: Barriers and facilitators to app-based healthcare

Source: Public Health Lincolnshire County Council, 2024

myCOPD is used in multiple locations across England, Scotland, Wales and New Zealand[11]. Early reviews of the model show that age, rurality and socioeconomic conditions do not prevent people from using the app[12], meaning it does not risk widening inequalities based on these factors. High engagement with the app produced improvements in inhaler technique[8] and a moderate reduction in healthcare resource use[10]. Moreover, the app's pulmonary rehabilitation course works as effectively as face-to-face rehabilitation[13]. The National Institute for Health and Care Excellence (NICE) believes that myCOPD has promise for self-managing COPD, though the clinical benefit of the app is still to be determined[14].

Application in Lincolnshire

How might a stronger focus on prevention and self-management impact the health and wellbeing of people in Lincolnshire? We can look at the impacts of the Community Health and Wellbeing Worker (CHWW) model to predict what the outcomes might be if we hire, train and use CHWWs throughout Lincolnshire.

In Lincolnshire, the mortality rate from all cardiovascular disease (CVD) in people aged 65 and older is 1,195 out of every 100,000 people. This is the 10th highest rate in England and much higher than the national average[15]. This number translates to 2,128 deaths each year. CHWWs have been linked to a reduction of 34% in mortality from cardiovascular disease through targeted health promotion and support for managing the disease. If we achieved a similar reduction in Lincolnshire, it would mean 723 fewer deaths from CVD each year.

CHWWs have also led to significantly higher rates of cancer screening. Screening is an important tool to help spot cancer at an early stage when it is most likely to be treatable. For example, research shows that over 90% of people survive bowel cancer when it is diagnosed at the earliest stage[16].

If we raised screening rates by 82%, which is in line with other CHWW programmes[8], we could expect to increase the proportion of the population screened for bowel cancer from 24% to 44%*. This would mean an additional 132,478 people screened over a 30-month period. If we achieved a similar increase in cervical screening, rates could rise from 34% to 62%. For breast screening, we could see a rise in screening rates from 13% to 24%.

Figure 20: What would the application of the CHWW model look like for Lincolnshire?

CHWWs could prevent

723

deaths from CVD annually

An increase in Lincolnshire screening rates by

82%

Could increase the number of people screened for cancer by*

70,968
for
breast cancer

132,478
for
bowel cancer

115,822
for
cervical cancer

*Based on: Breast: people screened in the last 3 years. Bowel: people screened in the last 30 months. Cervical: people ahead 25-49 screened in the last 3.5 years or aged 50-64 in the last 5.5 years.

Data source: ICS Joined Intelligence dataset, 2024[17]

What integrated approaches to prevention could mean for a Lincolnshire family – the Archer's Story

The Archers are a family of 2 adults and 2 school-aged children living in a Victorian terrace in one of Lincolnshire's market towns. Both parents work but still sometimes struggle to make ends meet at times, especially in winter when their house is expensive to heat and never feels as warm and dry as they would want it to be.

In order to keep the house as warm as possible, they tend to keep it closed up tight during cold weather. They noticed last winter that small patches of mould had started to appear in the bedrooms, where condensation tended to linger. Dad, Martin, has COPD and his son Joshua has recently been diagnosed with asthma by his general practitioner and started on treatment.

The local integrated care team had been informed of Joshua's asthma diagnosis and had decided to ask the local community health and wellbeing worker (CHWW) to offer the family a visit and help them plan for Martin and Joshua to stay as well as possible. The worker identified that they would both benefit from more information about their chest problems and from planning for how they could take care of themselves and act if things started to go wrong.

Their plans and their triggers for changing their medicines or seeking help, were devised with their health practitioners' input. Martin's individual plan was loaded onto the myCOPD app, and the CHWW helped Martin to be confident in using it to manage his condition. Both Martin and Joshua were supported to know how to take proactive steps in their plans when they needed to, rather than waiting until they were poorly enough to need healthcare input.

The CHWW, when visiting their home, had offered to help them identify things which may be increasing their risk of being poorly – and find solutions to help protect their health and keep them doing the things they loved.

As physical activity protects good lung health, the CHWW helped connect Martin to local physical activity opportunities and suggested that a conversation with the school about Joshua's safe participation in PE might help with his plan. Both Martin and Joshua are now more active and feel safer, especially where some triggers of their COPD and asthma might be involved such as exertion in cold conditions.

As the Archers rented their house, they were able to get some advice from the local council about keeping the house warm and preventing condensation, damp and mould from forming, and they even got some help describing the improvements needed to the house to their landlord.

The Archers now feel much more in control of their own health and much more confident in self-managing to stop their COPD and asthma from getting out of control and needing time off work and school. The house is warmer and drier helping everyone to feel better.

Key points

- Prevention is better than a cure; it stops illness and disease before it occurs, reduces pressures on the health and care system, and helps people live well for longer.
- By working in partnership with communities to design and implement prevention efforts, we can find more effective ways to engage people, in particular those at most risk of poor health, to improve their health and wellbeing.
- A holistic approach to prevention is needed, focused on changing the conditions that drive poor health alongside individual factors to create healthy communities, including creating quality housing, good education, and stable employment.
- Primary and community care has a role in empowering people to lead their own care by providing accessible information and education, health coaching and facilitating peer support.
- Self-management approaches which can be facilitated by digital health, can support people living with long-term conditions in better managing their symptoms, preventing the progression of illness, and reducing the need for costly healthcare interventions.

References

Prevention and self-care, helping people to stay well for longer

[1] Department of Health and Social Care (DHSC), 2024, *Independent investigation of the NHS in England.* https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

[2] The Kings Fund, 2019, *A Citizen-led approach to health and care: lessons from the Wigan Deal.* A Citizen-Led Approach To Health And Care: Lessons From The Wigan Deal | The King's Fund (kingsfund.org.uk)

[3] National Institute for Health and Care Research (NIHR), 2021, *Putting Community Health and Wellbeing Workers at the heart of primary care.* Putting Community Health Workers at the heart of primary care (nihr.ac.uk)

[4] Macinko, J. and Harris, M., 2015, Brazil's Family Health Strategy – Delivering community-based primary care in a universal health system. *New England Journal of Medicine, 372(23).* doi: https://doi.org/10.1056/nejmp1501140

[5] National Association of Primary Care (NAPC), 2021, *Community Health Workers leaflet: the eyes and ears for Primary Health Care in the community*. https://napc.co.uk/wp-content/uploads/2021/09/NAPC-Community-Health-Worker-leaflet.pdf

[6] Cometto et al., 2018, Health policy and system support to optimise community health worker programmes: an abridged WHO guideline. *The Lancet Global Health, 6(12).* doi: https://doi.org/10.1016/s2214-109x(18)30482-0.

[7] Rasella et al., 2014, Impact of primary health care on mortality from heart and cerebrovascular diseases in Brazil: a nationwide analysis of longitudinal data. *BMJ, 349.* doi: https://doi.org/10.1136/bmj.g4014.

[8] Ebikeme, C. 2023, Could Brazil's community health model ease pressure on NHS general practice? *BMJ, 381.* doi: https://doi.org/10.1136/bmj.p1203.

[9] Wildman et al., 2021, Evaluation of a Community Health Worker Social Prescribing Program Among UK Patients with Type 2 Diabetes. *JAMA Network Open, 4(9).* doi: https://doi.org/10.1001/jamanetworkopen.2021.26236

[10] North et al., 2020, A randomised controlled feasibility trial of E-health application supported care vs usual care after exacerbation of COPD: the RESCUE trial. *npj Digital Medicine, 3(1).* doi: https://doi.org/10.1038/s41746-020-00347-7.

[11] Mhealth, 2024, myCOPD. *myCOPD:* The COPD app for controlling your symptoms (mymhealth.com)

[12] Cooper et al., 2022, Evaluation of myCOPD digital self-management technology in a remote and rural population: Real world feasibility study. *JMIR MHealth and UHealth, 10(2).* doi: https://doi.org/10.2196/30782

[13] National Institute for Health and Care Excellence (NICE), 2022, *myCOPD for managing chronic obstructive pulmonary disease.* myCOPD for managing chronic obstructive pulmonary disease (nice.org.uk)

[14] Davies et al., 2023, myCOPD App for Managing Chronic Obstructive Pulmonary Disease: A NICE Medical Technology Guidance for a Digital Health Technology. *Applied Health Economics and Health Policy, 21(5).* doi: https://doi.org/10.1007/s40258-023-00811-x.

