








Lincolnshire Sustainability and Transformation Plan

Contents

Foreword

Lincolnshire has worked together more closely than ever in the past 3 years to develop the Lincolnshire Health and Care Programme; our Blueprint for future health and care services in Lincolnshire and our new model of care. The development of the Sustainability and Transformation Plan over the last year has built on this strong foundation and is a major milestone in a very complex and extensive programme of work. The implementation of this Sustainability and Transformation Plan will bring about the most radical change which most people will see in their working lives, but these changes do reflect the best evidence of what will give us the best outcomes for the people of Lincolnshire. As important as the evidence, there is also collective will to make it happen and a growing confidence, in our ability to deliver real change in challenging circumstances.

In 2013 the work of Lincolnshire Health and Care programme confronted the system with the fact that if we did not act soon not only would the quality continue to deteriorate in our services but we would face a growing overall system deficit in excess of £200m. By 2015/16 the deficit had risen from around £15m to around £73m but little action in reality had been taken confirming the need for radical change. For those whose task it is to scrutinise and critically evaluate this plan, the question must be "so what will be different this time and what has fundamentally changed in order for good ideas to be translated into action?"

These changes are as follows:

1. Changed awareness and understanding of the challenges. All organisations in Lincolnshire now realise that irrespective of statutory boundaries we are all inter-dependent and everyone has a part to play. All of these organisations now have a greater understanding of the priorities and the financial positions of other organisations thanks to the adoption of an open book process.

2. A changed approach to leadership – the leaders of the Lincolnshire system accept that there is a collective responsibility for addressing the issues and that in the light of the scale of the challenge; each senior leader will be needed to lead across the system. There is an acceptance from leaders that the well-being of the system and the people of Lincolnshire is the primary responsibility as leaders with organisational priorities secondary.

3. Changed behaviours in the past year - leaders and Lincolnshire organisations have worked hard to put behind them the historical adversarial and transactional relationships which have characterised the past to develop common agendas, common assessment of problems but also to hold each other to account in a positive and respectful way.

4. Changed understanding of the solutions – whilst historically we have been very focussed on issues around hospitals, there is an acceptance across the system that the key issue is the move to community services, the prevention agenda, proactive care and the development and scale of self-care for many of the people who currently use services. There is an acceptance that only by resolving these issues will we create the space to address the challenges our hospitals face.

This STP has been developed by cross-organisational working; much of its content has already been the subject of engagement with the public and with stakeholders through the LHAC process but some of it is new. Whilst people may see the headlines of the STP as acute reconfiguration, the major changes in reality are in the community. The scale of the efficiency gains and productivity gains dispersed and often disconnected as at the moment is significant. The need to modernise and develop our workforce will be very challenging and the need to fundamentally rebalance the capacity in both our community services and our hospitals will be very challenging indeed. In the past Lincolnshire has often attempted to please everyone, particularly where there is a choice between local access and the benefits of centralisation. Poor infrastructure, difficult travelling and sometimes local prejudice have made discussion regarding centralisation difficult.

It is vitally important to stress that whilst we have had to use an artificially constructed range of reconfiguration options in order to construct a model for this plan under the "do something scenario"; it does in no way constitute the preferred option nor the final option as full public consultation will be required. The choices we will be required to make will be complex and will inevitably involve change. It is vital that we have public and professional input to the process not just because it is a statutory requirement but because it will help make a better series of decisions. It is always a difficult line to tread between not testing out potential scenarios properly and giving the impression that decisions are already made; we hope that the dialogue we have established through the Lincolnshire Health and Care programme will help reassure the public since we have been discussing openly the challenges we face as a system and what potential solutions may be. Change can create fear, even when that change is for the better longer term; before we finalise our options for change we have a great deal of talking and more importantly listening to do.

This STP sets a foundation for a conversation with the people of Lincolnshire within which as leaders and professionals within the system, we must make the right choices together to ensure that our services are safe and sustainable for the future. A poor service that is very close to home is not an alternative option to a high quality service that is a bit further but is accessible.

Lincolnshire must start to capitalise on the scale of its population and begin to operate and plan and deliver its services for our ever growing population. For many services, the unit of delivery must be the Lincolnshire system and not a distinct locality. However, for the majority there will need to be a stepped change to move services closer to home with the development of Neighbourhood Teams and the significant expansion of primary care based services across all care groups. This will negate much of the need to travel longer distances that the current system often asks of people. The people of Lincolnshire deserve the best services. This STP is the start of our collective programme to make this aspiration a reality.

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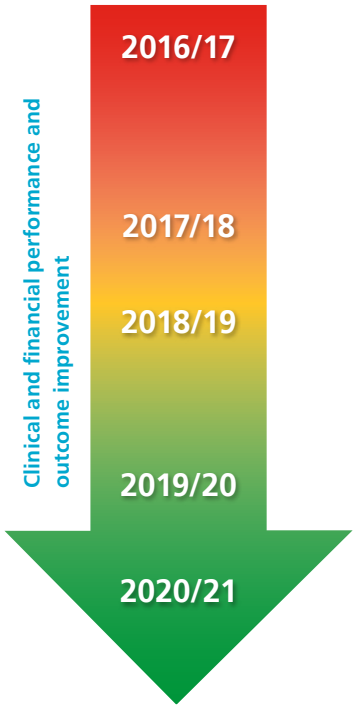
Lincolnshire Sustainability and Transformation Plan on a Page

Our Vision

To achieve really good health for the people of Lincolnshire with support from an excellent and accessible health and care service delivered within our financial allocation

Our Objectives

Develop Multi-speciality Community Providers alongside integrated strategic commissioning arrangements	System financial plans achieved annually and financial balance is achieved by 2021	High quality and effective services	Keeping people well and healthy	Change the relationship between the individual and the care system
Develop a network of community hospitals and primary care hubs supporting Neighbourhood Teams	Move care from acute hospitals to neighbourhood networks providing care closer to home	Simplified pathways for specific diseases based on what works well with fewer people travelling out of county	A smaller but more resilient acute hospital sector providing emergency and planned care	Develop resilient specialist mental health inpatient facilities in county



Drive delivery of 16/17 recovery plans for NHS
Constitutional Standards, Quality Innovation Productivity and Prevention Programmes and Cost Improvement Programmes

Deliver further financial improvement
- Realise benefits of Operational Efficiency and Commissioning Priorities /RightCare projects in 2017/18
- From 2018 onwards, realise further benefits in reduction in variation and demand plus deliver improved outcomes

Engage and consult with the public, finalise clinical redesign and start to implement

Promote prevention and early intervention and implement primary care strategy
- Build equitable mental health and emotional wellbeing capacity
- Achieve fully integrated health and care neighbourhood networks
- Reduce bed stock
- Establish Multispecialty Community Providers by 2020

Deliver a smaller but more resilient acute hospital sector
- Centralisation of fragile services and specialties to achieve critical mass and resilience

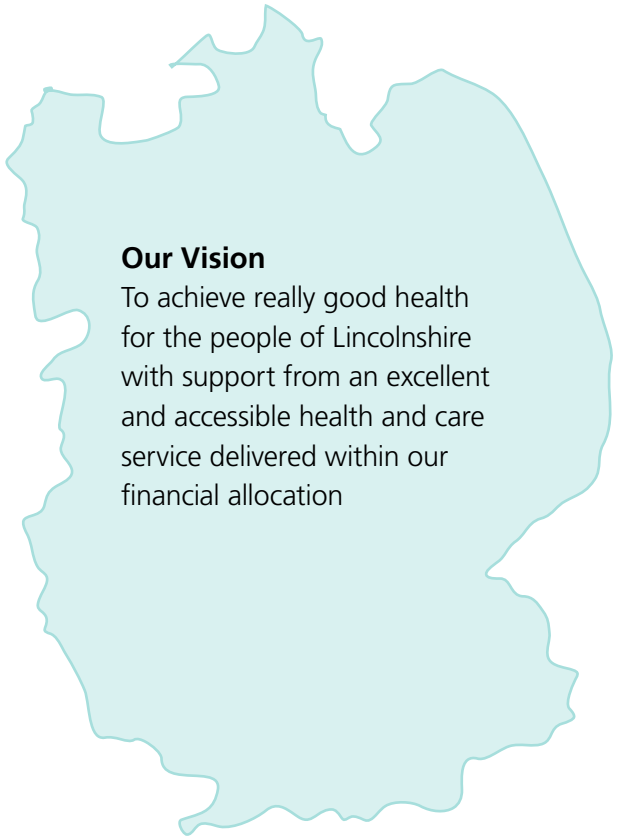
Clinical and financial sustainability secured
- Improvements in health and patient experience outcomes demonstrated
- Staff engagement results will be in top quartile by 2019
- 300 lives saved from mortality that is preventable by 2021.
- Non elective admissions are reduced by 10% by 2021

Executive Summary

There is a strong case for change which is shared by the collective leadership, partner organisations and stakeholders. There is shared acceptance that the "status quo" is neither safe nor sustainable which is the driver behind creating our vision. This has been developed by all organisations, drawn from engagement with over 18,000 people as part of our engagement programme and underpinned by proposals developed in our clinical expert reference groups with input from hundreds of clinicians

How will it be different for patients?

- Residents will take more responsibility for their own health, both in managing long term conditions and in making healthy lifestyle choices to keep fit and well.
- They will be able to access their records via the Care Portal to assist them with caring for themselves if they have self-limiting or long-term conditions.
- They will know who their GP is but are likely to have initial consultations with a range of primary care and community based health and care staff, often via phone or using telemedicine. They will find they don't need to explain their health and care issues in detail more than once.
- For ongoing health and care issues, their main contact may well be their GP. They can expect that most diagnostic tests and specialist consultations will be undertaken locally.
- If they need specialist emergency or planned care, they may need to travel to an acute hospital but will be able to return to their own community very quickly.
- They will find that all those caring for them are well trained and motivated, working effectively with their colleagues, and that their care is delivered in comfortable surroundings. They will be able to access the right service first time and will consistently receive good quality, safe care wherever they live in the county.



How will it be different for staff?

- Lincolnshire will be a great place to work, a place where staff feel valued and empowered to carry out their roles.
- Staff will have a clear understanding of their own role and skills and where these fit in with others across the health and social care setting, enabling them to work seamlessly with their colleagues.
- They will work in pleasant environments, mostly in community settings, free of the frustrations from IT systems and unreasonable work load expectations.
- They will have a good work life balance and their job roles will be varied and exciting with greater opportunities for development.

This Sustainability and Transformation Plan has been developed by the whole Lincolnshire system. It covers the underpinning changes that have been required to enable us to develop the plan and become ready for implementation, including how organisations and leaders:

- **Have changed their awareness and understanding of challenges,**
- **Have developed a changed approach to leadership,**
- **Have changed behaviours in the past year**
- **Have developed a different and shared understanding of the solutions.**

The plan shows how we have developed new governance to ensure we can maximise the benefit of our collective vision and get ready to deliver the changes; establishing:

- **Lincolnshire Coordinating Board** bringing together the chairs of all organisations together to bring oversight to the system
- **System Executive Team** all Chief Executives and Officers working together with senior Local Authority leaders and the Local Medical Committee
- **STP Programme Board** senior directors from all organisations leading across boundaries
- **Programme Management Office** to make delivery easier and accountability clear

This STP document represents a Lincolnshire system-wide submission to meet national planning requirements. It has been produced by clinicians and managers, incorporating contributions from County Council officers where appropriate and building on inputs, views and comments from over 18,000 residents, stakeholders and staff. It represents relevant Public Health and Social Care views. The STP submission remains draft and has not yet been subject to any formal sign off process by NHS Boards, Governing Bodies or within the County Council.

Lincolnshire faces a number of challenges:

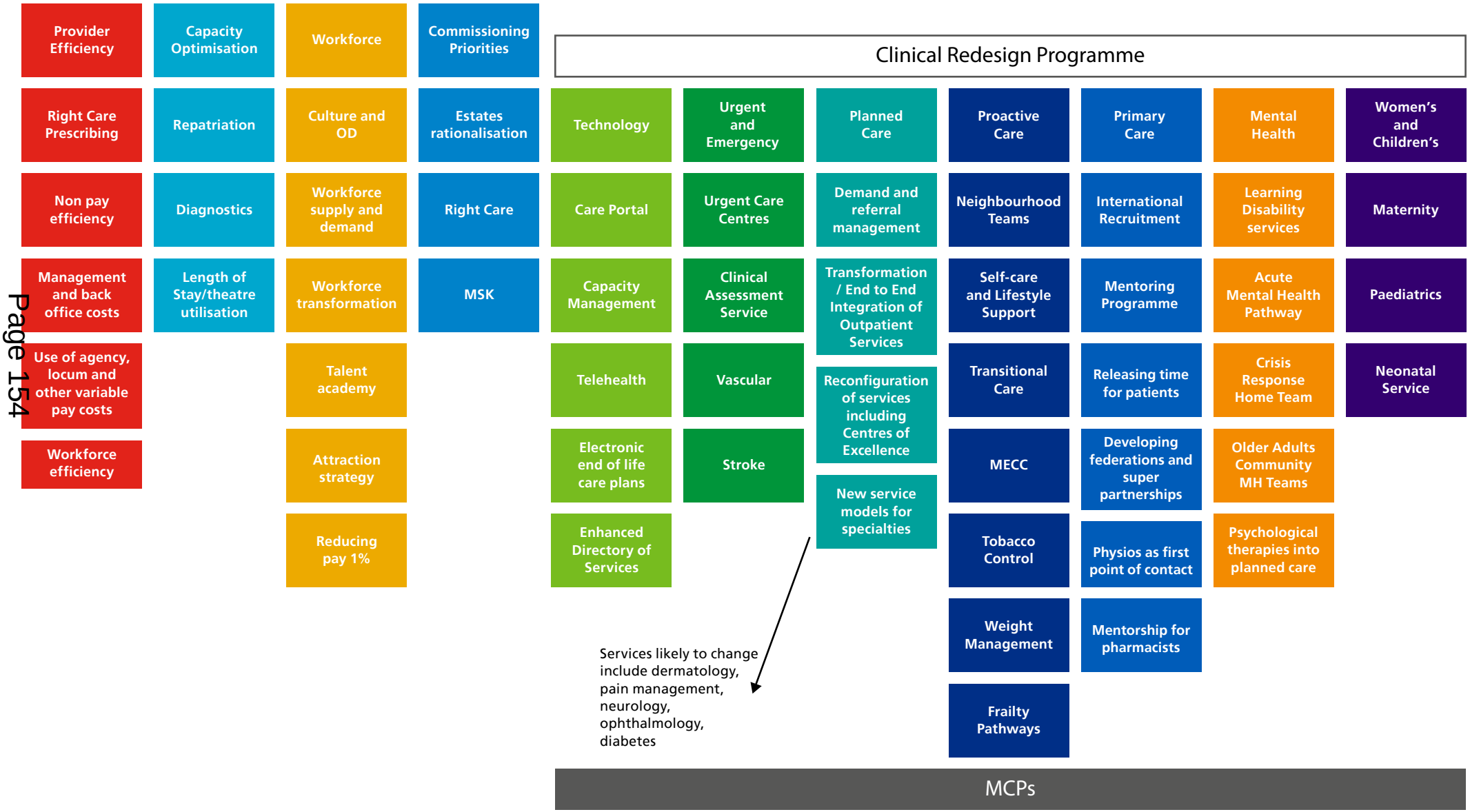
- **A growing but ageing highly dispersed population**
- **Inconsistent delivery of high quality services; fragile and dispersed delivery**
- **Patient experience that varies from excellent to poor depending on service or geographic location**
- **An outdated model of delivery based on response to crisis**
- **A workforce challenge across all sectors; recruitment issues and an ageing workforce that is less engaged than it needs to be in many services**
- **Financial challenges a £73m deficit in 2015/16**

It spells out the vision developed across the community **"to achieve really good health for the people of Lincolnshire with support from an accessible and excellent health and care service delivered within the financial allocation"**.