[15] Office for Health Improvement and Disabilities (OHID), 2023, *Mortality rate from all cardiovascular diseases, ages 65+ years*. Fingertips | Department of Health and Social Care (phe.org.uk)

[16] Bowel Cancer UK, 2019, *Bowel cancer screening*. https://www.bowelcanceruk.org.uk/about-bowel-cancer/screening

[17] Integrated Care System (ICS) Joint Intelligence dataset, 2024, *Lincolnshire ICS Joined Intelligence Dataset*

*Note: Estimated projected figures presented are intended for illustrative purposes only. Screening data is based on performance indicators produced by NHSE. Bowel cancer screening data counts people who have had a screening in the past 30 months and have not had a subsequent 'refused' code. Cervical screening data counts people aged 25-49 who have had a screening in the last 3.5 years or aged 50-64 in the last 5.5 years and have not had a subsequent 'refused' code. Breast screening data counts people who have had screening in the past 3 years. The data provided is the number of individuals who have had each type of screening.

6 | Streamlined access and a shift towards technology

Given the challenges of accessing health services and the growing long-term health needs outlined in Chapters 2 and 3, any redesign of primary and community health and care services must make access easier and create more pathways to care, especially for those facing barriers.

For the public, this means having more choice and flexibility in how they interact with the health system based on their individual needs and preferences. Some people will prefer to continue seeing the same healthcare provider, others will want same-day urgent care, and many may value convenient, timely and accurate health information and advice. Patients should be able to quickly access the service that is right for them and connect with the practitioner who can best meet their needs.

For clinicians, like GPs and community pharmacists, an intelligent and joined-up way of working would help them to make the best use of the available resources and free up capacity. By harnessing digital technology, services can be prioritised, and access can be streamlined. This will reduce the pressure on general practice while ensuring high-quality care and patient satisfaction.

Streamlined access

In Lincolnshire, our primary and community health and care system is delivered by a wide range of providers, each offering a variety of services. However, often these providers do not work together. Patients frequently do not know where to go to access the service that is right for them, resulting in GPs being the first contact. This can be a problem as other healthcare services, like pharmacists, might be more suitable for their needs. This leads to inefficiencies, delays in receiving care, and low patient satisfaction.

Data shows that around 1 in 6 GP appointments could be avoided if patients used other providers[1]. By improving partnerships and making better use of the information we have about the people we serve, we can streamline access to services and deliver more personalised care. Strategies to achieve this include:

- **Single team Primary Care Networks (PCNs):** made up of local general practices and providers working as one team to provide easy access to urgent same-day care and advice from healthcare professionals across a range of disciplines. This 'networked' approach pools resources, reduces service overlap, saves resources and ensures patients within the 'networked' area have equal access to care.
- **Simple and effective triaging:** should be easy for patients to access and use, correctly identifying patient needs and directing them to the right place and provider on first contact, preventing onward referrals and reducing pressures on GPs.
- **Using data to understand demand and capacity:** knowing how much demand there is and how much capacity providers have can help us improve services and make better use of our resources. By collecting data on demand and capacity, GPs can arrange their availability around peaks in demand, ensure a good mix of urgent and routine appointments and understand which conditions should be prioritised for in-person visits right away.

Enabler of change: Population Health Management

Population Health Management (PHM) is a process which uses current and historical health data to understand health needs. It focuses on finding the reasons behind poor health outcomes and identifies groups that are at risk. This helps plan and deliver targeted interventions and personalised care pathways to improve patient access and make better use of our resources[2]. PHM is an essential tool for addressing the wider determinants of health and reducing health inequalities[2].

Lincolnshire is leading the way in using PHM with the most comprehensive Joined Intelligence Dataset in the country. We have achieved full population coverage within our ICS Joined Intelligence Dataset, thanks to the engagement from every GP practice within our ICS. PCNs and GP practices can access this dataset to investigate and act upon its information.

One example of how we use PHM is through segmenting the Lincolnshire population based on their health needs. Figure 21 illustrates how this is done, with each person represented once in the data based on a health issue they have that has the highest need. Our PHM segmentation helps us better understand the needs of our population, sources of demand and health outcomes. This understanding allows us to design timely interventions and tailored services for our communities.

Figure 21: Lincolnshire population segmented by health characteristics

Generally Healthy	Acute Episodic	Long-term conditions	High Needs	End-of-life Care
351,092	**9,012**	**405,911**	**42,123**	**8,212**
At risk: **93,823**	Major episodic: **8,385**	Moderate frailty: **17,624**	Severe frailty: **13,502**	Cancer: **950**
Children and maternity: **98,146**	High-intensity use: **627**	Big six*: **93,774**	High complexity: **24,692**	Non-cancer: **7,262**
Low risk: **159,123**		Disability: **7,621**	Dementia: **3,929**	
		Mental Health: **150,645**		
		Musculoskeletal conditions (MSK): **52,589**		
		Living with illness**: **83,658**		

*Big six: cancers, chronic kidney disease, diabetes, heart failure, stroke, and chronic respiratory disease
**Living with illness: other long-term conditions not listed within subsegments

Source ICS Joined Intelligence dataset, 2024[5]

Case study: Foundry Healthcare Lewes, Primary Care Network

Foundry Healthcare, a PCN in Lewes, East Sussex, operates an innovative PHM approach designed to reduce unnecessary wait times and referrals, ensuring patients receive the right care from the right person the first time.

Segmentation

Foundry Healthcare utilises population segmentation to identify patients needing faster, reactive care for one-off problems or a proactive, continuous approach to care. This segmentation is informed by patient data such as medical conditions or age[2].

Figure 22: Foundry Healthcare PCN patient segmentation

Reactive Care		Proactive Care
Green	**Amber**	**Red**
Patients that are generally well where continuity is less important	Patients with ongoing conditions where continuity is important	Patients with complex needs where continuity of care is very important
Patient ↓ Call handler ↓ Any GP immediate call back 60% 40% Supported to self care / GP face to face Managed on phone / Nurse face to face	Patient ↓ Call handler ↓ Named GP 60% 40% Supported to self care / GP face to face Managed on phone / Nurse face to face	Single point of contact ↕ Patient Care plan Case manager Care coordinator/ navigator Named nurse Named GP/ geriatrician Community health coaches

Source: Tempo GP Networks, 2023[2]

Prioritisation

The PCN utilises a patient prioritisation system that assigns patients a priority level based on the urgency of their needs to define demand within each population segment, ensuring timely care for those who need it most[2]. Patients are assigned a priority level based on the urgency of their needs:

1. **On the day** e.g. acute illness, urgent prescription requests, urgent ongoing issues
2. **In a week** e.g. less urgent new illness, ongoing problems, medication queries
3. **In a month** e.g. non-urgent new illness, follow up, results
4. **Within 6 months** e.g. some types of chronic disease reviews
5. **In a year** e.g. routine reviews.

Source: Tempo GP Networks, 2023[2]

Demand and capacity modelling

The capstone of Foundry's data-centric approach is its in-house demand capacity modelling tool, which integrates rostering, workforce planning, and patient demand metrics[3]. This tool is used across its three practices to help staff understand real-time demand to make the most of their resources[2].

PCN integration

Foundry Healthcare PCN has combined resources from three GP practices, integrated their computer systems, and created hubs to speed up care. Foundry's multidisciplinary hub includes diagnostics, mental health services, community nurses, and third-sector organisations. This allows for in-house triaging and for tests to be conducted before GP appointments[5]. The 'Green Hub' within the PCN's Urgent Treatment Centre provides consultation and reactive care for 'Green' patients by GPs, paramedics and physiotherapy practitioners[2]. Factors like practice size, distance to a GP, and delays in speaking to a GP or nurse can influence hospital attendance and admissions[3]. Foundry's partnership and intelligence-led approach has the potential to address these factors.

Successes

Since commencing operation in 2019, Foundry Healthcare has reduced avoidable appointments from 7% to 4.5%[2]. The PCN has also seen higher patient satisfaction[4] and improved staff retention, with only a 4% turnover[5]. These successes have come after overcoming several challenges, including the cultural shift of getting single practices to work together as a larger network and dealing with limited workspace due to team growth.

However, some challenges still persist, including patients having difficulty in contacting the practice and 90% of patients not knowing which healthcare team they are assigned to[3].

Figure 23: Foundry Healthcare PCN successes

Between 2018 and 2023, Foundry Healthcare PCN reported:

A possible reduction of 12,480 bed days

A possible reduction of 751 A&E visits

A possible reduction of 720 locum GP sessions

A possible reduction of 170 ambulance conveyances

Source: KSS AHSN, 2023[4]

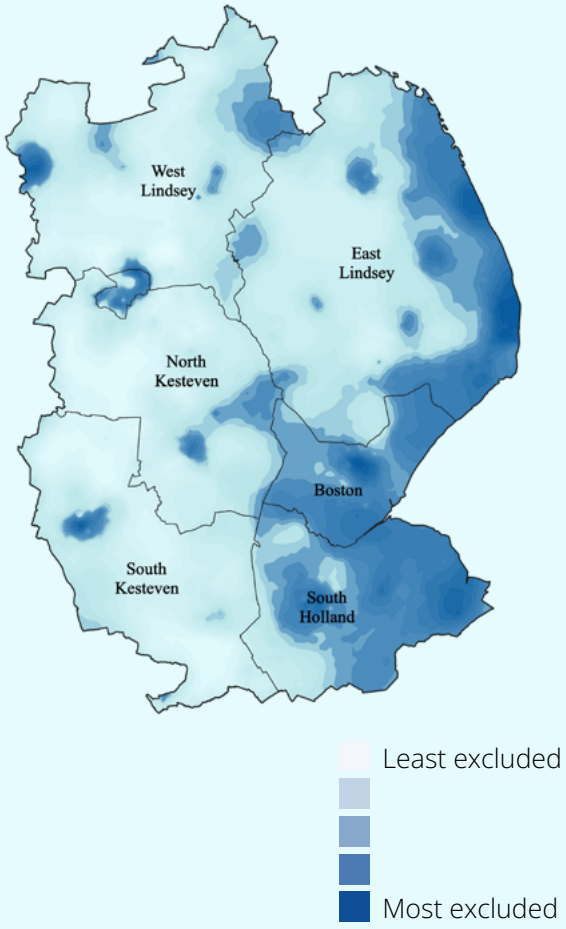
Technology-enabled care

Our health and care system should reflect the diversity of our population by providing a range of different ways to access care. Some people prefer to visit their family GP for face-to-face appointments, while others may choose to get health information and advice through digital platforms. No matter how care is provided, we must ensure that our approach is inclusive and considers the challenges people face in accessing care due to their location, skills, and resources.

The recent Darzi investigation into the state of the NHS recommends that we "tilt towards technology" to improve productivity[6]. The increasing popularity of the NHS app indicates that people are interested in digital health solutions. It has more than twice as many users as Netflix's 16.7 million subscribers[7]. Registration and use of the NHS app has steadily increased throughout 2023 and 2024, with almost 80% of the population now registered[8]. Digital-first models of care use video consultations, email, and web chat as the main ways to access healthcare. These options provide patients with a convenient and secure way to engage with their primary care providers.

While digital-first care may work for some individuals, we must recognise the risk of digital exclusion, leaving others without access and worsening existing health inequalities. To avoid this, it's essential to support and empower those who could benefit the most from technology-enabled care. Any effort to introduce this type of care must address barriers to use, such as opportunity, access, knowledge and skills[9]. The system-wide implementation of the new Lincolnshire Digital Inclusion Strategy 2024-2027 will be crucial to achieving this.

Figure 24: Digital exclusion



Source: Lincolnshire Digital Health Toolkit, LHIH, 2024[4]

Case Study: 100% Digital Leeds

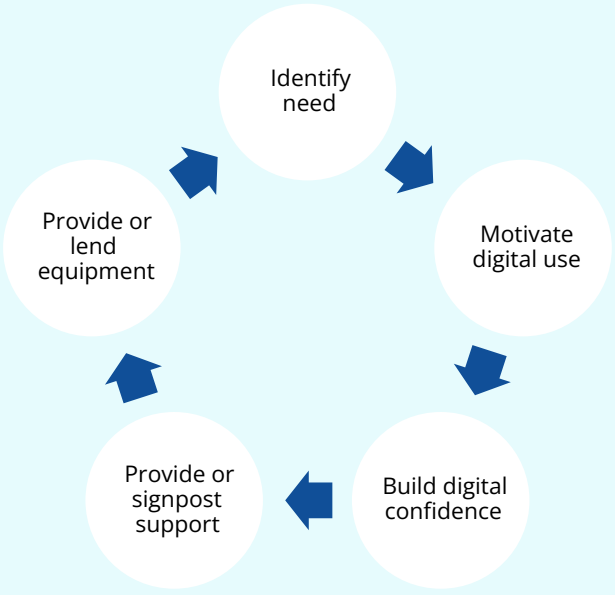
100% Digital Leeds is a partnership model involving health and care organisations and the voluntary, community, faith and social enterprise sector (VCFSE) with the goal of improving digital inclusion across Leeds[8]. Widespread digital inclusion means people can make informed choices when accessing services and that there is equal opportunity to use digital tools[2].

The 100% Digital Leeds partnership approach allows a better understanding of the different needs, preferences, and barriers specific groups have to digital care to co-produce solutions[8].

Digital Health Hubs

The 100% Digital model is facilitated by Digital Health Hubs, community spaces staffed with volunteers to provide supportive environments where people can learn about and build confidence with health-related information, technology, and resources for free[11]. The hubs are designed to encourage social activity and peer learning while addressing individual needs[12].

Figure 25: Digital Health Hub service provision

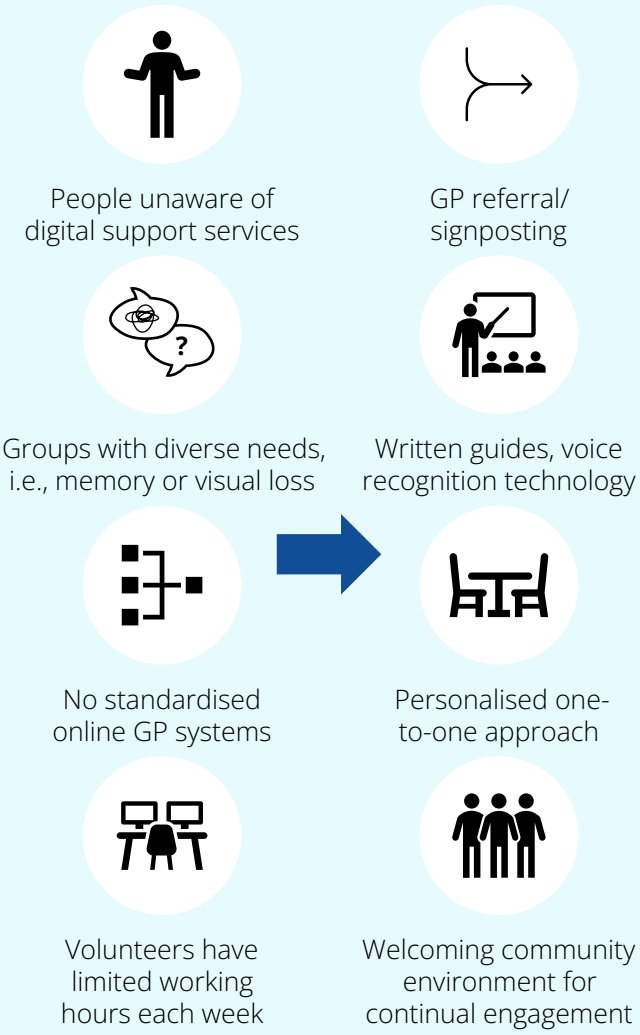


Source: Public Health Lincolnshire County Council, 2024

Cross Gates and District Good Neighbours Scheme (CDGNs) Hub

CDGNs was the first charity to launch a Digital Health Hub in Leeds. In 2020, the charity had 1,200 members over 60, with most attendees at their weekly wellbeing sessions living with long-term health conditions[10]. Members required support to use digital platforms or felt apprehensive about using technology. CDGNs successfully raised awareness about accessing healthcare online, introducing members to the NHS app and online GP systems while encouraging the usage of digital wellbeing apps such as bus timetable apps to help them avoid waiting in the cold[10].

Figure 26: Barriers and facilitators to Digital Health Hubs



Source: Public Health Lincolnshire County Council, 2024

Successes

In 2023, 15% of the partners working with 100% Digital Leeds supported over 20,000 people[11]. Out of these, 8,000 individuals participated in one-on-one or group skills sessions[11]. The model provided 12,000 SIM cards with free calls and texts to people experiencing data poverty and loaned over 1,000 devices[13]. On a larger scale, these efforts have encouraged people to take the lead in managing their health through digital resources[14] and given transient communities easier access to services, reducing the number of appointments and demand for services[9].

Community-embedded care

While technology-enabled care is a critical tool in our arsenal, it is not a silver bullet. We still need to provide in-person pathways to care in our communities, close to people's homes, to ensure equal access. We are already trying new approaches in Lincolnshire. For example, the Joint Aches and Pains Hub in Grantham. This program brought together services for people with musculoskeletal (MSK) conditions in a health village setting[15].