Lincolnshire's plan is based on the five key themes

Theme	Objective	Savings
Clinical redesign	• Services that can deliver national standards • Improved safety and quality • Sustainable workforce • Getting the clinical economies of scale • Primary, secondary and tertiary prevention are integral to all of our clinical redesign programmes	£36m
Capacity optimisation	• Reducing duplication • Reducing underutilised space • Increasing local capacity so that more patients have a choice of services in Lincolnshire	£14m
Operational efficiency	• Reducing management costs • Increased use of technology • Better procurement • Reducing costly duplication • Maximising the benefits of scale	£62m
Workforce productivity and redesign	• Developing a modern workforce • Increasing the productivity of teams • New roles and career pathways • Managing the growth in pay costs effectively • An engaged and innovative workforce	£18m
Right Care and Commissioning priorities	• Investing in interventions that deliver better value and outcomes for the people of Lincolnshire • Making sure we do what works and reflects best evidence	£6m

Diagram below is a representation of our STP programme

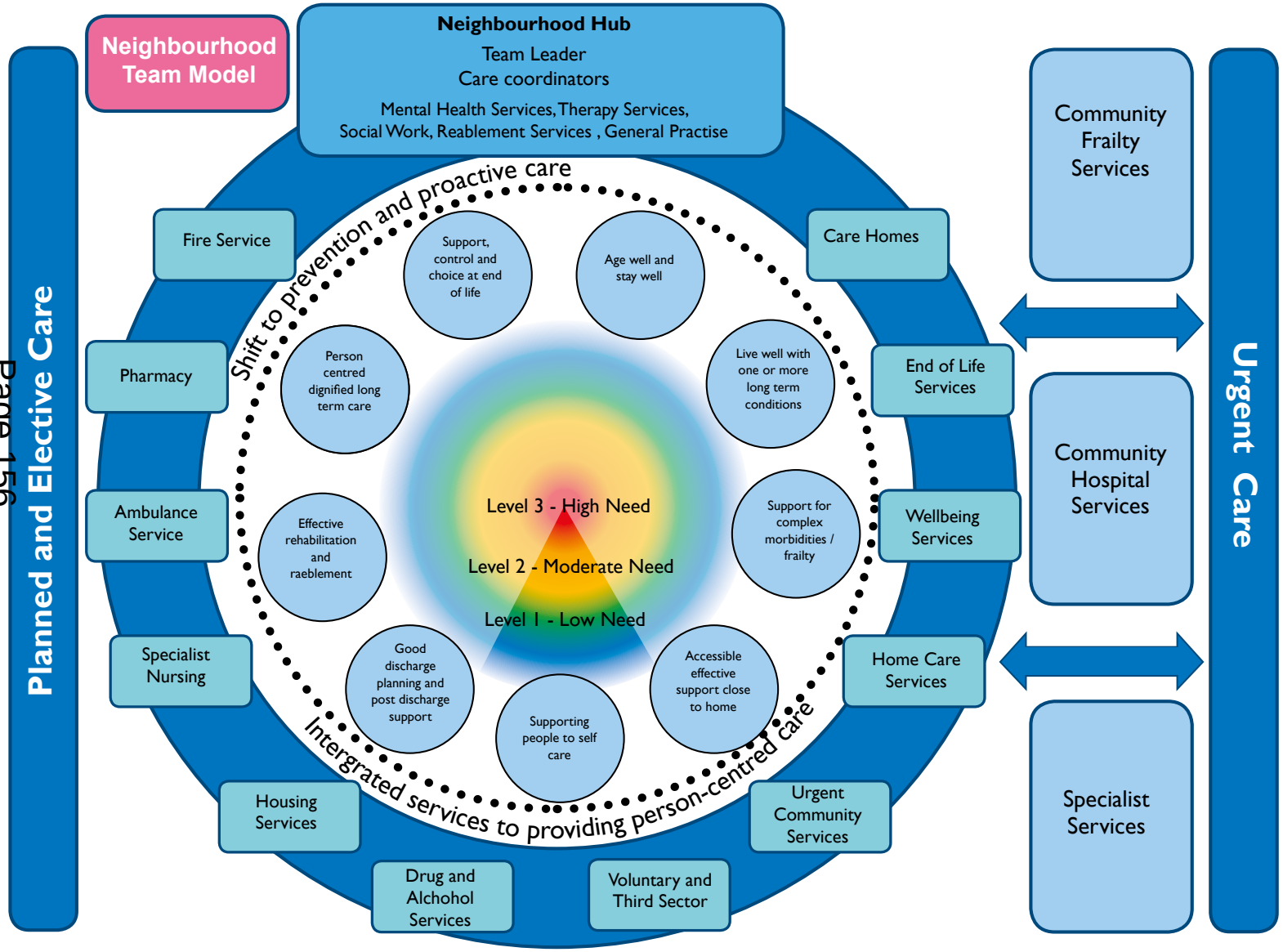


The plan begins by exploring what this will actually mean for patients and looks at what the difference at the end of the plan will be.

The plan recaps on the progress made so far as Lincolnshire has been working on developing its vision, moving towards implementation through its Lincolnshire Health and Care Programme and building on our success around integrated working between the NHS and local Government:

- Our early work on developing neighbourhood teams including case management,
- Our successes in the past and centralising services such as the Lincolnshire Heart Centre,
- Our track record around innovation such as the country's first Hospice in a Hospital,
- Our innovative work on recruitment and retention where we will be trail-blazing nationally on recruitment and introduction of GPs from within the EU,
- Our trail-blazing work on our Clinical Assessment Service (Urgent Care Clinical Hub) which has already started and
- Our nationally leading work on the Care Portal which we have now begun to implement.
- The plan spells out our overarching vision with a step change in how we deliver the care model:
- Developing prevention activities and self-care at scale
- Moving care closer to home through integrated Neighbourhood Teams and moving it to a proactive footing
- Enabling our hospital system to downsize, becoming more resilient and sustainable
- Offering more choice for Lincolnshire people to have their treatment locally than at present.
- Making better use of technology including our Care Portal enabling the sharing of clinical information and the ability of patients to contribute to their own records

The diagram below illustrates the new model of community care with community integrated Neighbourhood working at the centre of service delivery.



The plan outlines the journey, including the work on public engagement that has taken place over the last two years in developing the vision and also identifying some of the tough choices that need to be made for a sustainable future in Lincolnshire. This will inevitably be controversial however we all believe that we can present a coherent story to the people of Lincolnshire that will enable them to see the real improvements that can be made.

To date our engagement with the public has been very strong through the Lincolnshire Health and Care programme

- **Over 18000 people engaged in the LHAC programme; through different channels**
- **150 events and briefings carried out by the team in the past 12 months**
- **300 women engaged in the maternity design work**
- **Dedicated LHAC website**
- **Ongoing programme of briefings for County and District elected members**
- **Positive public media reaction to our published case for change document; specific engagement with 800 members of the public in response to it**

The plan shows how Lincolnshire will deliver against the national key elements outlined in the mandate and in the planning framework as well as how Lincolnshire will address its health and well-being challenge including any unwarranted variation that exist. It has already well documented the care and quality challenge and how Lincolnshire will close its financial gap.

The plan outlines the key clinical redesign programmes:

- **Proactive Care**, including **Primary Care**,
- **Urgent Care**
- **Planned Care**, including **Cancer Services**
- **Mental Health** and **Learning Disabilities**
- **Women and children**

The plan also addresses key themes in underpinning enablers:

- **Workforce and Organisational Development**
- **Technology**
- **Estates**
- **Transport**
- **Communications and Engagement.**

The plan outlines a very different future than at present for Lincolnshire with primary care and community services playing an increasingly central part in the system with greater integration between health and social care and services which are built around patients and citizens rather than services that they have to fit into. The plan outlines the key clinical reconfiguration options and some of which will be controversial and others less so but outlines the key options to deliver a stable, resilient and sustainable health and care system in Lincolnshire alongside how we will consult with and maintain ongoing conversation with our stakeholders.

The plan addresses also how, as a system, we will be responding to the Right Care programme, looking at how Lincolnshire will address the unwarranted variation that exists in health and care within the county and also when benchmarked against our peers. How we will ensure that patients get the right intervention at the right time and how we will make best use of the resources we have available and how we will ensure that interventions and in particular prescribing, reflects the best evidence. The plan also outlines in the financial detail, how Lincolnshire intends to radically improve its productivity, changing the shape of its workforce, changing the skill base and tackling the significant challenges around use of agency and locum staff across the system which impacts both on cost but more importantly on quality.

The plan also sets out on a practical level how Lincolnshire will deliver the five year forward view with the development of multi-specialty community providers, a different relationship between commissioning an acute sector based on an alliance type model and the critical path joining up both our reconfiguration agenda and our development and efficiency agenda.

This plan is a point in time based on the best assumptions available and the best intelligence available to the team in the system. There will inevitably be some assumptions that prove to be over ambitious or over optimistic and some that are overly cautious and overly pessimistic, however this is the first time Lincolnshire has a plan that is owned by the whole system and whilst there remains detailed work to do as we move to implementation, we find ourselves in a position that we can move forward together as a whole system rather than as a fragmented group of individual organisations.

Our vision

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Patient Stories

Vera's story

Vera is an 89 year old widow with a small family network. She has always been fiercely independent and coped well on her own until recently, despite falling and breaking her leg 8 years ago. Vera is determined to stay at home, in the local authority house in a small village, despite her declining health and independence. Over the past 2 years Vera's daughter-in-law has been helping with some daily tasks but lives over 25 miles away and works full time. Vera has a regular cleaner and a 'Piper' alarm, linked to a local call service, to summon help if necessary. She has a number of long term health issues including arthritis, anaemia and kidney problems for which she attends her GP and a consultant regularly for care. Over the last 6 months there has been a noticeable decline, particularly in respect of her mobility, a persistent cellulitis of her leg and increasing issues with continence.

In July, she had a fall and was not found for 12 hours. She was taken to hospital where she was found to have cellulitis and a urinary tract infection. She remained for 2 weeks, followed by a further week in a community hospital for rehabilitation. Vera was discharged home with reablement support; however, her family were not fully engaged with this decision which caused significant concern. A week later she fell again and had another 2 weeks in hospital, treated for anaemia. During this time Vera loses weight and further mobility. As a result of this Vera spent a further 2 and half weeks in a community hospital, gains weight and returns home with carers in place to support. However, within 10 days she had a further fall which EMAS attended but they did not admit her as she wanted to remain at home. The next day she was in considerable pain and was admitted to hospital where it was found she had a fractured neck of femur and that she had also had a mild heart attack. She has since had her hip repaired and remains in hospital.

Throughout this experience, the complexity of the system is a real issue. Vera's desire to return home leads to decisions being taken without a plan involving her family. There is little link up between the organisations supporting Vera. The GP is not involved. Over 10 weeks a relatively independent elderly lady now has a very uncertain future and will need significant care for the time she has left.

In the future Vera will:

- Be well known to her Primary Care Team.
- Be on their Frailty register for the last 5 years at least and regularly followed up to pro-actively manage her range of Long Term Conditions.
- Have a care plan that is agreed with Vera and her family.
- Be supported by the Integrated Neighbourhood Care Team
- Be 'pulled' from hospital much earlier following her first admission and taken home to manage her cellulitis, etc. in the community, thus minimising the loss of function.
- Have had access to the Wellbeing Service
- Be supported to work through what support and help she needs to keep her safely at home, before it is actually needed.

Paul's story

Paul is in his mid-20s, in full time employment in IT and living independently in shared accommodation with friends in Lincoln. He starts to get physical symptoms (back pain, deterioration of physical health) and has difficulty coping at work. After several visits to the GP, he is referred for physio. He is concerned about his health and regularly calls out the ambulance. The pain is not resolved and he is unable to sustain his job. His relationship breaks down with his flat mates and he returns to the family home. Increasing pressure with job searching leads to a break down in his ability to function. His GP is not sure what is going on and thinks there might be a further condition like epilepsy. Paul is referred to the Mental Health (MH) team but they refer back to the GP. Paul has 4-5 referrals back and forth and also takes himself to A&E for his back pain but A&E send him back to the GP.

Eventual pressure from the job centre leads to a crisis situation – his GP refers him to the community mental health team. He is put on various types of medication (anti-psychotic) but he doesn't take them consistently and none seem to work. His behaviour becomes more challenging and chaotic but he does not receive an assessment. He goes on a waiting list for an Occupational Therapist but deteriorates further during this time and the police and ambulance are called as he presents a risk of harm to his family. The police take him to A&E but there is no Mental Health crisis team and A&E discharge him back home.

Paul's family call the MH crisis team in the morning. After 36 hours, support is finally provided by the Community MH Team. They do an assessment the next day and think some time in a rehabilitation unit would be helpful. He is left with some phone numbers to call if he has further crisis. An hour later he collapses in another fit, unable to cope – his family call the crisis team and the triage car comes out to assess. The seriousness of his condition is finally acknowledged and Paul agrees to go into an acute mental health bed rather than be sectioned. A bed is available but it's in Somerset so he refuses to go. He is asked to consent to going into a bed before he knows the location and he refuses. Eventually a bed is found several days later 60 miles from his home which he agrees to go to. He spends 6 weeks in an acute MH bed and is then brought back to a local rehab unit near to his home where he is still an inpatient. He was seen by an Occupational Therapist but is waiting for a neuro-psychological assessment.

In future,
Services will be proactive and integrated meeting holistic physical and mental health needs acting early to prevent crisis where ever possible. But should a crisis happen mental health crisis support will be available 24/7 and sufficient specialist inpatient beds will available in Lincolnshire.

Paul will:

- Get a holistic assessment at his GP covering his physical and mental health through the Neighbourhood Team
- Be able to access specialist assessments from OT, neurology, psychological assessment more quickly
- Be referred at an earlier stage before crisis point is reached to specialist early intervention in psychosis services from the community MH team who will provide multidisciplinary support including psychological therapy and help and support to stay in work or return to employment.
- Have support from a mental health crisis team available 24 hours
- Have support in A&E from MH specialists and better coordination between police/ambulance/ A&E/MH.

Bob's story

Bob has been a resident in a nursing home for a while as he is frail and vulnerable; he has no mobility in the left side of his body and has a language impairment following a stroke. His wife takes him back to his own home (from the Care Home) 3-4 times a week, for a few hours a day, so they can spend quality time together to hold hands.

Bob arrives by hospital transport for an outpatient's appointment; he is cold and poorly dressed on a very cold day. His wife meets him in the outpatient department, to be with him at the appointment. She is concerned at his quietness; when he has warmed up, he is a bit brighter yet the clinician is worried about him going back on hospital transport. His wife has an adapted vehicle (van) and she offers to take him back to the Care Home; the clinician rings the home to inform them he didn't seem well and requests help for his wife to get him from the vehicle. The Care Home are defensive about Bob's health and condition and do not agree to help his wife. To add to his wife's stress, the van has a parking penalty ticket on it when the clinician helps Bob and his wife back outside. She parked in the disabled bay with blue badge showing but did not realise she needed to pay.

Bob spends a dreadful day in A&E the next day with a catheter problem and is eventually transported to Boston because there is no-one to deal with it after 12 noon at Lincoln. He endures another 5 hours of A&E in Boston, by which time he is too ill to have it dealt with. He is admitted and his wife spends the next four days and nights with him, sleeping on the floor beside his bed. His previous Care Home will not take him back when he is discharged because they say they can no longer meet his needs so he dies 24 hours later in another Nursing Home.

In future Bob will:

- Be able to have in-reach support into his Care Home to manage simple issues like his catheter, supported by the Clinical Assessment Service which would enable a senior clinician to provide a virtual assessment of the most appropriate response
- Experience joined up care, with all clinicians and care workers supporting Bob, able to ensure he gets the most appropriate support without delay
- Have a care plan which is put together by Bob, his wife and the team who support him in the Care Home and in the community setting, to avoid being admitted to hospital unless absolutely necessary
- Be met with compassion and support for both him and his wife, during any health and care experience
- Be supported to die in the place of his choice

Further animated patient stories can be viewed on www.lincolnshirehealthandcare.org

A lot has been achieved so far on our Journey to deliver our vision. Making the transformation a reality: what we're working on now.

Lincolnshire has a **strong track record of integrated working** between the NHS and Local Government and a growing capability for collective action which is afirm foundation on which to build at even greater scale and pace

80% complex people leaving hospital now have **an identified case manager**; more people are being supported to go directly home; partnership working with Third Sector; moving to a 'Home First' approach to ensure we support people at home whenever possible.

Self- care strategy finalised following extensive engagement and coproduction with the community sector, local authority and patients/ residents. Community Directory of services in place through Lincs2Advice, pilots for social prescribing, working with partners to develop neighbourhood networks locally to work alongside

Lincolnshire in the first wave of the National Diabetes Prevention Programme, providing 9 month intensive lifestyle support to those at high risk of becoming diabetic, over 500 people referred since July

Developed 12 Neighbourhood Care Teams harnessing the enthusiasm and ideas of staff on the ground who have grown the teams bottom up now established with populations circa 50,000 with currently seven **GP Federations** emerging alongside. We are already seeing evidence of improved outcomes for a small number of patients; work commencing to enable teams to further integrate and increase numbers seen

The **Lincolnshire Heart Centre** continues to deliver results above national average with survival rates better than national average. Learning from this success has informed our plans

The **Hospice in a Hospital** at Grantham is the first in the country and we will build on this success through further innovation

Recruitment and Retention – The MSC for frailty second cohort starting in September 2016 for 18 staff, new health and social care rotational apprenticeship to be launched in January 2017, GP international recruitment to see 25 new GPs starting January 2017, Lincolnshire attraction strategy well developed with new website to be launched imminently

Growing reputation for making it happen: The **Care Portal** goes live in October 2016
Phased implementation of the **Clinical Assessment Service** has started with full "go live" in October 2016. Both initiatives have been developed in response to feedback and input gathered through public engagement.

Lincolnshire has the 4th largest **Better Care Fund** in 2016/17 as it was in 2015/16 totalling £196m within pooled or aligned budgets. LD, integrated teams £63.2m, Mental health, integrated teams £69.0m integrated teams, Community Equipment £5.8m service re-procured and delivering substantial savings), CAMHS £4.8m, Proactive Care £49.0m.

IPC Demonstrator site Lincolnshire is an Integrated Personal Commissioning demonstrator site with strong commitment from health and social care partners working together. Personal Health Budgets are now the default option for people eligible for continuing healthcare in Lincolnshire and will extend within the next two years to all the people within our cohorts, which include people with complex health needs, children and young people with complex mental health needs and people with learning disabilities with high support needs. Patients are already starting to benefit from this transformation which, enables them to control, manage and commission their own care, supported by well-developed Peer Networks across the county.

Making our Vision a Reality: Our Key Objectives and work streams

We are committed as a system to build on these achievements to work at scale and pace to make our vision a reality through key objectives

Develop MCPs each overseeing a network of 6-7 Neighbourhood Teams covering 30-50,000 population alongside developing an integrated strategic commissioning arrangement, for health and social care, with appropriate clinical support and advisory arrangements

Focus resources on keeping people well and healthy; providing tools and support for people and communities to make healthy choices, take more control; this will improve quality of life and reduce numbers of people dying from avoidable disease

Change the relationship between individuals and the care system, with a move to greater personal responsibility for health; more people will use personal budgets for health and care

Move care from acute hospitals to neighbourhood teams in the community, closer to home; join up physical and mental health, health and social care; remove barriers between professionals, communities and patients so that people live well

Provide support to neighbourhood teams by a network of small community hospital facilities which will include an urgent care centre, diagnostic support such as x-rays and tests, outpatient facilities and a limited number of beds

Provide a small number of specialised mental health inpatient facilities to give expert support to neighbourhood teams and community hospitals

A smaller but more resilient acute hospital sector providing emergency and planned care incorporating a specialist emergency centre; specialist services for heart, stroke, trauma, maternity and children; hospital doctors providing expert advice into the community

Fewer referrals to hospital with thresholds and access criteria; a simplified journey for patients with specific diseases, based on what works well; fewer people travelling out of county for care; services stopped where they don't deliver good results for patients

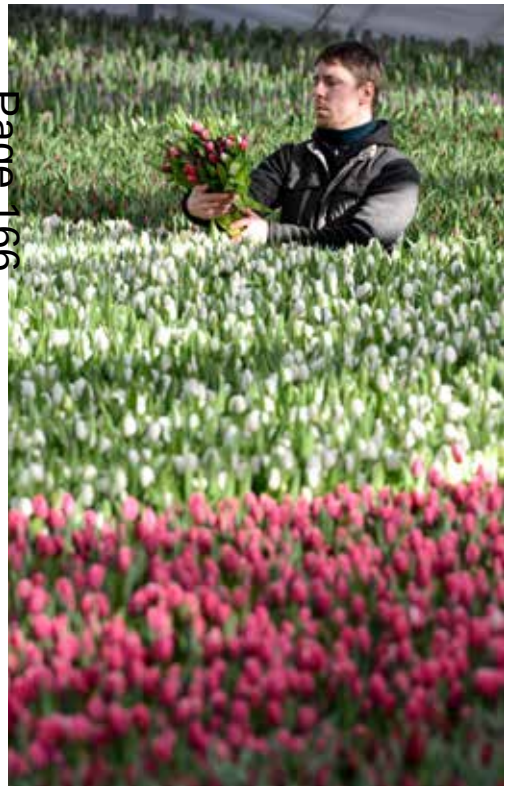
High quality efficient and effective services where NHS constitutional standards are met; all services are rated as good or outstanding; environments meet patient expectations; and permanent staff are the norm.

Lincolnshire's Hoshin Planning Matrix

The Hoshin Planning Matrix (see next page) captures our vision, objectives, workstreams, national prioritises and key success measures. Whilst it looks complex, it summarises the interdependencies across the whole of our system and will be used to communicate with the staff on whom the success of this plan depends and with staff who will be implementing the plan and working on its various objectives and tactics.

How will you achieve and maintain financial balance	How will you develop workforce you need to deliver?	How will you deploy technology to accelerate change	How will you improve quality and safety	How will you achieve our 2020 ambitions for key clinical services	How will you achieve and maintain performance against core standards	How will you implement new care models and address local challenges	How will you support , invest in and improve general practice	How will you Engaging patients, communities and NHS staff	Prevent ill health and moderate demand	**9 national must dos**	**VISION** **To achieve really good health for the people of Lincolnshire with support from an excellent and accessible health and care service delivered within our financial allocation**	**work streams**	Prevention	Proactive	Primary Care	Urgent Care	Mental Health Learning Disabilities and Autism	Planned Care	Women and Children	Operational Efficiencies	Capacity Optimisation	Workforce	Commissioning Priorities/ Right Care
X	X		X	X		X	X	X	X		Develop Multi-speciality Community Providers each overseeing a network of 6-7 Neighbourhood Teams covering 30- 50,000 population we will develop an integrated strategic commissioning arrangement		X	X	X	X	X	X	X	X	X	X	X
X					X		X				System financial plans achieved annually and financial balance is achieved by 2020/21		X	X	X	X	X	X	X	X	X	X	X
			X	X	X						High quality and effective services where all NHS Constitution standards are met and all services are rated good or outstanding.			X	X	X	X	X	X			X	X
X			X								Simplified pathways for specific diseases based on what works well with few people travelling out of county						X	X	X		X		
X			X		X		X				A smaller but more resilient acute hospital sector providing emergency and planned care					X		X	X				
X			X	X							Develop resilient specialist mental inpatient facilities in county						X						
			X				X		X		Develop a network of community hospitals and primary care hubs to support Neighbourhood Teams			X	X	X	X						
X		X	X				X		X		Move care from acute hospitals to neighbourhood networks in the community closer to home			X	X	X	X		X				
X		X	X						X		Change the relationship between the individual and the care system – greater personal responsibility for health		X	X	X		X						
X		X	X						X		Keeping people well and healthy		X	X	X		X						
											Lincolnshire's objectives												
											Top 10 Critical KPIs or success factors												
X		X	X	X			X	X	X		Potential to save 150 lives from mortality that is preventable by 2021. Aspirational trajectory is to save 300 lives from such mortality by 2021.		X	X	X		X	X	X			X	X
X	X	X	X	X		X	X				£14.9m identified for investment fund to support 5YFV.			X	X				X	X	X	X	X
	X			X		X	X	X			Multispecialty Community Providers established by 2020		X	X	X	X	X	X	X		X	X	
X	X	X	X	X	X	X	X	X			Non elective admissions are reduced by 29,377 (accumulative) equivalent to 10% by 2021. The number of emergency admissions being stopped in 2021 is equivalent to 28 per day. At a 3.8 day Length of Stay by 2021 this is equivalent to 118 acute beds being closed at 90% bed occupancy.			X	X	X	X				X	X	X
X	X	X	X	X	X	X	X	X	X		Five urgent care centres alongside proactive care services will divert 244,063 A&E attendances by 2021 which is equivalent to 235 per day.				X	X	X					X	
X	X	X	X	X	X	X		X			Centralisation of fragile services and specialties to achieve critical mass and resilience by 2020					X	X	X	X		X		X
X	X	X	X	X	X	X	X	X	X		Delivery of integrated care for 38,434 people by 2021 which is 5% of the population		X	X	X		X	X	X		X	X	X
X	X	X	X	X	X	X					All professionals in all NHS and LCC organisations have access to single care record by 2021		X	X	X	X	X	X	X			X	
X	X	X						X			Reduction of c.750 whole time equivalent staff by 2021											X	
X	X	X	X	X	X	X	X				Our overall staff engagement results in the NHS Staff Survey will be in the top quartile of the country by 2019 for all our NHS organisations.				X	X						X	

Lincolnshire Context



Lincolnshire is the fourth largest county in England covering 5,921 km2 with the 4th most dispersed population. There is seasonal variation in our population due to holiday makers along the coast; in addition the county is an attractive place to retire to. We have a registered population of 768,688. 9.9% of the population is 75 + with an expected increase of 20.1% 75-84 yr. and 19.6% increase 85+ yr by 2021 (above national average). In contrast the number of working age adults is not expected to rise. 14.2% of the population live in the most deprived areas in England. In addition there is significant housing growth planned across Lincolnshire with circa 5000 additional homes built in and around Lincoln alone over the next 5 years.

There are four Clinical Commissioning Groups (CCGs), four major healthcare providers, one upper tier local authority and 7 City and District Councils within the footprint; with other partners including Healthwatch Lincolnshire, private sector, third sector, and health and social care partners both within and outside our footprint that will affect this STP or have to plan with us for the consequences of this STP.

There is a long history of collaborative working across the four CCGs and between the NHS and local government with well-established infrastructure. This STP is built on and incorporates the Lincolnshire Health and Care (LHAC) programme in the clinical redesign workstreams. The work began in 2013, when a blueprint for health and care identified the issues which were making services unsustainable. In the second phase of LHAC, organisations worked together with clinicians and members of the public to develop options to address those issues which were completed in 2015. We are already working to consult with the public through "Lincolnshire Health and Care" (LHAC) where we will spell out our vision and the options and consequences on current services of moving to a new more effective model.

Lincolnshire is already on a devolution journey that will bring together "Greater Lincolnshire" which will include north and north east Lincolnshire (communities of Scunthorpe and Grimsby). At this stage, the STP footprint does not reflect this devolution footprint but there is an ongoing dialogue between the NHS and local government.

As stated, Lincolnshire has a strong record of integrated working across the NHS and Local Government both in terms of commissioning and provision, with Section 75 agreements in place on community equipment, CAMHS, Adult Mental Health and Learning Disabilities. There is well established commissioning infrastructure with a Joint Commissioning Board, which oversees deployment of the Better Care Fund resources. Lincolnshire has the 4th largest BCF Pooled Budget in 2016/17 (as it was in 2015/16) with £196m included within pooled or aligned budgets.

Whilst there will be increased opportunities for more pooling of resources to commission at scale as we have done with transitional (intermediate care), there is an increased focus on "personalisation" with the deployment of personal budgets across health and social care for people with dementia, learning disabilities and severe and enduring mental health problems. This approach will enable our residents to exercise greater choice and control over their own care and the hope is that it will be a stimulus to develop a more diverse range of care options and providers.

Operational integration is being driven through the neighbourhood teams development programme which will initially take operational delivery to the next level of integration for 4 sites in 2017; fully collocating teams around a small number of community hospital hubs and integrating case management as a precursor to full roll out.

Developing our Plan

Journey to system leadership

- Building on a 3 year Clinical redesign programme: Lincolnshire Health and Care (LHAC)
- 18,000 members of the public engaged over 3 years and 150 engagement events held this year alone to engage public in the debate and choices in the lead up to a full consultation
- Models and redesign options co-designed with Primary Care and Secondary care clinicians
- System Executive Team (SET) established and meeting weekly to bring collective executive leadership
- Lincolnshire Coordinating Board (LCB) established bringing together organisations' Chairs to have oversight of SET and to support better cross organisational cooperation
- Single whole system finance group bringing together finance leadership to develop our single financial plan
- Single system wide commissioner and provider planning group established to make STP assumptions central to the planning round 2017/2019
- Focus on a strong collective single system vision document agreed , now shared with staff, public and stakeholders and available on our website home page at www.lincolnshirehealthandcare.org ;
- Case for change developed collectively; http://lincolnshirehealthandcare.org/wp-content/uploads/2016/02/LHAC-Case-for-Change-2016.pdf as part of reengagement work
- Whole system modelling completed mapping the change in care model ; a single set of assumptions for the whole system now in use.
- Whole system workforce modelling undertaken with HEE supported work led by "Whole Systems Partnership"
- First whole system Workforce plan developed; mapping the change in workforce up to and beyond 2021
- First whole system OD plan developed
- System wide PMO (using Project Vision as a platform) developed and being rolled out; agreement on long term resources needed as we move to implementation

Financial summary

The local Health Economy has continued to work on the refinement of the STP since the initial submission at the end of June 2016. The high level reconciliation is included in the table below:

Changes to the Financial Gap Identified	2020/21
21 October 2016	-182,054
2016/17 CIPs now included in the base	-65,321
Revised phasing as a result of control total delivery	-12,911
16 September 2016	-260,285
Review of pay growth required to deliver increases in demand	-66,504
Clinical Negligence uplift Review	-14,105
30 June 2016	-340,894

This version of the Lincolnshire financial strategy includes:

- Resetting the base year to reflect 2016/17 plan or agreed forecast outturn
- Do something now consistent with CCG and Trust control totals
- The Social Care Better Care Fund position has now been included
- All organisations have reviewed the "do nothing" scenario and updated as appropriate – keeping within the minimum NHSE planning assumptions.
- Investments required to deliver 5YFV total £14.9m recurrently and reflect Lincolnshire's fair share of the £1.1bn transformation fund identified nationally
- An investment fund of £26m has also been identified to support the cost of transformation, any further investments required as well as a contingency against any financial risks inherent within this plan.

The issuing of financial control totals to organisations has provided a new challenge to the delivery of the STP financial strategy as it requires and earlier delivery of savings previously expected in later half of this planning period.

The "Do Nothing" Scenario

The do nothing scenario for Lincolnshire health and social care organisations generates a financial deficit of £182m which reflects a provider/commissioner split of £85m and £97m respectively.

For providers, this reflects the recognised current underlying financial deficit of £67m and the compounding impact of an implied efficiency reflected in the tariff uplift assumed.

In terms of the total income allocation to CCG commissioners, the table below demonstrates how the assumptions for increases in demand for clinical services outstrip the additional allocation received.

	Do Nothing				
	Base	Forecast	Growth	Growth	Growth
	2016/17	2020/21	£	% of base	% of Total
Financial Bridge	**£m**	**£m**	**£m**	**%**	**%**
Total CCG	987.7	1,092.9	105.2	11%	
Primary Medical Care (Mandate)	108.4	117.3	8.9	8%	
Specialised (Spec Comm)	165.4	198.4	33.0	20%	
Total Commissioner Income	**1,261.5**	**1,408.7**	**147.2**	**12%**	
Commissioner Investment					
Acute Care	528.2	595.9	67.7	13%	28%
Mental health	95.5	109.7	14.2	15%	6%
Community Health Services	99.6	110.4	10.9	11%	5%
Other NHS Services	0.1	0.1	0.0	23%	0%
Continuing Care	69.6	99.6	30.0	43%	12%
GP Prescribing	147.2	183.1	35.9	24%	15%
Other Primary Care	12.9	15.3	2.4	19%	1%
Running Cost (Admin)	16.4	16.7	0.4	2%	0%
CCG Other - Non-NHS, Non-Recurrent Reserve, Contingency	20.4	30.8	10.4	51%	4%
Social Care Expenditure	0.0	0.0	0.0	1%	0%
Sub total	**989.8**	**1,161.7**	**171.9**	**17%**	**72%**
Primary Medical Care (Mandate)	107.2	122.0	14.8	14%	6%
Specialised Expenditure (Spec Comm)	169.0	222.3	53.3	32%	22%
Total Commissioner Expenditure	**1,266.0**	**1,506.0**	**240.0**	**19%**	**100%**
Net Surplus/(Deficit)	-4.5	-97.3	-92.8		

The main points to note in this analysis of the do nothing scenario is that:

- Investment in acute care increases by 13%, which represents 28% of the total additional demand estimated
- Specialised Expenditure is assumed to grow by 32% which represents 22% of the total additional demand estimated
- GP prescribing and continuing care expenditure is forecast to grow by 24% and 43% respectively contributing a total of 27% of the total additional demand estimated
- Primary and Community (including Mental Health) services continue to receive the lesser share of any total new investment proposed

The "Do Something" Scenario

The local health economy has worked in a collaborative way to identify savings to close the gap in the do nothing scenario, whilst focussing on delivery the of vision to provide services out of hospital (where appropriate) and so to shift investment away from hospital based services into a primary and community base based integrated service closer to home.

The total savings identified of £130m include improvement to operational efficiency as well as changes to the way services are delivered, maximising benefits to patients as well as providing the cost savings required to invest in those areas of health and wellbeing services that promote delivery of the 5YFV.

The table below reflects the outcome of the Lincolnshire Financial Strategy for 2020/21.