Community pharmacies also offer an opportunity to provide more convenient access to healthcare services. They can help with healthy eating, exercise, quitting smoking, monitoring blood pressure, providing contraception, and giving flu and COVID vaccinations. The new Pharmacy First service further expands the range of services community pharmacies offer, providing care for seven common conditions[16]. In general, people have a positive view of community pharmacies, with 90% stating they would feel comfortable seeing a community pharmacist for a minor illness[17].

In Lincolnshire, there is a wide range of services provided by community pharmacies, but we have not yet fully assessed how well these services are carried out and whether everyone can access them easily. There are other factors that might limit access to these services. For instance, many general practices in Lincolnshire dispense medicines directly to their patients. While this helps people get their medicines, these dispensaries do not provide the same broad range of direct access services as community pharmacies.

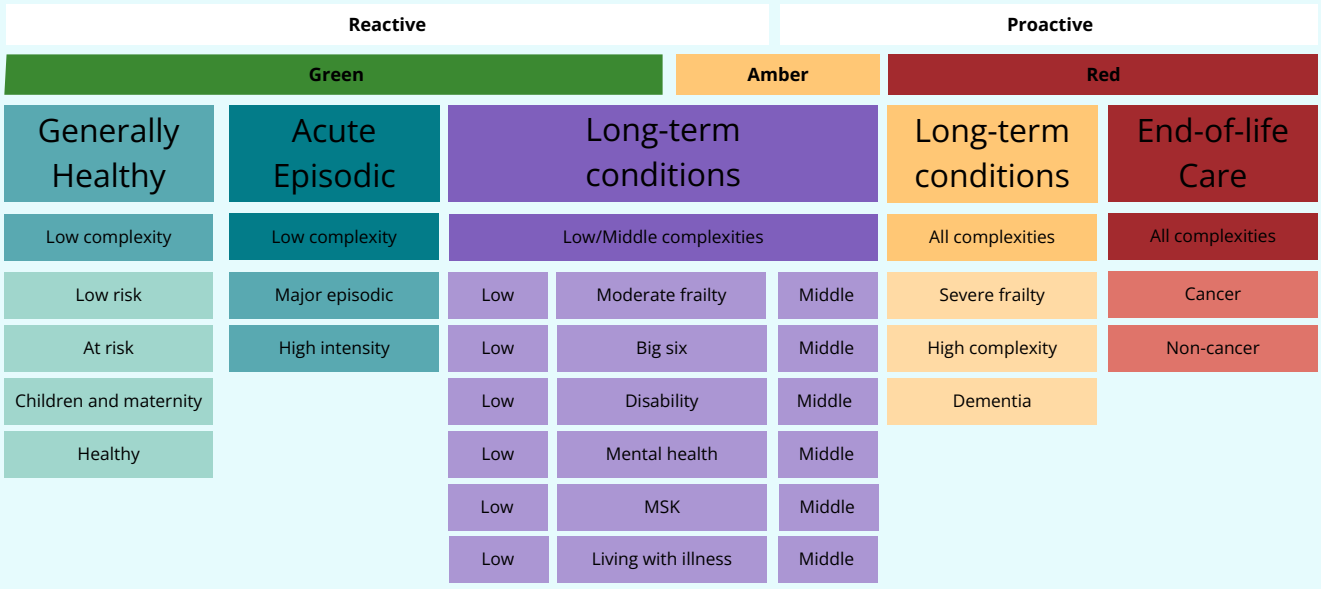
Application in Lincolnshire

By applying the approach of the Foundry Healthcare model, we can explore how to better manage the health and care needs of people in Lincolnshire.

Lincolnshire's Strategic Segmentation model divides the population into five main groups and several sub-groups based on their health characteristics (see Chapter 6, page 34). This model helps us understand and predict health needs. However, the needs of each segment must be met by integrated and simple service pathways.

Foundry Healthcare offers a model which translates a Strategic Segmentation model into a set of integrated services. Figure 27 illustrates how we could align Lincolnshire's population segments into a Foundry-like service structure, using three colour-coded categories: Red, Amber and Green (RAG), which guide the approach to service delivery to be taken.

Figure 27: Lincolnshire's strategic segmentation model mapped to a RAG service delivery approach



Source: Public Health Lincolnshire County Council, 2024

Using this RAG rating system, Lincolnshire's PCNs and GPs can better prioritise their resources by focusing on patients who need the most care while ensuring appropriate care pathways for those with fewer healthcare needs. This approach can improve patient outcomes, control costs, and support our workforce by more efficiently managing workloads.

Figure 28 shows the breakdown of the RAG rated GP population in Lincolnshire. It includes the total number of GP encounters and the calculated number of GP encounters per person per year (PPPY). The table highlights how different population segments influence demand on GP services. Those in the Red group interact with their GP most often, while those in the Green group interact the least.

Figure 28: Foundry model RAG rated GP Population in Lincolnshire

Green	Amber	Red
69% of the population	**24% of the population**	**7% of the population**
The majority of the patients, representing individuals with fewer or less complex health conditions. These patients generally require minimal GP involvement and are often well managed through routine care.	Individuals with moderate health issues, requiring more frequent GP visits for management of long term conditions. Likely to experience periodic health challenges requiring ongoing intervention.	Individuals with the most complex health conditions, often with multiple chronic conditions requiring intensive GP encounters and regular management. They account for a disproportionate share of healthcare resources.
GP Population: 567,589 **GP Encounters: 9,231,169** **GP Encounters PPPY: 16.3**	**GP Population: 196,494** **GP Encounters: 8,521,210** **GP Encounters PPPY: 43.4**	**GP Population: 54,232** **GP Encounters: 3,675,319** **GP Encounters PPPY: 67.8**

Data source: ICS Joined Intelligence dataset, 2024[18]

Foundry Healthcare used this segmentation approach to target and reduce potentially avoidable appointments. By helping patients manage their own health, improving digital access and offering alternative care pathways, Foundry Healthcare lowered avoidable GP appointments from 7% to 4.5%[2].

What would be the impact if we adopted a similar approach to delivering health and care across PCNs in Lincolnshire? Applying these estimates to Lincolnshire shows we could reduce unnecessary GP encounters*. Patients in Lincolnshire have over 21.4 million GP encounters each year. If we apply the national average of 16% avoidable appointments to these encounters[1]. We could avoid more than 3.4 million of these encounters each year.

If GPs across the county were to employ the strategies utilised by the Foundry Healthcare Model, we could feasibly achieve a similar percentage point decrease in avoidable appointments, from 16% to 13.5%. This would mean over 535,000 GP encounters could be avoided each year, representing a potential cost saving of over £4m annually.

Figure 29: What would application of the Foundry Healthcare model look like for Lincolnshire?

A reduction in avoidable GP encounters to

13.5%

could result in...

A reduction of over

535,000

unnecessary GP encounters

Equating to a cost saving of:

£4m

annually

Data source: ICS Joined Intelligence dataset, 2024[17]

What technology enabled care could mean for an acutely ill Lincolnshire resident – Antony's Story

Antony is a 60-year-old man who loves his rural life on the edge of Lincolnshire Wolds; he is generally well, although he lives with type 2 diabetes, which he manages with diet and physical activity. Having finished his week at work, he arrives home on a Thursday evening before the Easter weekend with a niggling headache, which he treats with the small stock of over-the-counter painkillers he keeps at home.

By Friday morning, his headache was worse, and he started to feel a bit nauseous. Recalling a session at his local Digital Health Hub a month prior, Antony accessed the NHS 111 website and ran through his symptoms. After answering the screening questions, which he knew would help diagnose the problem and direct him to the correct actions, he found that he may have a migraine. Antony takes note of the self-care advice, changes to a different painkiller, and rests up, noting the 'red flags' he should watch out for, which he shares with his partner.

Things have not improved by Sunday, and Antony's partner goes back to the NHS 111 site for more advice. The system now advises that a conversation with a 111 practitioner be conducted. A few hours later, Antony receives a call, and the practitioner undertakes a telephone assessment, which also indicates a migraine and rules out any red flags for more serious illnesses such as stroke. The practitioner advises of a specific pain killer, which can be purchased under the supervision of a pharmacist and tells Anthony where the nearest pharmacies are on the bank holiday weekend.

Antony's partner takes him to the nearest pharmacy armed with the assessment from NHS 111, purchases the recommended painkiller and returns home to rest. The pain is much better by Monday morning, but the nausea is worse. As Anthony is classed as an 'amber' person, he is directed to a remote consultation with a general practitioner who, having checked his diabetes control was not affected, sends a prescription for medicine for his nausea to the pharmacist.

Anthony starts to feel better quite quickly and makes a full recovery within the next 24 hours.