	Do Something			
	Impact of Solutions	Total	Net	Growth
		2020/21	Changes	% of Total
Financial Bridge	**£m**	**£m**	**£m**	**% (gross)**
Total CCG	987.7	1,092.9	105.2	11%
Primary Medical Care (Mandate)	108.4	116.8	8.4	8%
Specialised (Spec Comm)	165.4	198.4	33.0	20%
Total Commissioner Income	**1,261.5**	**1,408.1**	**146.6**	**12%**
Commissioner Investment				
Acute Care	-52.2	543.8	15.5	11%
Mental health	0.4	110.0	14.5	10%
Community Health Services	-4.4	106.0	6.4	5%
Other NHS Services	0.0	0.1	0.0	0%
Continuing Care	-4.8	94.8	25.2	18%
GP Prescribing	-16.2	166.9	19.7	14%
Other Primary Care	11.0	26.4	13.5	10%
Running Cost (Admin)	-4.6	12.1	-4.3	-3%
CCG Other - Non-NHS, Non-Recurrent Reserve, Contingency	-1.1	29.8	9.4	7%
Social Care Expenditure	0.0	0.0	0.0	0%
Sub total	**-71.9**	**1,089.8**	**100.0**	**71%**
Primary Medical Care (Mandate)	-2.7	118.7	11.5	8%
Specialised Expenditure (Spec Comm)	-23.8	198.4	29.4	21%
Total Commissioner Expenditure	**-98.5**	**1,407.0**	**141.0**	**100%**
Net Surplus/(Deficit)		1.2	5.6	

The do something changes reflects:

- Recognition of some growth in the acute sector – but at a much lesser rate
- Increased investment in Community physical and mental health services together with investment in primary care services to create a more sustainable and integrated out of hospital sector.

Risks to the delivery of the financial strategy include:

- The ability of all organisation to deliver 2016/17 savings plans on a recurrent basis. The Strategy currently does not make any normalising adjustments to the 2016/17 underlying financial positions of Trusts and CCGs.
- The solutions identified include significant operational productivity improvements and clinical service changes that are of a transformational nature. There is therefore a risk that the OD and behavioural changes required of patients, clinicians and managers extend the lead in time of the actual savings delivery.
- A structure of governance and project management has been established, however, the delivery of these savings plans requires a step change in capacity and capability required to manage the implementation of the identified schemes. In addition, there is a requirement to accelerate the pace of delivery for 2017/18 whilst continuing to deliver 2016/17.

- The delivery of savings will also requires the identification of funding to support any non recurrent transformational costs including costs of project management, any double running and pump priming costs, and support for stranded costs. The financial strategy includes c£26m of funding that has been identified to support the delivery of savings targeted at transformation as well as to support progress of the 5YFV. This fund can only exist if savings are released as planned and so focus for the allocation of this funding will necessarily need to be on those transformational schemes that can release costs.
- The translation of STP into organisational plans (and vice versa) is a programme of work that is live and developing. Whilst all organisations have signed up to the overall strategy, actual delivery will reflect an iterative process of review of risk and mitigation which will mean that the shape delivery will be subject to change. This includes ensuring that there is sufficient mitigation to off set any duplication of savings which have yet to be identified.
- Access to capital funding is critical to the delivery of the clinical service redesign that has been described in this STP.

Within social care, the new Business model implemented over the last five years continues to support the delivery of financial balance. This includes savings and efficiencies of c£42m which includes an innovative and targeted approach to the negotiation of long term fee rates with residential and homecare providers to the benefit of both health and social placements.

The Better Care fund has supported service delivery and financial balance in social care over the last four financial years; any review for the use of the targeted funding will be carefully considered to ensure that a sustainable service can continue to be delivered until 2020/21.

Lincolnshire County Council support to Adult Social Care until the end of the decade includes:-

- An additional 2% Social Care precept on the Council Tax each year reaching 8% by 2019/20, by which time it will be worth £20m per annum
- Proposed funding for service growth to offset demographic pressures

The STP financial strategy is underpinned by:

- **A small reduction in the overall workforce.** Right Care initiatives will focus attention on prioritising the delivery of clinically effective interventions that provide and best value and further emphasis on developing self-care and better engagement with the Third sector. In addition, the improvement in operational efficiency will support improvements in workforce productivity. Lincolnshire is also working with Whole Systems Partnerships and the local HEE teams to transform the roles of our front line staff in terms of the clinical skills and competencies for delivering the clinical outcomes required in the future. Significant savings in management and administration pay costs are also predicated on progressing back office Carter efficiencies and expected organisational changes in the later years of this plan.
- **A reduction in the management and administrative burden.** As stated above, we will review how we can deliver back office functions more effectively and efficiently through local and regional collaborations. Organisational structures will need to change to support a more efficient and effective clinically led and integrated service.
- **Capital Investment.** £205m is required to enable critical infrastructure changes to support clinical redesign.
- **Strategic Transformation Funding** £52m is assumed to be available to the health economy in 2020/21 to support financial balance.
- **National Transformation Funding** there is an assumption that Lincolnshire will benefit from a £14.9m share of the national transformation fund from 17/18 to 19/20. This is specifically targeted towards the delivery of the 5YFV.
- **£130m savings programme** managed by the STP Programme Management Board. A continuous process of confirm and challenge to minimise any duplication in assumptions and with a focus on improving confidence in delivery.

Communications and engagement

Robust and meaningful engagement with patients, carers, staff and stakeholders is vital for the successful implementation of our STP. Our approach to engagement on our STP is built on 3 years of focused dialogue, involvement and engagement through the Lincolnshire Health and Care programme. Appendix 1 gives details of how this engagement has been undertaken, how it has influenced LHAC initiatives which are already in progress and form part of our STP and some of the key themes and feedback received through this process.

Aim of engagement activity: to ensure that stakeholders, public and staff are informed and engaged in order to:

- Develop emerging options that respond and reflect views and feedback
- Provide an opportunity for questions, comment and input
- Prepare stakeholders for change

Since early 2014, STP partners have been working together through the LHAC programme to:

- Create countywide awareness and understanding of the reasons for the programme and the likely shape of the new model for health and care, in order to prepare people for change and start to build buy-in
- Ensure ongoing dialogue, engagement and involvement with all staff to create better understanding of the reasons for change and provide opportunities for employees to inform the development of solutions
- Make sure people who use health and care services can comment on and inform the proposals in a way that will ensure that these are designed to better meet their needs
- Improve the evidence base within the programme for where current health and care services meet people's needs and where they don't and
- Maximise the response rate for future statutory consultations
- We are fully committed to fulfilling our statutory responsibilities to engage and involve the public in the planning, development and consideration of proposals for change.

We have a full audit trail of engagement activity which shows how we have engaged and involved over 18,000 people in the development of proposals for a new model of health and care in Lincolnshire. Our STP submission takes account of this engagement and many initiatives are already underway, such as Neighbourhood Teams, the Care Portal, the Clinical Assessment Service, which have been explicitly designed to respond to the concerns and experiences of our population. Ongoing engagement activity within individual organisations has focused on preparing staff for change, putting in place plans for organisational and leadership development to give this major transformation programme the best chance of success.

You Said, We Did

The graphic below sets out how some of the specific feedback from public and stakeholder engagement has directly influenced the STP:

You Said	We Did
Services are confusing – it's not always easy to know where to go when you have a crisis	Developed the Clinical Assessment Service to deliver one route via 111 for those with urgent care needs who will be directed immediately to the most appropriate place for their needs
Why can't it be more joined up for those receiving care from a number of different places	Developed the Care Portal as our technology solution allowing instant access to a patient's records Designed integrated neighbourhood care teams to ensure a joined up service
I don't want to repeat myself all the time	Developed the Care Portal to ensure better communication between health and care professionals to deliver better care to the patient
I want to be at the centre of my care	Finalised the Self-Care Strategy with a number of initiatives to empower people to take more control over their own health and wellbeing
I don't know where to go for support in the community	Community Directory of Service up and running, provided by Lincs2Advice – online/telephone access to a wide range of local services with information on opening times, eligibility, access etc
I want services as close to home as possible with improved access	Developed Integrated Neighbourhood Care Teams; proposals for moving care from an acute to community setting; improvement plans to deliver GP FYFV to include 7 day access;
For mental health, I want to be treated at home or in my local community	Proposals in development for a community model of care in mental health and more acute mental health beds in county for those who need inpatient care
I want to have confidence that I will receive high quality, safe services	Proposals in development around a number of options to improve clinical services through hospital reconfiguration
I want to be engaged and involved in decisions about changing health and care services	Engagement with over 18,000 people; engagement plan developed for further engagement and involvement in the future; website fully operational with information about LHAC and the STP
We spend too much time chasing up referrals, results etc which wastes time and money and can lead to a poorer patient experience	Developed the Care Portal to enable clinicians and those professionals involved in supporting residents to access a selected view of a patient's records in order to deliver better, quicker decision making and ultimately improve care
Clinicians need to own the proposals and be at the heart of developing solutions	Clinical leadership through the "care design groups" and then the "expert reference groups"; several workshops, events and briefings to engage and involve clinicians; incorporating the work of ULHT's clinical strategy developed by their clinicians

The approach to engagement has followed a core step by step process in line with best practice whilst the STP has still been in draft format:

Jan-Apr

- Review LHAC engagement to date to identify gaps
- Agree single stakeholder database and coordinated approach to engagement

May-Sep

- Plan engagement activity, in particular core groups to involve (ie STP Boards, local authority stakeholders, Healthwatch, hard to reach groups like pregnant women on east coast)
- Engage and involve to inform submission

Oct-Dec

- Finalise engagement plan in line with critical path for implementation
- Feedback on assurance, publicise Plan

Summary of engagement deliverables produced from January-September 2016:

- Case for Change report published with extensive media coverage
- Vision for Lincolnshire 2021 published and shared with staff
- Single stakeholder database with over 500 major stakeholders identified and all engagement activity coordinated across STP partners
- Over 150 engagement sessions held with particular focus on hard to reach groups over summer 2016, with over 800 responses to latest survey developed following Case for Change publication
- Targeted engagement within specific workstreams with core stakeholder groups, including clinicians
- Updated website which includes all LHAC public materials, presentations and media coverage as well as the latest information on key initiatives like the Care Portal and all engagement analysis from the STP programme

Engagement channels:

- System-wide communications and engagement team coordinating dissemination of information to all staff, to identified core stakeholders (over 500 identified) and through existing networks and channels (for instance to Trust members)
- Working with independent partners like the People's Partnership, Health Overview Scrutiny Committee, and the District Council Chief Executives Group etc.
- Briefings and face to face engagement with Councillors and MPs
- Maximising reach of information through mainstream and social media to reach as wide an audience as possible using a range of materials including information leaflets, animations (see website homepage), direct face to face discussion, surveys, interactive workshops and focus groups
- Focus on a strong collective single vision and voice, now shared with staff, public and stakeholders and available on our website home page at www.lincolnshirehealthandcare.org; our case for change developed collectively; http://lincolnshirehealthandcare.org/wp-content/uploads/2016/02/LHAC-Case-for-Change-2016.pdf

CCG Improvement and Assessment Framework (current position)

CCG Improvement and Assessment Framework (IAF) (current position) The CCG IAF has been designed to supply indicators for adoption in STPs as markers of success. In turn those plans will provide vision and local actions that will populate and enrich the local use of the CCG IAF. The CCG IAF is still under development and further national work is taking place to develop metrics for all indicators.

						Clinical Commissioning Group				
	Area	**IAF Target**	**Period**	**Eng**	**Lincs STP**	**Lincs E**	**Lincs W**	**SW Lincs**	**S Lincs**	**Better is...**
Better Health	Smoking	Maternal smoking at delivery	15-16 Q3	10.6%	12.1%	14.1%	12.4%	11.0%	9.3%	↓
	Child obesity	% children aged 10-11 classified as overweight or obese	2014-15	33.2%	33.3%	38.3%	31.1%	28.2%	33.6%	↓
	Diabetes	Diabetes patients that have achieved all three of the NICE treatment targets	2014-15	39.8%	38.4%	39.3%	39.7%	34.7%	37.8%	↑
		Diabetics diagnosed less than a year who attend a structured education course	2014-15	5.7%	16.1%	15.9%	20.6%	14.3%	9.3%	↑
	Falls	Injuries from falls in people aged 65 and over per 100,000 population	Nov-15	2,026.8		1,762.5	1,702.7	1,912.9	2,332.4	↓
	Personalisation and choice	Offered choice of provider and team when referred for a 1st elective appointment	Feb-16	50.0%		80.0%	73.0%	76.0%	58.0%	↑
		supporting measure of % of referrals made by e-referral								
		Personal health budgets per 100,000 population (absolute number in brackets)	15-16 Q4	14.4	21.8	19.2	25.4	25.6	17.7	↑
		% deaths which take place in hospital	15-16 Q3	46.9%	46.6%	47.8%	45.4%	43.4%	48.8%	↓
		People with a long-term condition feeling supported to manage their condition	2015	64.4%		65.2%	64.6%	63.3%	69.0%	↑
	Health inequalities	Inequality in avoidable emergency admissions	15-16 Q2			686.5	642.0	515.6	705.9	↓
		Inequality in emergency admissions for urgent care sensitive conditions	15-16 Q2			1,536.1	1,559.4	1,102.4	1,362.2	↓
	Anti-microbial resistance	Appropriate prescribing of antibiotics in primary care (target showed in brackets)	15-16 Q4			1.2 (1.2)	1.1 (1.2)	1.0 (1.2)	1.1 (1.2)	↓
		Anti-microbial resistance: prescribing of broad spectrum antibiotics in primary care	15-16 Q4			11.8 (11.8)	12.0 (12.0)	11.2 (11.2)	10.8 (10.8)	↓
	Carers	Quality of life of carers - health status score (EQ5D)	2015			78.90	79.80	79.40	82.10	↑
	Care ratings	Use of high quality providers								
Better Care	Cancer	Cancers diagnosed at early stage	2014	50.7%		36.5%	33.3%	42.8%	48.3%	↑
		Urgent GP referral having 1st definitive treatment for cancer within 62 days	15-16 Q4	81.9%	74.1%	72.1%	76.5%	71.3%	76.3%	↑
		One-year survival from all cancers	2013	70.2%		68.8%	69.9%	69.3%	71.1%	↑
		Cancer patient experience	2014	89.0%	87.4%	85.9%	88.2%	84.2%	91.0%	↑
	Mental Health	Improving Access to Psychological Therapies recovery rate	Feb-16	47.6%	53.1%	52.3%	51.4%	61.2%	48.3%	↑
		1st episode of psychosis starting treatment within 2 weeks of referral	Mar-16	62.9%	43.9%	0.0%	50.0%	100.0%	44.4%	↑
		Children and young people's mental health services transformation								
		Crisis care and liaison mental health services transformation								
		Out of area placements for acute mental health inpatient care - transformation								
	Learning Disability	People with a learning disability and/or autism receiving specialist inpatient care	Mar-16	58		69.0	69.0	69.0	69.0	↓
		People with a learning disability on the GP register receiving an annual health check	2014-15	47%		47.0%	25.0%	46.0%	32.0%	↑
	Maternity	Neonatal mortality and stillbirths per 1,000 births	2014-15	7.1	6.4	6.5	4.2	8.5	8.3	↓
		Women's experience of maternity services	2015			83.2	80.8	73.8	82.4	↑
		Choices in maternity services	2015			68.0%	61.9%	63.7%	65.4%	↑
	Dementia	Estimated diagnosis rate for people with dementia	Apr-16	66.4%	64.0%	63.0%	63.5%	57.3%	71.5%	↑
		Dementia care planning and post-diagnostic support								

	Area	IAF Target	Period	Eng	Lincs STP	Clinical Commissioning Group				Better is...
						Lincs E	Lincs W	SW Lincs	S Lincs	
Better Care continued	Urgent & Emergency Care	Achievement of milestones in the delivery of an integrated urgent care service								
		Emergency admissions for urgent care sensitive conditions per 100,000 population	15-16 Q2			2213.7	2395.9	1871.6	2102.7	↓
		% patients admitted, transferred or discharged from A&E within 4 hours	Apr-16	89.0%	87.4%	89.6%	89.2%	80.4%	83.9%	↑
		Ambulance waits - % of cat A red 1 incidents responded to within 8 minutes	16-17 Q1	71.8%	66.3%	66.3%	66.3%	66.3%	66.3%	↑
		Delayed transfers of care attributable to the NHS and Social Care per 100,000	Apr-16	13.0	17.4	17.4	16.8	17.5	18.2	↓
		Emergency bed days per 1,000 population	15-16 Q2			0.58	0.58	0.54	0.58	↓
	Primary Medical Care	Emergency admissions for chronic ambulatory care sensitive conditions	2014-15	811.8		770.3	730.7	692.1	688.0	↓
		Patient experience of GP services	Jan-16	84.9%	85.2%	82.7%	87.5%	84.2%	86.9%	↑
		Primary care access								
		Primary care workforce - GPs and practice nurses per 1,000 population	2015			1.33	1.08	1.30	1.27	↑
	Elective Access	Patients waiting 18 weeks or less from referral to hospital treatment	Apr-16	91.7%	92.9%	92.6%	93.0%	92.5%	93.7%	↑
	7 Day Services	Achievement of clinical standards in the delivery of 7 day services								
	NHS Continuing Healthcare	People eligible for standard NHS Continuing Healthcare per 50,000 population	15-16 Q3	47.9	70.7	71.6	66.0	69.0	77.1	↑
Sustainability	Financial sustainability	Financial plan	2016			Amber	Green	Green	Green	↑
		In year financial performance								
	Allocative efficiency	Expenditure in areas with identified scope for improvement								
		Outcomes in areas with identified scope for improvement								
	New models of care	Adoption of new models of care								
	Paper-free at the point of care	Local digital roadmap in place								
		Digital interactions between primary and secondary care	15-16 Q4			72.3%	70.6%	69.7%	59.0%	↑
	Estates strategy	Local strategic estates plan (SEP) in place	2016-17			Y	Y	Y	Y	↑
Well Led	STP	Sustainability and Transformation Plan								
	Probity & corporate governance	Probity and corporate governance								
	Workforce engagement	Staff engagement index	2015	3.80		3.7	3.7	3.7	3.8	↑
		Progress against Workforce Race Equality Standard	2015	0.24		0.26	0.2	0.27	0.33	↑
	CCGs' local relationships	Effectiveness of working relationships in the local system	2015-16			68.3	62.0	78.6	63.9	↑
	Quality of leadership	Quality of CCG leadership	2016-17			Green	Green	Green	Green	↑

Meeting Our Health and wellbeing challenge

The table below outlines the summary health and wellbeing challenges, Lincolnshire baseline position against key health and wellbeing indicators, national benchmarking and target for 2021. Full detail of the health needs of our population can be found in Appendix 2 Lincolnshire Health Profile

Summary Health and Wellbeing Challenges	Key Health and Wellbeing Indicator	STP (current)	National Benchmarking	Target 2021
The health of the population • **Main causes of premature mortality** (<75years) in Lincolnshire are cancer, cardiovascular disease and respiratory (Director of Public Health Annual Report, 2014) **186 lives are lost prematurely per year** from circulatory respiratory disease alone compared with the best performing like CCGs (Commissioning for Value). • Obesity is a particular public health priority with 70% of adults having excess weight (27.4% obese) and over one fifth (22%) of children aged 4-5 years and a third (33%) of children aged 10-11 years being overweight or obese • **42,000 reported residents with diabetes** (higher than national average) • Nearly **one third of adults (30%) are inactive** • **Ageing population living** longer with multiple illnesses • **Care models are reactive** and very hospital based • **Overall Lincolnshire has lower levels of deprivation than nationally, but we have pockets of significant deprivation**, linked with rural isolation, impacting on the health and wellbeing of those communities. • **Life expectancy at birth** is similar to that in England but there is greater variation reflecting local health inequalities with more deprived communities having lower life expectancy • Life expectancy at birth is similar to that in England but there is greater variation reflecting local health inequalities with more deprived communities having lower life expectancy • Healthy life expectancy at birth is similar to England but there are m**any years different between overall life expectancy and healthy life expectancy** (for example 17.2 years for females).	Maternal smoking at the time of delivery (current data quality issues with maternal smoking data will not be resolved until 18/19)	11.9%	11.4%	11.4%
	Smoking prevalence in Adults	17.1%	16.9%	15.0%
	% 4-5 years old being overweight or obese.	22.0%	21.9%	19.0%
	% 10-11 years old being obese.	19.0%	19.1%	16.0%
	Excess Weight in Adults	70.0%	64.6%	64%
	Diabetes patients who have achieved all 3 of the NICE recommended treatment targets	38.1%	39.8%	40%
	People with diabetes diagnosed less than a year who attend a structured education course	16.10%	5.70%	20%
	Mortality rate from causes considered preventable (all persons)	177.7 (4,167 lives lost in 12/14)	182.7	1% annual reduction (3,867 lives lost in 19/21) (300 lives saved)
	Injuries from falls in people aged 65 and over per 100,000 population	1,892	2,125	1,800
	% deaths that take place in hospital	47%	47%	40%
	People with a long term conditions supported to manage their condition	Lincs CCG rates between 63.3% to 69.0%	64.4%	70%
	Antibacterial resistance – appropriate prescribing of antibiotics in primary care	1.111	1.072	1.070
	Antibacterial resistance appropriate prescribing of broad spectrum antibiotics in primary care	11.6%	9.7%	9.5%

Meeting our Care and Quality Challenge

The table below outlines the summary health and wellbeing challenges, Lincolnshire baseline position against key health and wellbeing indicators, national benchmarking and target for 2021. Full detail of the Case for Change ; http://lincolnshirehealthandcare.org/wp-content/uploads/2016/02/LHAC-Case-for-Change-2016.pdf

Summary Health and Wellbeing Challenges	Key Health and Wellbeing Indicator	STP (current)	National Benchmarking	Target 2021
Quality is inconsistent despite best efforts of staff; we struggle to meet Constitutional Standards; some care is great, some is not • Not met the 4 hour standard for waiting times for A&E since the summer of 2014 • Consistently we do not meet standard for the number of paediatricians on site at ULHT • We cancel over 2000 planned operations per year often at very short notice due to emergencies and urgent care taking priority • Over 15% of ambulances wait for over 30 minutes to hand over patients at A&E • 300 patients with mental health needs were admitted to a mental health bed outside of Lincolnshire last year **We can't get the skilled work force and staff are overstretched** • 450 Clinical vacancies at least in our system; high use of expensive locums • We have an ageing workforce with, for example 27% of GPs and 29% of Practice Nurses over 55 in the east of the county • Average ratio in Lincolnshire is 1 GP to 2080 patient, NHSE uses a safe figure of 1 GP to 1750 patient • We have 40 GP vacancies with a current workforce of 340 WTE GPs • Our workforce needs to change its shape and its skill base to be sustainable	Cancers diagnosed at an early stage	39.0%	50.7%	60%
	People with urgent GP referral having first definitive treatment for cancer within 62 days	74.2%	84.3%	National standard
	People with a first episode of psychosis started treatment within 2 weeks of referral	80.0%	68.7%	National standard
	Improving access to psychological therapy recovery rate	55.1%	45.0%	55%
	Neonatal and still births per 1,000 births	4.78	4.61	4.5
	Estimated diagnosis rate for people with dementia	64.2%	67% target	67%
	Staff vacancy rates	450 clinical vacancies	N/A	Lowest quartile
	Staff survey - staff engagement	CCG & provider range: 3.85 to 4.28	3.8	Top quartile
	Delayed transfers of care attributable to NHS and Social Care per 100,000 population	16.8	12.3	Top quartile
	A&E attendances	358,414	N/A	-27.5%
	Emergency admissions for urgent care sensitive conditions per 100,000 population	CCG range: 1,871 to 2,395	2,609.20	1,800
	Management of long term conditions: Emergency admissions for Chronic ACS conditions per 100,000 population	688.6	806	Remain top quartile
	Emergency bed days per 1,000 population	CCG range: 0.54 to 0.58	0.68	0.52

Summary Health and Wellbeing Challenges	Key Health and Wellbeing Indicator	STP (current)	National Benchmarking	Target 2021
Our system is outdated and unaffordable – too much demand on a hospital system already £60m in deficit • Demand is increasing because of an ageing population with long term conditions • People travel too far to hospitals for care that could be delivered by their GP, at home or in their community • We're not smart at joining up services – users of multiple services, who are often our most vulnerable residents, end up with a fragmented, and often poor, service • Level of integration varies; multiple assessments are not uncommon • Efficiency in our system needs to significantly improve • Lincolnshire has huge opportunities to achieve efficiencies of scale if it moves away from dispersed delivery of more specialist services • Healthcare estate requires reshaping and investment to enable new models of care and sustainable services • Our acute hospital services are constantly under pressure and this stifles our ability to develop proactive and community-based care; in turn suboptimal community care increases demand for secondary care acute services. We need to break this cycle. • Over 50% of people requiring a planned operation have their surgery outside of Lincolnshire	Percentage of patients admitted, transferred or discharged form A&E in 4 hours	80.4%	83.9%	95%
	Patients waiting 18 weeks or less from referral to treatment	91.0%	90.9%	92%
	People eligible for standard NHS Continuing Healthcare per 50,000 population	70.66	47.90	50.00
	Patient experience of GP services	85.24%	85.20%	85.5%
	Cancer patient experience	87.40%	89.00%	90%
	Ambulance waits - % of cat A red 1 incidents responded to within 8 minutes	66.3%	71.8%	National Standard
	Out of area placements – Learning disabilities	23	N/A	9
	Out of area placements – Mental Health	305	N/A	Nil by exception

The Quality challenges for Lincolnshire

We know there are issues around the quality of many of our services and in some areas we are not meeting the national core standards. This leads to care that does not come up to the standards our staff want to deliver and unsatisfactory patient experience. In particular there is a high demand for certain services, made more challenging by the wide geographical spread of our population.

We have not met our 4 hour waiting time at A&E since the summer of 2014.

We regularly have more people attending at A&E than we can cope with, leading to crowded and uncomfortable waits.

Some of our mental health wards are not fit for purpose. For example, some wards are on the first floor which restricts patient access to outside space.

Older people are being admitted to hospital and staying longer than necessary because of a lack of availability of alternative community support services, and poor coordination between hospital and out of hospital services.

In Lincolnshire our population is spread over a large geographical area with a shortage of skilled staff. In order to have sufficiently skilled staff to deliver high quality care we know it is vital that we bring together our key services across fewer sites, as well as providing more services closer to home where possible and protecting some hospital beds for planned treatment.

Our stroke services have struggled to meet the essential national standards and have struggled to recruit and retain key staff largely due to the challenges of staffing 2 rotas for a service that is delivered on two sites as opposed to one. Far too few Lincolnshire patients have early access to a specialist stroke unit when compared with the best in England.

The Clinical Senate who reviewed our vascular surgery services in 2014 indicated that it needed to be sited in Lincoln closer to the other key specialties delivered there and that we needed to develop a wider partnership with another provider to make sure we can attract and retain specialist staff.

40% of people who go to A&E in Lincolnshire leave without the need for any treatment. Of the 154,128 people who went to A&E at Lincoln, Boston and Grantham hospitals between April 2015 and April 2016, only 40,727 of those were admitted to hospital. This could suggest that these people could have their needs met in an alternative health setting.

The Royal College of Obstetrics and Gynaecology suggest that you need at least 6,000 births a year on a single large urban site to maintain clinical safety for women and babies. Across Lincolnshire we have on average just over 7,000 births per year, with 5,500 births taking place within United Lincolnshire Hospitals NHS Trust, which are spread across two maternity units in Lincoln and Boston. That means that the volumes of deliveries and thus the clinical experience of the staff may be less than recommended, it also means that smaller services with more demanding rotas find it hard to attract and retain staff.

Nationally there is a serious shortage of paediatricians and paediatric nurses and Lincolnshire has felt the effects of this. Currently all babies born in county under 29 weeks have to go out of county for their care as our Neo-natal services are dispersed onto two sites and cannot meet the required national standards to provide care for these babies.

We consistently do not meet national standards for the number of children's clinicians on site and this has implications for the sustainability of both our paediatric and our maternity services as they are currently configured. By having our paediatric services spread across two sites we often make it difficult to make sure the volumes going through the service are sufficient to maintain the skills and expertise needed and as standards continue to rise this will become increasing unsustainable.

Over 50% of people requiring a planned operation now have their surgery outside of Lincolnshire; shortages of staff and a lack of access to protected bed capacity especially in winter has meant that local access to elective treatment and cancer services has been variable. Cancer NHS

Constitutional Standards are not consistently met. Whilst local work has delivered some improvements, in order to get to where we need to be as a system more radical change is needed.

305 patients with mental health needs were admitted to a mental health bed outside of Lincolnshire last year resulting in friends and families having to travel to support them, in many cases the local services have not been able to provide the right skills and environment to care for them locally.

Last year our acute (general) hospitals spent more than £30m on agency staff because they couldn't fill permanent posts

We have a shortage of all core roles, in particular emergency care consultants, A&E middle grades, paediatricians and paediatric nurses and radiologists.

We have over 300 nurse vacancies across our acute (general) hospitals and there are serious shortages in Nursing Care Homes in the County.

Nationally, over 8% of GP posts are unfilled. The situation is worse in Lincolnshire; there are 40 vacancies with a current workforce of 340 whole time equivalent GPs (11%)

Our mental health service has 170 vacancies, 150 of these are clinical

We have an ageing workforce – for example 27% of our GPs and 29% of our nurses are over 55 in the East
We have problems recruiting to key roles in the community, particularly in the East of the county, in both health and care services.
It has been well documented nationally that there are gaps in the quality and safety of NHS care, most notably via a number of high profile national reviews (Winterbourne, Francis, Keogh and Berwick). Lincolnshire has had very real challenges; significant whole system work was required to enable ULHT to leave the "special measures" regime, and whilst this demonstrates what we can do when we work together it has acted as a very significant reminder of how fragile our system can be. Despite the significant progress made in reducing mortality rates and improving the quality of care across organisations, Lincolnshire recognises it remains a system under pressure and has identified a number of persisting quality issues, the below provides examples but is not an exhaustive list:

- A recent intermediate care review identified high diversity of services across Lincolnshire, high bed provision compared with the national average and a huge increase in 30 day bed usage with poor outcomes
- The current primary care models are not sustainable coupled with a predicted rise of 33% in consultations by 2035 and increasing shortage of GPs and Practice Nurses
- The general public are confused around the variety of provision of urgent care, walk in centres etc. and as a result A& E is often the default
- There is a significant outflow of patients from Lincolnshire for treatment and care for a number of specialities. This is affected by geographical issues e.g. proximity to out of County hospitals, but improvements to patient experience and better published outcomes would influence the number of patients using services within the County
- Hospital bed occupancy service capacity and utilisation vary across the county
- Our local Hospitals perform less well than peers in a number of areas /specialities e.g. length of stay, new to follow up ratios, outpatient did not attend rates
- There is continued focus and actions required across organisations to improve Acute Standard Hospital Mortality Indicator Rates; despite improvements we are not complacent
- Quality concerns that arise within maternity and children's services largely relating to the relatively low volumes of provision across sites and workforce constraints across sites.
- Reducing excess mortality rates for people with Mental Health Conditions, Learning Disability and Autism is a key priority given there is a significant gap in mortality rates between these groups and with the wider population.

Our Quality Ambitions

All STP partners are committed to ensuring high quality services and this will be the underlying mantra and core principle of the STP. To achieve this there are robust processes in place across providers and commissioners to actively monitor and improve patient experience, patient safety and clinical effectiveness. This is on a continuum but there are high priority areas that will continue to be addressed as per the examples above. Robust Quality Assurance systems and processes are essential as the STP is progressed.

These will include:

- Wide reaching initiatives driving an open culture that supports positive change within our organisations
- Service changes guided only by rigorous Quality Impact Assessment
- Continuing to ensure adequate workforce numbers through a suite of recruitment and retention initiatives,
- Surveillance and action on any outlier quality metrics/ markers across the whole field of quality (patient experience, patient safety and clinical effectiveness) for All partner organisations, including of course mortality rates and mortality case reviews
- Effective utilisation of quality incentive initiatives e.g. CQUINs and Quality Premiums.