Key Points

- Providers working together as a single integrated team can reduce service overlap and make it easier for people to access care.
- Using data and Population Health Management approaches to understand health needs can help us invest our resources more wisely and develop targeted interventions that lead to better care, a more supported workforce and happier patients.
- Providing technology-enabled care while ensuring equal access can improve health outcomes, remove barriers to care and reduce health inequalities.
- Offering person-centred, face-to-face, community-based care closer to people's homes is key to reducing digital exclusion and empowering individuals to take the lead in their own care.

References

Streamlined access and a shift towards technology

[1] National Health Service England South East (NHSE, SE), 2023, *ELITE Programme Pilot report.* https://www.scwcsu.nhs.uk/doclink/elite-pilot-report-may-2023/eyJ0eXAiOiJKV1QiLCJhbGciOiJIUzI1NiJ9.eyJzdWIiOiJlbGl0ZS1waWxvdC1yZXBvcnQtbWF5LTIwMjMiLCJpYXQiOjE2OTQ1OTMxNTQsImV4cCI6MTY5NDY3OTU1NH0.chJXKT5LNmc8f9cuqRyCq5E4OzCbuVsdDILI9bulLZ4

[2] Tempo GP Networks, 2023, *Population Health Management Enabling Personalised Care*. https://tempo.gpnetworks.co.uk/about-tempo/foundry-pcn-model/

[3] Kent Surrey Sussex Academic Health Science Network (KSS AHSN), 2023, *Foundry Healthcare Lewes PCN Evaluation report.* Foundry Healthcare Lewes PCN - Unity Insights

[4] National Health Service Confederation (NHSC) 2023, *Genuine commitment to primary care at scale.* Genuine commitment to primary care at scale | NHS Confederation

[5] National Health Service England South East (NHSE, SE), 2024, *Modern General Practice working – a population health approach Foundry PCN, Lewes – Sussex.* Modern-General-Practice-working-Foundry.pptx

[6] Department of Health and Social Care (DHSC), 2024, Independent investigation of the NHS in England. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

[7] National Health Service England (NHSE), 2023, *NHS App reaches record users on fifth anniversary.* NHS England » NHS App reaches record users on fifth anniversary.

[8] Department of Health and Social Care (DHSC), 2024, *Independent investigation of the NHS in England: Technical Annex.* https://assets.publishing.service.gov.uk/media/66e1b517dd4e6b59f0cb2553/Independent-Investigation-of-the-National-Health-Service-in-England-Technical-Annex.pdf

[9] The Kings Fund, 2023, *Moving from exclusion to inclusion in digital health and care.* https://www.kingsfund.org.uk/insight-and-analysis/long-reads/exclusion-inclusion-digital-health-care

[10] Lincolnshire Health Intelligence Hub (LHIH), 2024, *Lincolnshire Digital Health Toolkit.* Lincolnshire Digital Health Toolkit - Lincolnshire Health Intelligence Hub. Contains OS Survey Data ©.

[11] National Health Service Providers (NHSP), 2024, *Health Hubs: A community centred prevention initiative to address health inequalities.* Health hubs: a community-centred prevention initiative to address health inequalities

[12] Good Things Foundation, 2020, *Digital Health Hubs: An evaluation for the NHS Widening Digital Participation Programme.* GoodThings_DigitalHealthHubsReport_2020.pdf

[13] Leeds City Council, 2024, *100% Digital Leeds update 03 April 2024.* Corporate report template for committee and officer decisions (new)

[14] Leeds City Council, 2021, *100% Digital Leeds evaluation.* PowerPoint Presentation

[15] It's All About People, 2024, *Grantham Joint Aches and Pains Hub*. Joint Aches and Pains Hub: Lincolnshire STP (itsallaboutpeople.info)

[16] National Health Service England (NHSE), 2024, *Pharmacy First.* https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/#:~:text=Community%20pharmacies%20offer%20a%20more,contraception%2C%20flu%20and%20covid%20vaccinations.

[17] Ipsos, 2022, *Public Perceptions of Community Pharmacy*. https://www.ipsos.com/en-uk/public-perceptions-community-pharmacy

[18] Integrated Care System (ICS) Joint Intelligence dataset, 2024, *Lincolnshire ICS Joined Intelligence Dataset*

*Note: Estimated projected figures presented are intended for illustrative purposes only. The development of a comprehensive analytical model remains a challenge due to the lack of a robust methodological framework and baseline data. We acknowledge the limitations of using external audit forms for identifying avoidable appointments and the restriction in applying these to a large GP population of over 800,000. We also acknowledge the limitations of equating GP appointments to GP encounters.

7 | Personalised care through multidisciplinary teams

A common theme among new models of primary and community health and care is a strong focus on personalised care and multidisciplinary team (MDT) working. These two aspects work hand-in-hand – patients are provided with personalised support tailored to their needs from an appropriate health worker, who works as part of an integrated and multi-professional team.

Patients with long-term health conditions are most likely to benefit from a joined-up and personalised approach to care. Patients are empowered to play a key role in decision-making about their care, to ensure that what matters to them is at the heart of their treatment plan.

A personalised and multidisciplinary approach enables health professionals to work closely with other providers in primary and community care, as well as with other partners in the healthcare system. This encourages a culture of shared learning and quality improvement, providing staff with the opportunity to build their professional skills and empowering them with decision-making authority. MDT working has been linked to greater job satisfaction among health professionals, in turn leading to improved retention within organisations..

Care with the person at the centre

Personalised care places the patient at the centre of health services, focusing on their specific needs. This means taking into account the individual's preferences, values and needs when making clinical decisions and providing care that is respectful and responsive to them.

The Health Foundation identifies four principles of person-centred care (Figure 30)[1]:

1. Affording people dignity, compassion and respect
2. Offering coordinated care, support or treatment
3. Offering personalised care, support or treatment
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

Figure 30: The Health Foundation's four principles of person-centred care

Source: The Health Foundation, 2014[1]

Person-centred care benefits not only the patient but also health professionals and the wider health system. Evidence suggests that when people play a bigger role in decision-making around their treatment and care, they are more likely to stick to their treatment plans, take their medicines correctly, and are less likely to use emergency services[1].

Personalised care and support planning for people with long-term conditions is one way to put the principles of person-centred care into practice. Through this approach, health professionals undertake shared decision-making with patients - asking what matters to them, supporting them to set goals, and jointly working to identify treatment options that will best meet their needs and preferences.

Lincolnshire's Integrated Care System is committed to personalised care and support planning as a way of working across all services. Steps are already being taken to achieve this, including promoting the co-production of service design and providing personalised care and support planning training for staff.

For person-centred care to work effectively, it must be a system-wide approach. It's not just a tool or a role for a set number of individuals. It is a philosophy that should underpin the planning and delivery of all health services.

Case study: Esther Model, Jonkoping, Sweden

In Jonkoping County, Sweden, the Esther model uses voluntary multidisciplinary teams made up of caregivers, clinicians, patients and families[2]. This is part of an obsessively person-centred approach designed to support independence and improve quality of life[3].

What is Esther?

"Esther" refers to a symbolic person with complex care needs who requires coordination and integration between the hospital, primary care, home care and community care.

The Esther model functions as a network of health and care providers and organisations. Each organisation participates voluntarily as an equal partner and must consider its role in coordinating care with the next provider and what information needs to be shared to ensure Esther's smooth journey through the care system[4].

Figure 31: What is best for Esther?

Under the Esther model, providers should guide care provision by asking "what is best for Esther".

Source: Public Health Lincolnshire County Council, 2024

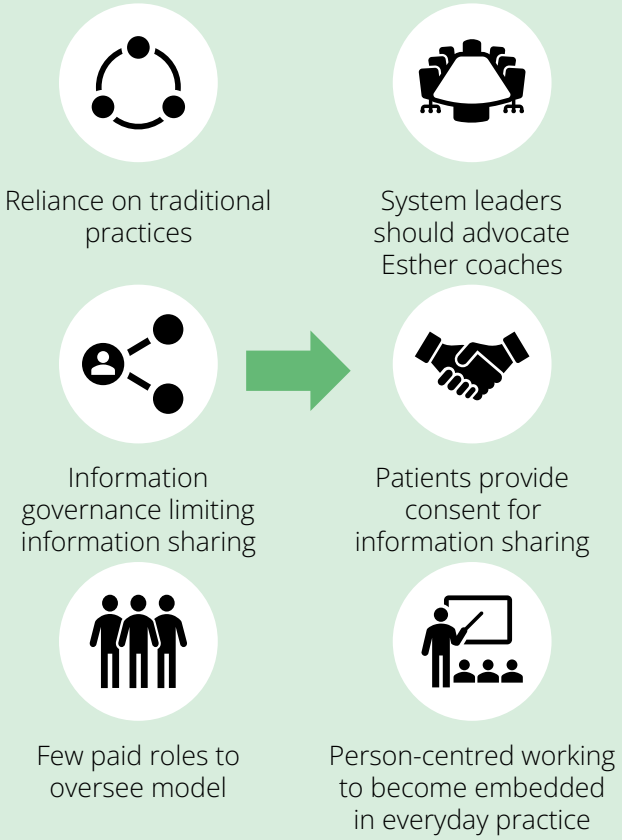
Esther Cafes

To involve Esther in the design of care, patients and service providers gather at regular Esther café summits to learn and improve based on the lived experiences of patients with health and social care services[5]. These cafes focus on the challenges and issues faced from Esther's perspective rather than that of a professional[6].

Esther Coaches

The Esther model builds a culture of continuous quality improvement through specially trained clinical and administrative staff from participating organisations[3]. These staff act as improvement coaches trained in quality improvement and client focus. Their role is to improve workforce skills, model best practices, and promote resource efficiency.

Figure 32: Barriers and facilitators to person-centred approaches to care



Source: Public Health Lincolnshire County Council, 2024

Successes

The Esther model has been linked to several positive changes in Jonkoping. There was a reduction in hospital readmission rates, a decrease in hospital length of stay for surgery from 4 to 3 days, and a drastic reduction in length of stay for rehabilitation from 19 to 9 days between 2009 and 2014[5]. However, a lack of comparative information makes it difficult to attribute these improvements exclusively to the model[5].

Integrated neighbourhood teams

The idea of organising care through integrated neighbourhood teams is not new in Lincolnshire. However, the focus here is not on past or current models, but on what evidence and guidance say about these essential building blocks for integrated, personalised care.

Two prominent reports have called for the establishment of integrated neighbourhood teams for health and care delivery in England, embracing MDT working and promoting shared ownership for the health and wellbeing of communities[7].

Integrated neighbourhood teams are made up of a wide range of professionals from different organisations across health and care and the voluntary sector, all working together at a neighbourhood level to provide coordinated care focused on the needs of the patient. These teams typically include GPs, district nursing, mental health professionals, pharmacists, social prescribers, social care and other council services.

The organisation of the health and care workforce into MDTs like Integrated Neighbourhood Teams, is required for the successful delivery of person-centred care. MDT working helps break down barriers in a health system that has traditionally been fragmented and difficult for patients to navigate.

For the individual this means benefitting from continuous support from a dedicated team of health professionals who get to know their needs, circumstances, and preferences. These professionals work together to provide care as close to home as possible. MDTs are not set up to manage every single health condition, but rather, they are designed to provide a holistic and personalised approach to care. Services may include:

- Support to individuals with chronic conditions through ongoing monitoring, treatment, and education
- Rehabilitation services to help individuals regain independence after illness
- Social care support to assist with social factors that influence health, including housing, financial issues, and social isolation.

Case study: An Accelerated Cluster Model, Cardiff Southwest

The Cardiff Southwest Primary Care Cluster (CSWPCC) is a group of 11 neighbouring general practices delivering health services to a population of 74,000 people across an area with high levels of deprivation[8]. CSWPCC has developed an 'Accelerated' cluster model that makes use of all its local assets, bringing them together in a multidisciplinary team to improve patient engagement with community services, promote good health, prevent ill-health and reduce emergency admissions.

Discharge hub

CSWPCC set up a discharge hub to identify and contact potentially vulnerable patients within 48 hours of hospital discharge to address unmet needs and offer support from providers. Dedicated pharmacists staff the hub to resolve any medication issues promptly, and a Cardiff council worker manages any household adaptations or meal provision. From 2020 to 2021, the cluster discharge hub contacted nearly 5,000 patients and completed over 3,000 medicine reviews[8].

Figure 33: CSWPCC service offering

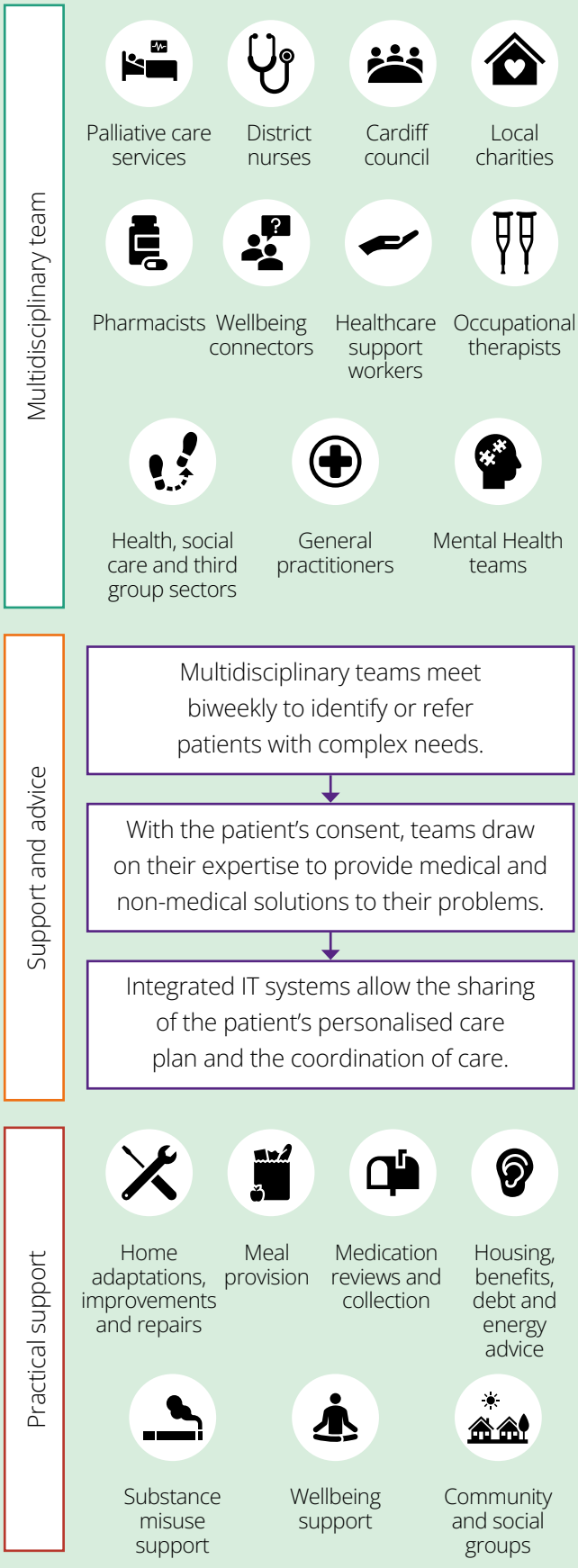
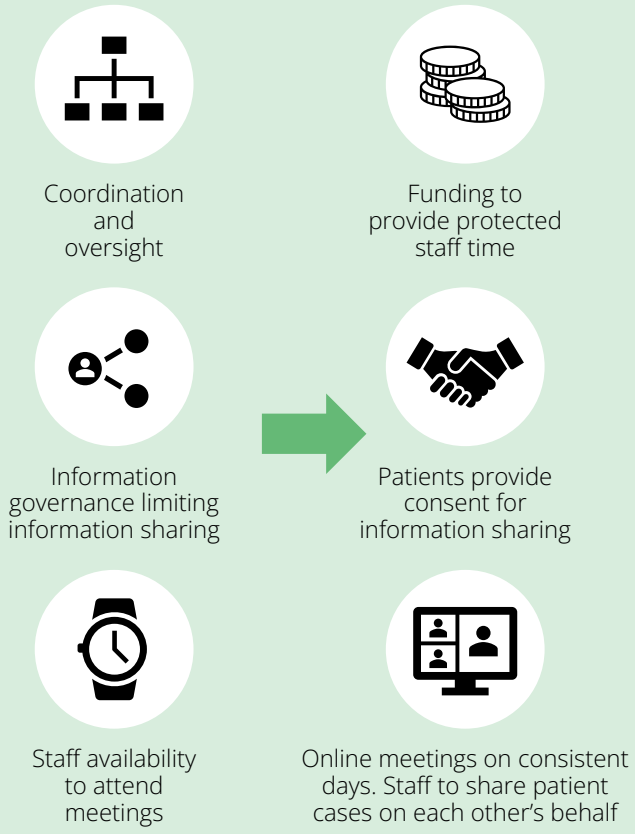


Figure 34: Barriers and facilitators to multidisciplinary team working



Source: Public Health Lincolnshire County Council, 2024

Successes

Research suggests that the CSWPCC's preventative approach has been successful in improving staff satisfaction and reducing GP attendance and hospital admission. Between 2019 and 2021, the multidisciplinary team discussed 592 unique patients, observing a 20% reduction in GP contact after issuing support and advice[8]. The accelerated cluster model was also linked to 800 avoided monthly referrals for assessment and a 50% reduction in monthly emergency bed days[8].