The System Plan focuses on making real improvements in quality; by 2020/21 Lincolnshire will be well on the way of a journey where there will be;

Patient Experience

- Consistent improved access to care; RTT delivered to national standards and all cancer standards to be delivered consistently
- Increased personalisation through care planning, case management and increasing use of integrated personal budgets in long term conditions
- Significant reductions in cancellations of procedures as a result of a lack of resilience in services
- Consistent and easily navigated pathways of care across Lincolnshire that reflect best practice
- Improved patient recorded outcomes that reflect top quartile performance
- Friends and Family test responses in top quartile
- Carers feel fully involved as partners in care
- Care is genuinely closer to home
- Patients “can’t see the join” between mental health and physical health services

Safety

- Consistent and continued compliance with national standards on key services including A&E, Stroke, Paediatrics, Maternity and Cancer
- Safe and sustainable staff rotas 7 days per week 365 days a year in the community as well as hospital
- Reduced mortality across all age groups
- Reduced levels of Hospital Acquired infections
- Never events never occur through sound process management and a learning culture

Effectiveness

- Reductions in low value interventions and increased investment in high value interventions; the right thing at the right time
- Thresholds are clear, easily understood and applied in a consistent and professional way
- Lincolnshire's care pathways reflect best practice
- Significant reductions in unwarranted variations in care across primary and secondary care
- Improved adoption of new innovation and technology

Value for money

- A system where efficiency benchmarks well against comparators
- A stable and sustainable financial position
- Significantly reduced spending on temporary staffing across the system
- Prescribing in the top quartile
- Back office functions spend across the system benchmarks well against competitors

Staff Engagement

- Significant improvements in staff survey results across the whole system
- A thriving development culture where leaders are developed at all levels
- Clinical leadership is at the front of all organisations
- New roles and new career paths over opportunities not currently available
- The workforce reflects the growing diversity of Lincolnshire

Closing the financial gap

- Health economy directors of finance have collaboratively developed the financial model supporting the STP including agreement to the underpinning planning assumptions which have been informed by those nationally specified as well as some that are locally determined.
- The application of these planning assumptions means that the current System underlying deficit of £73m in 2015/16 deteriorates to a "do nothing" deficit of £182m by 2020/21

In developing solutions to address the financial gap, the local health economy has focussed on the following main areas:

- Clinical redesign, including prevention.
- Progressing Right Care initiatives
- Optimising Capacity, including repatriation of activity delivered out of county and in the independent sector together with the reduction in duplication of diagnostics.
- Operational productivity to drive Carter efficiencies across all sectors of provision including primary care prescribing.
- Workforce
- All organisations within the STP footprint recognise and sign up to the delivery of the solutions detailed in this plan.
- The requirement for a Development fund has been identified to support capacity and capability requirement as well as transitional costs, stranded costs and exit costs linked to the implementation of clinical redesign work streams.
- Health economy directors of finance are working to translate this strategic plan into individual operational two year plans and will sign off individual organisations "do nothing" and "do something" elements of the STP financial plan.
- The critical path for delivery of the financial strategy is informed by the CCG business rules and the NHS providers control totals issued on 30 September 2016
- Early focus is on operational productivity at both provider and CCG level as well as early review of unsustainable services and commissioning prioritises, e.g. Right Care.
- Risks to delivery of these solutions include capacity and capability to implement changes at the accelerated pace required.
- Recognition of the delivery of the system wide control total requires an improved mechanism for collaborative working and holding individually accountable organisations to account for the delivery of the system control total.

Working as a system to manage growth in demand

Over the past two years the health and care organisations in Lincolnshire have created a number of working groups or expert reference groups, led by doctors and nurses, to look in detail at specific pathways of health and care for the people living in Lincolnshire. Detailed discussion has also taken place in ULHT as part of their clinical strategy development and in the community. All organisations have had representation at the expert reference groups. The aim was to find ways of providing the best, most efficient and sustainable services which address the challenges faced by the local health and care community and which deliver the best possible care for patients. A set of initial ideas was developed by these clinician-led groups, informed by independent, expert, clinical advice and by engagement with patients, the local community, staff and many others.

Running in parallel to this work we have also modelled the impact of new pathways designed to support a volume shift away from traditional hospital based care into community and primary care based models or by reducing overall demand through self-care models. By 2020/21, by implementation of these new pathways the following activity will be displaced. The activity is for the population of Lincolnshire.

The table below details the seven High Impact Objectives

Point of Delivery	% Activity shift over 5 years
A&E	-27.5%
Non Elective Admissions	-10%
Elective In-patients	-12%
Acute OPA	-21%
Mental Health Inpatient	-10%
Community Services	-21%
Primary Care	+10%

For further details and a breakdown of activity by year and care settings – see Appendix 2 for the workbook called Lincolnshire STP Activity Model 26_6_16

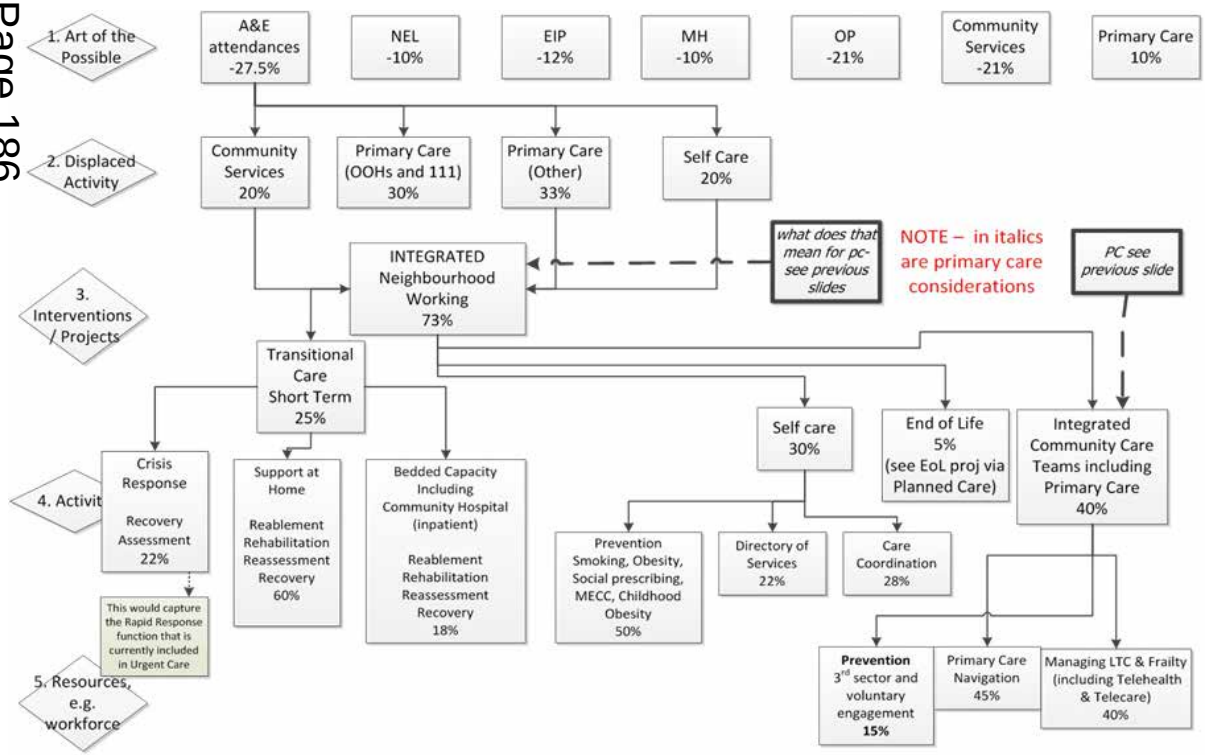
These core planning assumptions have been adopted as the basis for a more detailed planning of delivery models in and out of Hospital.

Firstly, seven care delivery scenarios were modelled for ULHT services. This modelling built on the options considered for ULHT's internal clinical strategy and added in the high impact objectives, additional productivity gains including an ambition for a reduction in length of stay to the top quartile in the country for all specialties and improved theatre utilisation. The modelling tool used was developed by KPMG, is at HRG level and clinicians made decisions about how patient choice and flow would affect market loss or gain for ULHT. The modelling also considered the interdependencies between clinical services, for example, A&E services, critical care and diagnostics.

The output of this modelling suggests that some services can be improved through different ways of working; however other services would require reconfiguration to ensure clinically sustainable and affordable services in the future. A range of options will require public consultation, to inform future decisions. The scenarios that require public consultation are detailed on page 78.

Secondly, the clinical redesign programmes then reviewed all the interventions or projects that would deliver this activity movement (displacement) in the high impact objectives. These interventions or projects had been identified as part of the original work done by the working groups or expert reference groups so was a process of strengthening and refinement opposed to new work. Clinicians and managerial leads then came together, as a system, to review all the interventions and together they mapped back all interventions to the seven high impact objectives. This work is captured in Resource Maps. An example is below but for further details – see Appendix 3 called STP Resource Maps v07

The diagram shown below is an example of the Resource Maps developed for every one of the seven high impact objects described as the "Art of the Possible" on these maps. This Resource Map shows how Proactive Care will deliver a reduction in A&E attendances.



Activity was then modelled for the first four levels of each Resource Map so activity could be attributed from the seven high impact interventions to each project. Whole Systems Partnership, our Workforce partner, then took the activity at intervention / project level and converted this into WTE staff which supported the delivery of our Workforce Plan and financial modelling. For further detail – see Appendix 4 called STP WF workforce requirements for displaced activity.

Transformation Schemes overview

In order to deliver our STP, we have developed five "solutions" or workstreams to achieve our objectives. These workstream are Clinical Redesign, Operational efficiency, and Commissioning Priorities: Right Care, Capacity optimisation/ Workforce Productivity which will be further developed through public consultation. They are supported by enabler workstreams that are Workforce and Organisational Development, Technology, Transport, Estates and Communication and Engagement. The following section gives an overview of the five workstreams

1. Clinical Redesign Workstreams

Six programmes form the clinical redesign workstream and reflect the Lincolnshire Health and Care (LHAC) programme. The STP Prevention Plan (see Appendix 5) provides information on the preventative activities supporting these workstreams.

Proactive Care

The vision for good Proactive Care comprises the identification and coordinated proactive management of people to prevent illness where possible, manage ill health and long term conditions, and avoid unnecessary crises. Core components of this include:

- Activating patients, their carers and resilient communities to look after themselves and their own care needs
- Genuine cross-professional cross-organisational working, including primary care, community nursing, mental health practitioners, social care professionals, hospital based expertise and diagnostics, third sector and others – focussed on the needs of the populations
- Sharing of information around needs, up to date care plans, interventions and carer responsibilities.

The Proactive Care Workstream is building on a well-established programme of work focused on delivering a full population based, preventative, pro-active approach which enables a strong sense of community and that emphasises 'self-care'. However when more intensive care and support is required it will be excellent, responsive and wherever safe to do so delivered in, or as close to, people's own home as possible.

Primary Care

Primary care is pivotal in preventing ill health and moderating demand (particularly reducing high cost preventable causes of ill health such as cardio vascular disease, cancer, respiratory disease) through focus on screening, early intervention, and prevention. The GP list system will enable us to do whole population health management well with the primary care and proactive care workstreams inextricably linked.

The vision for primary care is one of consolidation and joint working with access 365 days a year provided by a network of practices working together as federations or super practices and working with community services to provide a wider range of services delivered by a new more integrated workforce. Primary care will become a resilient, reliable workforce that reduces variation and is able to offer a portfolio career to it workforce. We would want to see the proportion of GP partners stay the same, strengthen leadership capacity and capability but reduce the ratio of senior GPs to allied health professionals. We would mirror that with an increase in other professional groups working in primary care, e.g. pharmacists, wider nursing teams, physicians associates, advanced nurse practitioners, paramedics. These roles will be embedded in practices, led by GPs as part of our Multispecialty Community Provider new models of service delivery.

By 2021, Primary care will be the driver of the system not the recipient operating as part of our MCPs. Access into primary care will be better managed through increased use of self-care, use of IT and access to a wider range of primary care / community staff providing integrated care and care

coordination, releasing GPs to take clinical leadership roles and focus on seeing people with the most complex needs, supported by access to secondary care consultant time and greater peer review.

Urgent Care

The vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population (young or old, with physical or mental health needs).

This workstream is also building on a well-established programme of work that focuses on the following proposed changes;

- "Choose Well" - supporting people to self-manage their conditions themselves and helping them to select the right service if necessary
- "Hear and Treat" – ensuring people's needs are met in the right way at the first contact and preventing unnecessary traveling
- "Targeting those most at risk" - supporting appropriate and timely access to services through case management and primary care interventions
- "Community-based urgent care" - developing and implementing integrated, responsive services to support people at home or in the community
- "Consistency" – reducing variation in assessment and delivering consistent interventions and onward referral if necessary. This will help to grow people's confidence in services.
- "Effectiveness" – people will benefit from an integrated, networked urgent care services meaning the correct level of expertise is rapidly accessible regardless of the care setting, 365 days a year. "No decision is made in isolation" principles.

We expect our urgent care interventions to deliver the following key outcomes;

- Simpler system for people to understand (professionals as well as the general public)
- Improved patient experience – more people being assessed and treated first time by the most appropriate person; the patient will not have to repeat their story numerous times.
- More people being treated in the right place – Reduction in A&E attendances by 244,063 accumulative effects by 2020/21.
- National standard of 4 hours consistently met; aspiration is that urgent care centres will deliver a 2 hour target
- Reduction in non-elective admissions is 29,377 accumulative effect by 2020/21.
- For those people who still need admitting, they will spend less time in hospital – Reduction in Length of Stay to the top quartile for over 75 population admitted non electively. The emphasis is on having the correctly resourced community services "pulling" people out of hospital to a more appropriate care setting.

Planned care

The vision for Planned Care is a single end-to-end pathway; improvements in the way referrals are managed will support clinicians to determine the right intervention and make appropriate referrals to the person best able to address the patient need; reconfiguration of service delivery will promote effective use of resource and safeguard clinical quality by ensuring clinicians undertake a critical mass of activity required to retain clinical competence whilst minimising disruption to patient care. Recovery and transition to long term care will be facilitated by follow up / ongoing care delivered by the most appropriate person.

This means that the systems and process for a patient journey on Planned Care should be streamlined and there should be a further shift towards primary and community management and support, instead of in a hospital setting.

The Planned Care will deliver the following:

1. **Demand and Referral Management**

- E-referrals and Electronic Bookings
- Shared decision making
- Triaging
- Quality Control Mechanisms (Referral rejection and peer review of referrals)
- GP Access to Advice and Guidance
- Alternatives to outpatient appointments
- Consultant to consultant referral protocols
- Direct access to diagnostics
- Management and monitoring of follow-ups

2. Commissioning Prioritises/Right Care

- Procedures of Low Clinical Value
- Referral Criteria / Thresholds

3. Transformation / End to End Integration of Outpatient Services

- Standardised Pathways
- Identification of activity to be delivered in the community
- Configuration of Specialist Teams

We will approach this work specialty by specialty. Work has already started, or is soon to start, on MSK, Urology, Neurology, Diabetes, Gynaecology, Gastro, Cardiology and General Surgery.

4. Service reconfiguration to support elective in-patient care

- Secondary care services, such as Cancer services, will be organised to ensure they are co-located with services where there are clinical interdependencies,
- Elective in-patient care will be arranged to minimise disruption and cancellation and may be provided in specialist centres supported by local outpatients
- Interventions will reflect best practice and where possible will be provided as day cases supported by enhanced recovery programmes
- Community surgical schemes will be optimised
- Acute trust federations / partnerships will be arranged on a speciality by specialty basis to support provision of clinical expertise and integrated treatments for specialties where access to specific diagnostic or treatment equipment is required e.g. ULHT work in partnership with Leicester for urology, or the volume of patients does not provide a critical mass to assure clinical competence or where recruitment is challenged.

Mental Health, Learning Disabilities and Autism including Transforming care

Much work has already been done to develop these services including the recent transformation of Learning Disabilities services to meet the national Transforming Care for Learning Disabilities standards; the introduction of an assessment and liaison service for adult autism; the introduction of a new Hospital Liaison service for mental health; and the transformation of community Child and Adolescent Mental Health services that was implemented in April this year.

The work programme for this workstream includes interventions in the following areas:

- Review of the Adult Inpatient pathway - including development of a new PICU facility; a new Clinical Assessment Unit and the review of Crisis care for mental health
- Adult Community Mental Health Team transformation – focussing on integration with other providers and wider community services through the Neighbourhood teams
- Psychological therapies into planned care – making sure patients with conditions such as cancer or chronic pain have access to structured psychological therapies
- Older Adult services transformation – increasing the community service offer to reduce the reliance on inpatient beds, see more patients and avoid unnecessary admissions
- Learning Disabilities reconfiguration - Continue the fully developed integrated community service and the consultation on the closure of Long Leys Court - the unit has been temporally closed since June 2015.

Women and Children

The vision for maternity services for Lincolnshire is that maternity services will be safe, personalised, kind, professional and family friendly, and that every woman will have access to information that will enable her to make decisions about her care, and where she and her baby can access support that is centred round their individual needs and circumstances.

In two years' time our maternity services will have made significant progress towards this vision and will have gone a long way to implementing the national maternity review recommendations. In particular the services in Lincolnshire will have a focus on ensuring that every woman has a comprehensive health assessment and personalised care plan developed to support her throughout her pregnancy, and during and after birth of her baby. The Lincolnshire maternity system is focused on further developing the out of hospital and community services to strengthen access and choice for women in relation to the place and type of birth that they want. Women in Lincolnshire will feel supported and will receive appropriate health support and education prior to, during and after their birth so as to maintain their, their babies and their families' health and wellbeing.

Operational efficiency

This programme will;

- Reduce costs of prescribing in all sectors and reduce the costs of pharmacy provision (service)
- Implement E-prescribing
- Expand the use of Digital services, e.g. workforce productivity through e-rostering
- Further control the use of agency / locum and other variable pay costs
- Reduce management costs
- Implement the sharing of back office functions
- Reduce Non-pay through improved procurement to impact on estates and clinical products
- Rationalise estate
- Improve pathology efficiency through procurement

Commissioning Prioritises/Right Care

This programme will implement Right Care and decommissioning estates in the community. There are therefore interdependencies with two other solutions which are the Operational Efficiency - Carter Review Recommendation 6 and Clinical Redesign - Planned Care workstream.