Person-centred, integrated mental health care

Mental health and wellbeing care needs should also be met using a person-centred MDT approach. In Lincolnshire this is already being put into practice through the mental health transformation programme, which brings together the voluntary, community, faith and social enterprise (VCFSE) sector alongside primary and secondary care partners to improve mental health care. People with lived experience are involved in all aspects of the programme, and personalised care is embedded throughout.

The mental health transformation team includes a variety of roles, such as psychologists, pharmacists, primary care mental health practitioners, social prescribing link workers and peer support workers. A range of community wellbeing hubs, satellite clinics, and outreach provision cover the county. This includes "Night Light Cafes" to provide face-to-face help when people are struggling in the evening. Volunteers with lived experience help make decisions about how the hubs are run and what they provide locally.

Evidence demonstrates that multidisciplinary teams provide better holistic care and increase access to all services available across the health and care, social, and voluntary sectors. In doing so, they lead to improved health by supporting individuals and their care teams to more effectively manage long-term conditions, improve recovery rates, and provide help early before more serious health issues occur. This is a more efficient way to deliver care, reducing costs for the health system and improving patient satisfaction.

Enabler of Change: Asset-based working

Asset-based approaches to health and care seek to build on the existing strengths of individuals and communities. Instead of focusing on what is missing or wrong, these approaches value and nurture local and personal strengths. This could include investing in local voluntary sector organisations to increase the scale and impact of their activities, multi-agency working with police, housing and employment services to address wider determinants of health or building the skills of health professionals to encourage innovation and positive risk-taking.

A successful example of this approach is the Buurtzorg model in the Netherlands, where self-managed nursing teams provide home-based social and clinical care[9]. Buurtzorg nurses are valued as assets and given a high level of autonomy in their work. They work to the top of their license and have the professional freedom to make independent decisions about what is best for their patients. The nurses make the most of the resources available to the individual patient by creating a support network of family, friends, and community and build the capabilities of the patient themselves to make independent living possible. This has resulted in high rates of job satisfaction among the nurses alongside high levels of patient satisfaction[10].

Application in the Lincolnshire context

How might this approach be applied to support Lincolnshire's goal of integrating care closer to people's homes? Many of the assets and services described in the models above are already in place. However, the approaches outlined here require services to be integrated in ways which make them work as a single system under a single leadership, regardless of the organisation name on their ID Badge. It requires all people involved in a patient's care to be able to see and contribute to their patient record and care plan, with the most appropriate person in the neighbourhood team ensuring continuity of care by responding to the needs of the patient over time. It also requires specialty team members to provide rapid response to the most urgent needs.

In the community of Tranås, as part of the Jonkoping Esther Model, a "Welcome Back Home" package was introduced for patients being discharged from hospital. This included systematic follow-up within 72 hours of patients being discharged and social care staff being present when patients returned home to make sure they had food, a clean bed, the right equipment and medication, and a personal alarm. Following its implementation, hospital readmission rates within 30 days of discharge for patients aged 65 and older dropped from 17.4% to 12.1%.

Noting that the demography and living conditions in Lincolnshire are not exactly like those in Jonkoping, If we were to use a similar approach in Lincolnshire, we could achieve a meaningful reduction to hospital readmission rates, outlined in Figure 35*.

Figure 35: What would the application of the Esther model look like for Lincolnshire?

In Lincolnshire

3,275

people aged over 75 are readmitted to hospital within 30 days of discharge annually

A reduction in hospital readmissions to a rate of

12.1%

could result in...

580

fewer readmissions within 30 days of discharg eannually

Data source: NHSE, 2024[11]

What integrated neighbourhood care could mean for an elderly Lincolnshire resident - Helen's Story

Helen is 83 and lives alone in a small bungalow, which she chose as she has a range of back and lower limb problems which make stairs impossible for her. She is fiercely independent, but her mobility problems mean she depends on her children to support her wish to stay at home, whatever happens.

She has a number of long-term conditions requiring multiple medications, giving her side effects, which has led to the occasional fall at home in the past. Her neighbours are great at keeping an eye on her, and to help her maintain her independence, her son funds a telecare alarm system, which includes an intelligent monitored medicines dispenser.

Helen has a first-name relationship with the health care assistants attached to her neighbourhood team, and these workers know what is normal for her and what her preferences are for her care when she needs it. Under the supervision of a registered nurse, they check in with Helen and her informal carers on a regular basis and take any issues she has back to the team.

Recently, Helen had a fall whilst trying to hang out some washing on a blowy autumn day. She hates drying her washing indoors, and being able to do this is really important to her. Through the neighbourhood team, Helen's support following her fall was easily coordinated, with immediate care for a small wound treated by the nursing team. A team member with some expertise in falls prevention was with Helen a few days later, looking at the layout of her routes around the bungalow and advising on changes.

The local pharmacist had already been asked to review her medicines again. The GP made the necessary changes, while the nurses attending to her wound dressing ensured Helen and her family understood and implemented the changes.

The local council made an appointment with Helen to talk about levelling the route from the back door to the washing line and ordered, through their Wellbeing Service, a smart little basket for laundry designed to attach to her walker that had already been provided by the integrated Occupational Therapy team. At no point was care provided outside of the community and primary setting to manage this episode of falling for Helen, nor to plan to reduce future risk in line with her choices.

Within no time, Helen's life returned to normal, and she could more safely hang out her laundry when the weather allowed. Her healthcare team were able to confirm through the shared records that everyone involved had restored routine contact with Helen.

Key Points

- Delivering person-centred care benefits both individuals and the wider health system. It can lead to improved adherence to treatment plans, correct use of medicines and reduced use of emergency services
- Person-centred care is a philosophy that requires a change in culture across the entire system with the approach embedded in the planning and delivery of all services
- Multidisciplinary teams provide an efficient way to deliver care by increasing accessibility to all services available across the health and care, social, and voluntary sectors, while improving patient satisfaction
- Using an asset-based approach provides an opportunity to invest in and upskill the health workforce. By valuing the skills and expertise of all cadres of health professionals and giving them a high level of autonomy in their work, staff satisfaction can be increased.

References

Personalised care through multidisciplinary teams

[1] The Health Foundation, 2016, *Person-centred care made simple: what everyone should know about person-centred care*. https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf

[2] Qulturum, 2017, *ESTHER*. ESTHER, Qulturum, Region Jönköpings län (rjl.se)

[3] 1000 Lives Plus, 2011, *Quality, Development, and Leadership – Lessons to learn from Jonkoping.* https://folkhalsaochsjukvard.rjl.se/api/Evolution/pdf/c134b8f2-22c9-4ddb-98ec-cbdafdfbaacf

[4] The Commonwealth Fund, 2016, *Sweden's Esther Model: Improving Care for Elderly Patients with Complex Needs.* Sweden's Esther Model: Improving Care for Elderly Patients with Complex Needs | Commonwealth Fund

[5] Kent County Council, 2022, *The Esther Model: Learning from Health and Social Care in Sweden.* The-Esther-Model.pdf (kent.gov.uk)

[6] Qulturum, 2017, *What is best for ESTHER?* https://www.rjl.se/globalassets/qulturum/dokument/qulturum/esther/esther_broschyr_21_april_2017_english_rb_final.pdf

[7] National Health Service England (NHSE), 2022, *Next steps for integrating primary care: Fuller stocktake report.* NHS England » Next steps for integrating primary care: Fuller stocktake report

[8] Withers et al., 2024, *A long way from Frome: improving connections between patients, local services and communities to reduce emergency admissions. BMC Primary Care 25(1). doi:* https://doi.org/10.1186/s12875-024-02557-4

[9] Buurtzorg International, 2015, *The Buurtzorg Model.* The Buurtzorg Model - Buurtzorg International

[10] Drennan et al., 2018, *Tackling the workforce crisis in district nursing: can the Dutch Buurtzorg model offer a solution and a better patient experience? A mixed methods case study. BMJ Open, 8(6). doi* https://doi.org/10.1136/bmjopen-2018-021931

[11] National Health Service England (NHSE), 2023, Compendium – *Emergency readmissions to hospital within 30 days of discharge.* Compendium - Emergency readmissions to hospital within 30 days of discharge - NHS England Digital

*Note: Estimated projected figures presented are intended for illustrative purposes only. The development of a comprehensive analytical model remains a challenge due to the lack of a robust methodological framework and baseline data. We acknowledge the limitations of the baseline data for emergency readmissions to hospital within 30 days of discharge, which is only available by age bands <16 years, 16+ years, 16-74 years, and 75+ years.

8 | Conclusions and recommendations

Conclusions

The overall population trends for Lincolnshire show that we have made significant progress in increasing life expectancy for children born today. We should take pride in this achievement but be mindful that far too many people spend these extra years in poor health.

Without us all agreeing to take faster and more ambitious action for change, the results of this ongoing trend will be difficult to accept. More and more of us will stay unwell for longer periods of our lives, creating demands for support from health and care services which cannot be met ether financially or by our equally ageing workforce.

The actions required to start counteracting our population's growing health needs and ensure our health and care system's future ability to meet demand are less evidenced than we may like. However, many approaches have been known for some time that we can start embedding now.

In line with this report's emphasis on putting people at the heart of care, let's frame our conclusions around what is important to a person, what they require for their care, and what we conclude they need.

More focus on prevention at all stages of life and wellbeing is key to reducing and delaying our risks of poor health. None of us should be unsure of the best ways to protect our own health and where to find trusted sources of information, advice and support.

When we need some support, we need our own networks of friends and family to be around to lend a hand, and we should have easy access to community-based health workers near where we live who can assist us.

Many of us make use of digital tools to access this help. It's important that more of us are supported in making effective use of technology to do everything from learning how to manage our own health to knowing where to look when we are poorly. We need more than just some of us to be encouraged to go digital when we have evidence of the benefits that digital can have for the unconnected people in our county.

Services need to be closer to where we live and work, and they should work together as one system, or where this is not possible as simple systems. These systems need to be centred on what we need and what matters to us, from the top level of design down to the conversations we have with people.

Some of us will have health needs that are so changeable day to day that we will benefit from having people with an interest in our health keeping in touch with us. This group can include family, friends, carers and healthcare workers who know what is normal for us and will help us spot when things are changing for the worse. When this happens, they will see it and agree with us on what we want to happen to enable us to stay where we have chosen to live.

In this report, we have described the unique challenges our county faces and laid out the case for change in primary and community healthcare delivery as a starting point to address these. We have described several approaches we can start implementing now, and the following recommendations indicate areas where we might begin to make these changes.

Recommendations

1. Develop new relationships with the public where they are supported to take the lead for their health and care.

- Treat personalisation and the person-centred design of services as a culture change initiative, not just a service add-on, and build on work that has already begun under the personalisation programme.
- Promote self-care practices and build peoples skills and confidence to self-manage their long-term health conditions to help ease symptoms and improve quality of life through interventions such as health coaching and digital health apps.

2. Develop a renewed focus on prevention.

- Redesign a service or pathway for better health outcomes and include self care and prevention at every stage of the redesign
- Develop more systematic approaches to prevention and self-care by transforming our wide range of 'social prescribing' roles into a network of Community Health and Wellbeing Workers who work in communities to promote healthy behaviours and support self-care.
- Systematically address wider determinants of health at an agreed population level through partnership working between the health and care sectors, local authorities, and public services. Focus first on people whose health needs are closely linked to social and environmental factors.

3. Harness digital technology to innovate the delivery of care and use digital inclusion to avoid leaving people behind.

- Speed up and scale up the use of digital technology to improve access to health and care information and services. Make digital-first models the preferred entry point for people to access health and care and use digital apps to support them in self-care and self-management.
- Integrate digital inclusion approaches in all health and care initiatives that use technology. For example, provide resources, spaces and opportunities for people to learn skills and build confidence in using health-related technology.

4. Deliver person-centred care closer to home through integrated multidisciplinary teams.

- Build on the work of primary care networks to develop integrated teams to triage, assess, refer and treat people.
- Extend current efforts to integrate teams of different disciplines and sectors to incorporate all primary and community services at an agreed population level. Evidence would suggest at a population level of 60,000-100,000 people.
- Take forward the design of a system-wide 'Green' channel for people with one-off or newly presenting health and care issues, with an easy-to-navigate digitally driven triage, advice and sign-posting front end.
- Streamline pathways into care into the smallest number of pathways possible, avoiding creating specialist or niche pathways unless safety considerations demand it. Make them simple for people and practitioners to navigate and use effectively.

5. Support and invest in our workforce to co-produce and embrace new models of care.

- Through the establishment of multidisciplinary teams, systematise partnership working and shared learning among health professionals and wider system partners for skills building and quality improvement.
- Give health workers the professional freedom to make independent decisions about what is best for their patients, encourage them to innovate, and support them in positive risk-taking in order to make possible the implementation of new, person-centred models of care.

Glossary

Community Health Care – Community health teams support people with complex health and care needs to live independently in their own home for as long as possible. Additionally, services include promotion services such as school health services and health visiting. They are made up of a wide variety of professionals including community nurses, allied health professionals, district nurses, mental health nurses, therapists and social care workers. (NHS England)

Community Pharmacy – Community pharmacies offer a more convenient way to access healthcare that includes support for healthy eating, exercise, stopping smoking, monitoring your blood pressure, contraception, and flu and covid vaccinations. (NHS England).

Digital Exclusion – This covers three things: Digital skills – being able to use digital devices such as computers and the internet; Connectivity – access to the internet through broadband, wi-fi, and mobile phone; and Accessibility – Services designed to meet all users' needs, including assistive technology. (NHS Digital)

Health Inequality – Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. (NHS England)

Health Literacy – Health literacy is a two-sided issue, comprising both an individual's ability to understand and use information to make decisions about their health and care, and a 'systems issue', reflecting the complexity of health information and the health care system. There is a strong social gradient in the population, with lower levels of health literacy much more common among the socially and economically disadvantaged. (NHS England)

Integrated Care System (ICS) – ICSs are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are 42 ICSs across England, covering populations of around 500,000 to 3 million people. (The King's Fund)

Multidisciplinary Teams (MDTs) – A group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users. MDTs are used in both health and care settings. (NHS England)

NHS Confederation – The membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. (NHS Confederation)

Office for Health Improvement and Disparities (OHID) – OHID is part of the Department of Health and Social Care (DHSC) and focuses on improving the nation's health so that everyone can expect to live more of life in good health, and on levelling up health disparities to break the link between background and prospects for a healthy life. (OHID)

Person-centred Care – Focusing care on the needs of the individual. Ensuring that people's preferences, needs and values guide clinical decisions and providing care that is respectful of and responsive to them. Health and wellbeing outcomes need to be co-produced by individuals and members of the workforce working in partnership, with evidence suggesting that this provides better patient outcomes and costs less to health and care systems. (Health Education England)

Personalised Care – Personalised care represents a new relationship between people, professionals and the system. It happens when we make the most of the expertise, capacity and potential of people, families and communities. (NHS England)

Population Health Management (PHM) – PHM improves population health through data-driven planning and the delivery of proactive care to optimise health outcomes. This means moving to a proactive system that focuses on interventions to prevent illness, reduce the risk of hospitalisation, and address inequalities across England in the provision of healthcare. (NHS England)

Primary Care – Primary care services provide the first point of contact in the healthcare system and includes: General practice; Community pharmacy; Dentistry; and Eyecare. (NHS England)

Primary Care Network (PCN) – PCNs are made up from groups of neighbouring general practices brought together to work at scale. This means they should have a greater ability to recruit and retain staff; manage financial and estate pressures; provide a wider range of services to patients; and to more easily integrate with the wider health and care system. (The King's Fund)

Secondary Care – These are services provided by medical specialists who in general do not have first contact with the patient. This includes: Planned or elective care – usually in a hospital; Urgent and emergency care, including 999 and 111 services, ambulance services, hospital emergency departments, and out-of-hours GP services; and Mental health care. (NHS Digital)

Segmentation – Data segmentation is the process of taking the data you hold and dividing it up and grouping similar data together based on the chosen parameters so that you can use it more efficiently to understand the health needs of the population. (Experian)

Self-care – Self-care is about keeping fit and healthy, understanding when you can look after yourself, when a pharmacist can help, and when to get advice from your GP or another health professional. (NHS England)

Tertiary Care – Tertiary care is highly specialist treatment, such as: Neurosurgery, Transplants, Plastic Surgery, and Secure forensic mental health services. (NHS Digital)

Voluntary, Community, Faith and Social Enterprise (VCFSE) – Partnership working between voluntary, community, faith and social enterprise (VCFSE) organisations and ICSs to improve health and care outcomes. (NHS England)

Lincolnshire
COUNTY COUNCIL
Working for a better future

Lincolnshire County Council
County Offices, Newland, Lincoln, LN1 1YL
www.lincolnshire.gov.uk