Capacity optimisation

This programme will reduce duplication and underutilised space, plus increasing local capacity so that more patients have a choice of services in Lincolnshire.

Workforce Productivity

This programme will restrict pay increases to 1%. This will be through national direction and, should this not happen, will need to be managed differently in Lincolnshire.

Detail for the Transformation Schemes

The following section gives further detail on the five workstreams and enablers.

Clinical Service Redesign

Prevention

The STP Prevention Plan (see Appendix 5) provides information on the preventative activities supporting these workstreams

Vision

More focus and resources targeted at keeping people well and healthy for longer; we will give them the tools, information and support within their community to make healthy lifestyle choices and take more control over their own care. This will improve quality of life for people who live with health conditions and reduce the numbers of people dying early from diseases that can be prevented.

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Smoking Cessation To provide evidenced based smoking cessation services to reduce the burden of disease and the demand in healthcare settings caused by smoking.	To develop further smoking cessation services to support smokers with medical conditions, mental health and pregnancy. To increase the number of health care front line staff trained to deliver very brief advice (3 A's) Ask, Advise, Action as a minimum, which will: • Increase 'brief advice' on smoking to all patients • Increase the uptake of smoking cessation treatment in the targeted groups • Maintain quality of treatment to ensure a high level of quit rates.	To reduce the: • Pressure on primary and secondary care services • Incidence of circulatory disease, cancers and respiratory disease • Exacerbations of long term conditions such as asthma and diabetes • Post-operative complications and improve surgical recovery • Number of low weight babies, stillbirths and miscarriages.	Increase the number of primary care, community pharmacy and secondary care engagement with smoking cessation. Increase the capacity for smoking cessation from 6,115 set quits and 3,172 4-week quits to 15,227 set quits and 7,790 4-week quits.	Implement aligned with current service provision April 2017. Build capacity to target by March 2018 and maintain during STP.

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Adult Obesity To provide evidenced based weight management and lifestyle support services to help people lose weight to reduce the burden of disease and the demand in healthcare settings.	To develop tier 2 adult weight management services for patients with a BMI 30+ (or a BMI of 28 to 29.9 with existing co-morbidities) aged 16+.	To reduce: • BMI and when maintained, reduced incidence of conditions associated with obesity: CVD, type 2 diabetes, hypertension, osteoarthritis and some cancers. • Demand on healthcare services. • Post-operative complications and improve surgical recovery	5,500 referrals into tier 2 weight management annually with a minimum of 60% completing and 60% of those completing achieving a 5% or above weight loss at 12 weeks.	Implement Sept 2017 and maintain during the STP
	To develop a multi-disciplinary team tier 3 Adult Weight Management service for people with a BMI 35+ and who have completed a minimum of 12 months in a tier 2 weight management service.	As for tier 2 weight management.	For further work to be completed by end of November 2016.	For further work to be completed by end of November 2016.
	The develop a Healthy Lifestyles programme (based on PHE One You) to deliver integrated services to support people to adopt and maintain a more healthy way of life through a multiple approach of physical activity, healthy eating and behaviour change. To provide the National Diabetes Prevention Programme as part of the Greater Lincolnshire first wave.	Interventions will: • Result in behaviour change in relation to diet, activity, alcohol consumption, weight loss and improved confidence and self-efficacy. • Reduce the use of primary care services, less reliance on prescribing medicines, better pain management. • Reduce the incidence of diabetes (NDPP)	Potential scale per annum: 5,000-10,000 new One You clients and/or supported with digital technology. 8-12,000 adults supported locally to achieve the One You goals through multiple local providers. The NDPP has a range of metrics that are used as part of the Greater Lincolnshire Programme.	Implement April 2017 and maintain during the life of the STP

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Childhood Obesity Halt the growth in the number of children who are overweight or obese by 2017, and reduce numbers by at least 2% in both categories by 2020.	Lincolnshire will support a workforce skilled to promote healthy interventions and influence behaviour. A 'making every contact count' (MECC) approach will raise awareness and offer support to families every time a child comes into contact with a professional or care worker, resulting in improved health outcomes for children and their families. Agree a local Healthy weight in childhood in Lincolnshire plan to address four strategic themes: • Promote a healthy lifestyle (healthy eating and physical activity) and raise awareness of the health risks of obesity. • Implement a 'life course approach' to reduce childhood obesity. • Continually review evidence based interventions to inform NHS and other partners' commissioning across clinical and wider determinants of health, constructing a multi-agency, holistic obesity prevention and care pathway. • Build capacity and increase partnership working within Lincolnshire, creating stronger links and joined up activity within existing networks	Childhood obesity has both immediate and long-term effects on health and well-being; a reduction in the number of children becoming overweight or obese will: • Reduce the number of children suffering from bone and joint problems, sleep apnoea, and social and psychological problems, such as stigmatisation and low self-esteem in childhood. • Reduce the likelihood of obese children becoming obese adults with these same health problems, plus other health problems including type 2 diabetes, pregnancy complications, cardiovascular disease and cancer • Reduce the risk of morbidity, disability and premature mortality in adulthood.	Halt the trend. Reduce rates of overweight and obese children by 2020: Reduce over weight levels in reception and year six primary school children from 22% in 2014/15 to 19% and from 33% to 28% respectively. Reduce obesity levels in reception and year six primary school children from 8% in 2014/15 to below 7% and from 19% to 16% respectively.	2020

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Making Every Contact Count (MECC) To make use of existing day-to-day interactions in order to support people to make positive changes to their lifestyles.	To deliver MECC training to frontline staff across a wide range of organisations (face to face and e-learning). To provide an e-forum through which trained staff can access up-to-date resources and information and can share ideas and good practice. To coordinate a network of MECC Champions to promote on-going engagement with MECC principles.	• Supporting people to make small changes to their behaviour (for example in relation to alcohol, diet and physical activity levels) will have a significant impact on their health across the life course. • MECC forms a key part of the self-care agenda by increasing individuals' health literacy in order that they can take greater control of their own health. • Diverting people away from health services through the provision of timely advice and signposting. • Changing organisational cultures towards a focus on prevention.	• Increase the number of trained staff (15,000 staff by 2020/21) • Creation and coordination of network of MECC Champions (200 over two years, starting 2017)). • Increase referrals to lifestyle services (10,000 depends upon which lifestyle services are being commissioned).	Implement enhancement from April 2017. Build infrastructure during 2017/18 and activity to be maintained during the life of the STP.
Self-Management/Care Active support to enable people to be more active in managing their health.	Initiatives will relate to the proactive work, in relation to neighbourhood teams, self-care and the re-commissioning of the Wellbeing Service (LCC). The role of social prescribing is being explored as non-medicalised support within communities as part of the STP.	The offer a gateway to refer patients with long term conditions to community-based services to complement traditional medical interventions: • reducing the demand on costly primary care, hospitalisation and other specialist services • broadening and diversifying provision for patients with complex needs, and • Offering an alternative and holistic approach.	TBC – metrics to be developed to define • Improved health and wellbeing • Increased confidence and self-esteem • More opportunities for social contact • Greater ability to manage own condition • Increased independence and more control over decisions • Stronger economic / welfare resilience • Greater opportunities for employment and meaningful occupation. 3,000 service user capacity to be developed across 2017 & 2018.	Implement linked with the delivery of the Self Care Plan for Lincolnshire and the Wellbeing Service re-procurement for Sept 2017.

Primary Care

Vision

The vision is one of consolidation and joint working with access to 7 day urgent care provided by a network of practices working together as federations or super practices and working with community services to provide a wider range of services delivered by a new more integrated workforce.

Primary care, becomes resilient, variability in access and outcomes and patient experience are reduced and is able to offer a portfolio career to its workforce. The proportion of GP partners stay the same, and see an increase in other professional groups working in primary care (embedded in practices, led by GPs).

By 2021 Primary care will be the driver of the system not the recipient. We will have 13 hubs working towards voluntary contract (or working under an alliance contract) and 7 day urgent care services.

Access into primary care will be better managed with work taken off GPs via more self-care, use of IT and access to a wider range of primary care / community staff providing integrated care and care coordination, releasing GPs to take clinical leadership roles and focus on seeing people with most complex needs- supported by access to secondary care consultant time and greater peer review.

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
1. Stabilise Primary care	**WORKFORCE DEVELOPMENT** **International recruitment** - Lincolnshire LMC is leading the national scoping pilot for international recruitment to inform the international recruitment of 500 GPs in the GP Forward View.	Improved continuity of care, improve patient experience, and improved access to GPs through higher rate of substantive appointments	25 new GPs recruited and in post across Lincolnshire Jan 2017 % of GPs in post who are substantive appointments	Interviews Nov 2016
	GP Mentorship Programme £100,000 HEE funded LMC mentorship programme for those GPs who are stressed or wanting career direction. To keep GPs working / offering different ways of working in order to retain them in the workforce.	Improved continuity of care, improve patient experience, and improved access to GPs through higher rate of substantive appointments	Vacancy rate GPs	2016
	Lincolnshire General Practice Workforce Data LMC developed (HEE funded) software system that enables practices to enter workforce data in real time. This will be retrievable by HEE at any point as opposed to what the national data collection allows.	More responsive workforce planning improves continuity of care	Real time workforce data available	2017

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
	Lincolnshire Healthcare Attraction Strategy Lincolnshire LMC on behalf of General practice is leading on an 'Attraction Strategy' for Lincolnshire health providers. The strategy allows the health community to demonstrate all of its excellence and transformation projects by way of branding, marketing, recruitment fairs, careers fairs, and ongoing branded advertising campaigns.	Improved continuity of care, improve patient experience, and improved access to Primary Care professionals through higher rate of substantive appointments	Vacancy rate GPs and Practice Nurses	2016-2018
	Marketing Lincolnshire Project - to improve GP recruitment funded by CCGs and LMC	Improved continuity of care, improve patient experience, and improved access to GPs through higher rate of substantive appointments	Vacancy rate GPs and Practice Nurses	2016 -2017
	QUALITY & ACCESS Release time for patients - Systematically implement the 'Releasing Time for Patients' Programme – resourcing, timings and emerging national guidance will inform planning in this initiative.	Improved patient experience and improved access to primary care professionals	10% shift from admin duties to patient facing time	2016-17 LMC Creating Capacity Workshop
	DIGITAL PRIMARY CARE PATHWAYS – will be developed as part of the local health system including, self-help advice, e-consultations, on line booking, apps.	Improved access to advice and care Support for patients to self-care	95% of primary care patients offered e-consultations and other digital services	2019

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
2. Develop the primary care element of community hubs	**Lincolnshire Community Provider Education Networks (Training Hubs)** - There are three sites across the county in Lincolnshire South, West and East who provide a hub and spoke model of enabling training placements in general practice. These sites are currently engaged in providing medical student, GP registrar and nurse placements. These sites are also going to provide placements for clinical pharmacists as part of the General Practice team. The LMC together with GP tutors have been working with the University of Lincolnshire School of Pharmacy to facilitate a programme very much like the GP VTS to enable placements from year 3 of the 5 year pharmacy graduate scheme. There is no reason why with the appropriate resource this could not be extended to other disciplines working within the community.	Improved patient experience and improved access to primary care professionals	Number of training placements by discipline	2016 ongoing 3 sites hub and spoke model training placements 2019-2020 pharmacy training placements
	GPwSI Mentorship Programme - LMC & CCG Federation Risk Accreditation team partnership, £45,000 to set up a mentorship programme to facilitate the development and sustainability of GPs with a special interest. This enables the matching of GPwSI with a mentor in secondary care and likewise a mentor in general practice for those secondary care clinicians who are deskilled because of transfer of work. This scheme also includes existing GPwSI's.	Improved patient access to specialist advice and care in primary and community settings Reduced patient travel Improved patient experience	Number of GPwSI on plan Reduction in referral to secondary care in specified specialities Primary Care Patient Survey	

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
	Development of Federations and Super Practices - To deliver primary care at scale. We are in a good state of readiness for provision of primary care at scale with primary care proactively working with other professionals to integrate and co- locate. Practices in the south of Lincolnshire are furthest ahead with other practices keen to learn from this and accelerate change. Development across Lincolnshire will be incremental but at pace taking account of different starting points and rate of transfer of secondary care services e.g. from partnership working to pilot of true integration and co-location together with a move of services from secondary to primary care. We will develop extended practice hubs at 30,000- 50,000 population working closely with community services. Size of MCPs in Lincolnshire will be determined by local needs.	Improved access and reduced waiting times to see a GPs as patients will be able to access a wider range of professionals to best meet their needs and GPs will have more time to care for patients with the most complex needs Access to more holistic care via a greater range of integrated services provided locally in hubs Better patient experience	Number of hubs developed (include new voluntary contract around new model of care) Access evening / weekend for urgent care. 95% of tests to be digitally transferred between organisations CQC ratings in top quartile National Patient survey result Secondary care activity growth moderated % reduction in non-elective inpatient bed days	2016-17 mobilise pilots 2017-18 – 1 pilot hub 2018- 20121 roll out 12 hubs
	Pilot physiotherapists as first point of contact – under development where the physio takes all MSK related appointment requests and proactive management of patients health through exercise etc.	Improved access to primary care by freeing up GP capacity to concentrate on complex medical care, and improved access to MSK specialist advice.	% of MSK conditions seen as first contact by MSK physio in primary care	TBC
	Employment, mentorship and supervision of existing pharmacists to work in general practice - we are developing a scheme with partners (in advance of the undergraduates at Lincoln University) to provide pharmacists on a sessional basis to practices/federations to start to build up that necessary skill set at scale.	Access to more holistic care via a greater range of integrated services provided locally in hubs	Benchmarking - prescribing costs Measurable improvement in antibacterial prescribing and resistance rates	2016- 2017

Proactive Care

Vision

To empower people and communities to take an active role in their health and wellbeing with greater choice and control over their care. Work to ensure it supports the improvement, integration and personalisation of services.

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
1. Better quality of life and enhanced health and wellbeing.	Implementation of Prevention Strategy in partnership with Local Authority – see separate Prevention Programme slide			
	• Development of individual Neighbourhood Networks – identification of a range of self-care options that will support the 12 Neighbourhood localities. Self-care will deliver: • Self-Management Programmes • Peer support • Health coaching • Group activities	These Networks will provide different options for local people to remain independent for as long as possible and be empowered to manage their own conditions. People will know where to access information and advice.	Evidence of increase community capacity within each Neighbourhood locality. Comprehensive Directory of service in place by Dec 2017 Significant numbers of people knowing about and accessing self-care support – 30% of the population	April 2017 December 17 2021
2. Fewer Crises that lead to unplanned admission to hospital and institutional care	Self-Care – as above. Providing access to a range of low level support and care for individuals aimed at supporting them to maintain their independence e.g. Wellbeing Service		Increase the number of people accessing Wellbeing Services to support them at home.	2021
	Transitional Care – a range of services that work together to deliver 'step up & step down' care. This consists of community bedded capacity, rapid response function, home based support packages with a range of professionals – re-ablement, nursing, therapy, third sector care providers.	Transitional care will ensure people can access an enhanced level of care that will increasingly support people at home – 'home first'. When necessary support people, safely and quickly home following a stay in hospital	• This service will support the achievement of: • 27.5% reduction in A&E activities • 10% reduction in UEA	April 2021
	Neighbourhood Care Teams – will provide rapid support to known patients who experience an exacerbation of their conditions.	This will aid the continuity of care for complex patients who are supported by the Neighbourhood Care Teams.	As above	

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
3. Enhanced experience of care through better coordination and personalisation of health, social care and other services	Integrated Neighbourhood Care Teams. These will be integrated cross-organisational teams, including Primary Care, who will over the next 5 years work together to deliver a range of functions including: • Supported self-care • Personalised Care & Support Planning • Care co-ordination & Navigation • Rapid support at times of crisis • Secondary Prevention • Chronic Disease Management • Community led Frailty Care • Falls management • Recovery and re-ablement • Early supported discharge planning & support • Mental Health & well being • Dementia Support/Care • End of Life care	These teams will work together with people to ensure local populations are able to: • Remain well and independent for as long as possible. • Able to support people safely at home in times of crisis • Support people home more quickly following a hospital admission • Ensure first class end of life care	Ensure that the 'top 2%' are identified and have a care and support plan in place. Ensure the 'top 5%' of the population are known and have a care and support plan in place. Increase in the number of people holding a PCB to 2,470. Fewer people will be placed into long term care Increase in the number of people able to die in their preferred place of death	2017 2018 2021

Urgent Care

Vision

Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population (young or old; with physical or mental health needs).

Our proposed initiatives to achieve this vision for urgent or emergency care are:

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
1. Choose well - supporting people to self-manage their conditions themselves and helping them to select the right service if necessary	Implementation of Prevention strategy in conjunction with Lincolnshire County Council, please see prevention slide Note CAS interdependency will ensure patients will access the correct pathway first time.	Reduction in potential years of life lost from conditions amenable to health care	See prevention workstream	See prevention workstream
2. Hear and treat ensuring people's needs are met in the right way at the first contact and preventing unnecessary traveling	Collaborative working with NHS111 and Lincolnshire Clinical Assessment Service. Direct 111 appointment booking of OOH appointments to commence before end of the calendar year. Data can be sent between providers to improve interoperability/care planning/decision making – autumn 2016 with the implementation of the IT Care Portal. Capacity for NHS111 and out of hours is jointly planned – work commenced. To be delivered by 2017. The SCR will be available in the hub and elsewhere with the implementation of the IT Care Portal. Care plans and patient notes are shared - with the implementation of the IT Portal. Appointments can be made to in-hours GPs – 2018/19. Early pilot testing with selected GPs to open up designated slots to 111 to begin in 2017 via DOS changes.	Right pathway first time for patients. Improved patient experience Improved decision making through senior clinical decision makers. Simpler system for people to understand (professionals as well as the general public)– more people being assessed and treated first time by the most appropriate person; the patient will not have to repeat their story numerous times. Consistent achievement of A&E 4 hour standard.	5% of GP booked appointments from NHS111 in hours.70% of booked appointments out of hours Emergency admissions for urgent care sensitive conditions per 100,000 population Reduction of 10% Emergency hospital admissions per 1,000 population by 2021 Emergency bed days per 1,000 population Percentage of patients admitted, transferred or discharged form A&E in 4 hours Reduction in A& E attendances by 27.5% by 2021	Booked apt. Q1 2017/18 Care portal implementation in CAS Nov 2016

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
3. Targeting those most at risk - supporting appropriate and timely access to services through case management and primary care interventions	Risk stratification of the most "at risk" patients to support ongoing care	More patients will be cared for in their homes or community settings.	Ensure that the 'top 2%' are identified and have a care and support plan in place. Ensure the 'top 5%' of the population are known and have a care and support plan in place.	2021
	Neighbourhood Care Teams working as a network of health and care professionals including third sector to support people at home. See Neighbourhood Care Team slides.	More patients will be cared for in their homes or community settings. End of Life Care will be supported in the community where possible to avoid acute admissions.	See proactive care Increase in the number of people able to die in their preferred place of death	2021
4. Community-based Urgent Care - developing and implementing integrated, responsive services to support people at home or in the community	Partnerships with care homes and independent sector already in place with direct access plans for Care Homes to have a 'speak to' clinician capability with the new clinical hub and Care Home Trusted Assessor roles facilitating discharge.	Increased speed of initial response, including reduction in variation in assessment and delivery of onward referral, in order to reduce A&E attendances.	Direct Dial provision into Lincolnshire CAS and rapid response support to the independent sector Care Homes in avoiding unnecessary A&E attendances and Emergency Admissions, and caring for patients closer to home.	
5. Consistency – reducing variation in assessment and delivering consistent interventions and onward referral if necessary. This will help to grow peoples' confidence in services.	Rapid response from community services including mental health response teams. Improved use of telecare Centralisation of stroke and vascular centres subject to final analysis, Clinical Senate assurance and public consultation.	Evidence based centralisation of services saves lives	Reduction in mortality, reduction in length of stay in acute services, improved clinical outcomes.	Q1 19/20 centralisation of vascular and stroke centres

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
6. Effectiveness – people will benefit from an integrated, networked Urgent Care services meaning the correct level of expertise is rapidly accessible regardless of the care setting, 365 days a year	Federated practices will be delivering seven day working for primary care services. Neighbourhood Care Teams will be cross – organisational teams including community pharmacy federated Primary Care and social care.	More people being treated closer to home in community setting, by the most appropriately skilled professional.	7/7 urgent care response	Q1 18/19 additional urgent care capacity through federated working Q3 17/18 Urgent Care centres
	Urgent care centres will be developed in front of Emergency departments on acute sites, co-located with paediatric assessment units which will enhance the concept of assess to admit rather than admit to assess. These will be primary care led assessment services.	Patients will be treated in a different setting to ensure EDs are not seen as first point of contact for minor urgent care.	A network of 5 urgent care centres and clinical hubs ensuring a consistent approach and local service Urgent Care Centres and Clinical Hubs throughout Lincolnshire ensuring consistency of approach to Urgent Care.	Q1, 18/19 Implementation of agreed option for Grantham Implementation of agreed option of NE locality Implementation of UCC at Spalding

Planned Care

Vision
Planned care will be delivered in a way that promotes independence and maintains or improves quality of life

There will be minimal disruption to people's lives when planned care is required – minimal cancellations of operations etc.

Protocol -driven single end to end pathways

Individuals actively identified and managed through risk stratification

Planned care will be accessible and convenient

One stop services for diagnosis and assessment where ever possible managed by GP and closer to home

Follow ups wherever possible will be managed closer to home

Planned Care in Lincolnshire will be aligned to national best practice

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Demand and Referral Management	• Explicit referral guidance • E-referrals and Electronic Bookings • Shared decision making • Triaging • Quality Control Mechanisms (Referral rejection and peer review of referrals) • GP Access to Advice and Guidance • Alternatives to outpatient appointments • Consultant to consultant referral protocols • Direct access to diagnostics • Management and monitoring of follow-ups Work has already started on Neurology, Diabetes, Gynaecology, Gastro, Cardiology	Systems and processes for patient journeys through Planned Care will be streamlined and standardised to support clinicians to decide the appropriateness of referrals and ensure that they are to the right setting Patients receive appropriate care in a timely manner Reduction in unnecessary appointments and non-value adding specialist contact There will be a reduction in hospital referrals and patients will be directed to community-based alternatives where appropriate, meaning that they are likely to be treated closer to home Improve communication between clinicians and patients Shared decision making will result in more involved and informed patients who have better outcomes through better compliance with treatment plans Aids early diagnosis across all specialities, notably Cancer in line with the Cancer Strategy and NICE Referral Guidelines	• 12.6% reduction in new referrals • 8.4% reduction in follow ups • Increase in referrals that use advice and guidance • Reduction in inappropriate referrals • Decreased average referral to appointment waiting times • Achieve the financial savings target assigned to the planned care programme • Reduction in consultant time spent on PLCV • 100% of referrals electronic • Increase in planned care being delivered in a community setting • Reduction in locum costs • Reduction in cancellations • Increase in number of referrals with appropriate supporting information • Increase in follow ups by phone or technology • Increase in positive patient reported outcome measures • Meeting of all constitutional standards	Decision on referral management infrastructure (buy in service or not) in 16/17 Q3 Thresholds finalised and implemented in 16/17 Q3 Gynaecology, Gastro and Cardiology e-referral/ advice and guidance fully operational March 2017. Plans in place for referral management initiatives for all other specialties to be implemented on prioritised basis by 17/18 Q1 E-referrals – full implementation by March 2018

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Transformation / End to End Integration of Outpatient Services (across primary and secondary care)	• Standardised end-to-end clinical pathways • Identification of activity to be delivered in the community • Managed transitions from acute treatment to recovery/long-term condition management/palliative care • Configuration of Specialist Teams • Develop the skill of our extended workforce to treat the needs of patients • Ensure alignment of pathways and requirements with proactive care programme We will approach this work specialty by specialty. Work has already started, or is soon to start, on MSK, Urology, Neurology, Diabetes and General Surgery.	Care delivered closer to home Improved outcomes and patient experience Stop wasting patient's time and reduce dependency on scarce hospital resources Reduced level of specialist contact and improved self-management, supported by Primary and community teams Improved access to same day appointments Enhanced quality of life for people with long-term conditions Helping people to recover from episodes of ill health Improved access to palliative/end of life care planning Reduction in pathway costs for providers and commissioners	• 12.6% reduction in new referrals • 8.4% reduction in follow ups • Increase in referrals that use advice and guidance • Reduction in inappropriate referrals • Decreased average referral to appointment waiting times • Achieve the financial savings target assigned to the planned care programme • Reduction in consultant time spent on PLCV • 100% of referrals electronic • Increase in planned care being delivered in a community setting • Reduction in locum costs • Reduction in cancellations • Increase in number of referrals with appropriate supporting information • Increase in follow ups by phone or technology • Increase in positive patient reported outcome measures • Meeting of all constitutional standards	Planned care programme of transformation agreed by specialty in 16/17 and 80% to be delivered by end of 2018/19 New pathways operational for headache and epilepsy in 17/18 Q1 New diabetes, dermatology and end of life service models in place 17/18 Q3 Transformation review of OP services completed 17/18 Q3 New MSK service starts 18/19 Q1 Implementation of new pathways for progressive neurological diseases 18/19 Q1 New Urology and ENT services start 18/19 Q3

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Service Configuration (any proposed changes will be subject to full public consultation)	• Acute Site Reconfiguration (ULHT-led workstream that will be informed by change in demand and patient flow as a consequence of other workstreams) • Consolidation of service to make best use of resource, infrastructure and technology. This is likely to include Breast Services, Orthopaedics and acute Ophthalmology & ENT • Movement of planned care activity into the community (possibly to include, diabetes medicine, dermatology, ophthalmology, orthodontics, pain management, Endocrinology, Neurology, Rheumatology - depending on outcome of cost-benefit analysis) • Establish a network of acute trust partnerships for specialties with low demand or workforce challenges	Improve patient experience and outcomes due to higher concentration of specialist input Patients may have to travel further for their care but will see the specialist that will best meet their needs Critical mass will ensure clinical competence Application of NICE guidance and other evidence	• 12.6% reduction in new referrals • 8.4% reduction in follow ups • Increase in referrals that use advice and guidance • Reduction in inappropriate referrals • Decreased average referral to appointment waiting times • Achieve the financial savings target assigned to the planned care programme • Reduction in consultant time spent on PLCV • 100% of referrals electronic • Increase in planned care being delivered in a community setting • Reduction in locum costs • Reduction in cancellations • Increase in number of referrals with appropriate supporting information • Increase in follow ups by phone or technology • Increase in positive patient reported outcome measures • Meeting of all constitutional standards	Ophthalmology – capacity and demand modelling post application of thresholds complete by 17/18 Q3 to enable decision on configuration of service Diabetes reconfiguration 17/18 Q3 Implementation of agreed option for consolidated inpatient and diagnostic breast service 18/19 Q1 Single site for ENT by 18/19 Q3

Mental Health Learning Disabilities and Autism

Vision

To improve system wide service delivery for people requiring general and specialist support for Mental Health, Learning Disability or Autism needs

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
1 **Objective:** to implement national policy and deliver Transforming Care agenda for people with learning disabilities	**Learning Disability Specialist Services in Lincolnshire** Deliver a clear programme with partners to implement Transforming care for people with learning disabilities – next steps: In summary the Transforming Care programme focuses on the five key areas of: 1. empowering individuals 2. right care, right place 3. workforce 4. regulation; and 5. data analysis.	Improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. Increased access to mainstream services in line with national agenda for people with a LD and/ or ASD who have physical health or mental health needs Ensure there is a commissioned NICE compliant autism diagnostic pathway	Reduced numbers of patients admitted to inpatient care More people cared for in their own home/place of residence Reduced out of area placements for admission to inpatient care	Compliant service model in place from 1.4.16 Further work on national policy over next three years (to 2020)
	Service in Lincolnshire is four (CCG based) multi-disciplinary (specialist LD) teams and a 24/7 Community Home Assessment Team working to agreed pathways and with a focus on keeping people at home with specialist input and support as needed (team around the person approach). This is working well with a significant reduction in the number of people who need specialist LD admission to out of area beds. The inpatient unit at Long Leys Court, Lincoln, remains temporarily closed (from June 2015) and the staff/service/ investment is diverted to the community teams (cost neutral to LPFT).	Increased uptake of annual health checks This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.	Better support for carers	

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
	The new LD service also includes enhancing access to mainstream services through Mental Health, Physical Health and Autism Lead nurses and liaison nurses. The remit of the liaison nurses includes increasing uptake and awareness of annual health checks for people with a learning disability. A NICE compliant integrated autism diagnostic pathway is also now available. The new model includes embedded peer support workers within the service to make sure people with lived experience lead the way we deliver care. Next step is to engage with the public, patients and partners about options for the future and implementation of Transforming Care.	Enhanced multi-disciplinary specialist teams in place to give holistic care to patients and carers Training to support wider professional group to keep people safe and well at home or their place of residence	Patients accessing mainstream services to have reasonable adjustment care plans Increased GP practices receiving training on annual health checks	Public consultation on Long Leys planned to start December 2016
2 **Objective:** to significantly reduce the number of out of county inpatient placements and to improve the quality of care for people with severe and enduring mental health problems by providing a clear pathway from community to crisis through to inpatient and rehabilitation back in to community	**Adult Inpatient Mental Health Services in Lincolnshire** A range of interventions/services are needed to achieve this ambition:- • 10 bed male Psychiatric Intensive Care Unit (PICU) (to open Summer 2017) • Female High Dependency Unit (HDU) • Expanded Crisis and Home Treatment services (CRHT) • A new community rehabilitation team/ transitional support team • A new 6 bed Psychiatric Clinical Decision Unit (PCDU) • Investment in supported housing To ensure people only go into inpatient services when they really need to and for as shorter time as possible there also needs to be a transformation of the community and crisis services in Lincolnshire and a clear local offer of the range of treatments available to patients within each stage of the community and in patient pathway.	Care closer to home Reduced length of stay and more timely transition through the care pathway Closer liaison with community and inpatient services to support recovery Improve the housing offer to people with mental health problems who are ready to be discharged and who do not have access to appropriate accommodation in the community	Reduction in the number of patients placed in PICU and other adult inpatient beds outside of Lincolnshire Reduction in length of stay in inpatient services Reduction in the number of patients with a delayed transfer of care. Reduction in the number of patients readmitted	Male PICU – July 2017 PCDU – Q3 2017 CRHT Expansion - Q3 2017 Community Rehab - Q1 2018 Supported housing – Q1 2018 Female HDU – Q4 2018

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
3 **Objective:** Design a modern and sustainable community service offer that will reduce the reliance on inpatient services for people with functional and organic illnesses and increased integration with Neighbourhood Teams	**Older Adult Mental Health Services in Lincolnshire** Agree overall service strategy and pathways of care that reduce overall reliance on inpatient beds and take a step forward on integrating care for frail older people including those people with mental health problems	Right care in right setting Beds in appropriate locations to meet needs of population Avoid unnecessary inpatient admissions and reduce length of stay	Reduction in the number of patients with a delayed transfer of care Increased proportion of people cared for in their own homes or place or residence	Q3 2018/19
4 **Objective:** Making sure patients with Long Term Conditions have access to structured psychological therapies in line with the five year forward view for mental health.	**Psychological therapies into planned care** This will require pathway reviews to maximise current resources and increased investment in future years.	Increased self-care Improved recovery rates 'upstream' savings for physical health services	Access rates for IAPT Increased psychological mindedness across the local health and social care environment including embedding the recovery model across the system.	25% access to IAPT by 2021

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
5 **Objective:** Full participation in Neighbourhood Teams	**Adult Community Mental Health Team transformation** Full service review focusing on improving integration with other providers and wider community services through the Neighbourhood Teams	Community asset building Integrated physical and mental health services Proactive care to reduce reliance on specialist and inpatient services	Development of Neighbourhood Teams Reduced inpatient admissions Reduced admission of first episode psychosis cases and reduced readmission of assertive outreach cases and reduced duration of stay for both client groups.	Q3 2017
6 **Objective:** Implement the Mental Health 5 Year Forward View	**Mental Health 5 Year Forward View** • Increase access to individual placement support for people with severe mental illness • Increased Perinatal Services for Mental Health • Court/Police diversion and liaison services • Suicide prevention strategies	Parity for esteem for Mental Health	MH5YFV metrics	2017/18 – 2018/19
7 **Objective:** Mental Health prevention and promotion linked to Social Prescribing in Primary Care, through the delivery of	**Mental Health Promotion and Prevention** • Expansion of the Managed Care Network for Mental Health • Expansion of the Dementia Support Network • Expansion of the Mental Health Recovery College • Expansion of the Individual Placement Support Service	Increased community capacity Increased community support Better self-care Reduced inpatient admissions	Reduced inpatient admissions Social return on investment Self-reported quality of life benefits	2018/19

Women and Children

Maternity Vision

The vision for maternity services for Lincolnshire is that maternity services should be safe, personalised, kind, professional and more family friendly, and for every woman to have access to information to enable her to make decisions about her care, and where she and her baby can access support that is centred around their individual needs and circumstances.

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
To ensure that women are informed of risks and are supported to make decisions which keep them as safe as possible. Women will have their needs assessed by their midwife, and obstetrician if appropriate as part of developing their personalised care plan, this personalised care plan will continuously be reassessed to ensure that it continues to meet the needs of both women and their unborn babies	Implementation of a personalised care plan, that has been developed with the midwife and other health professionals	Women will feel more supported to make decisions about their care and therefore more empowered throughout their pregnancy, improving patient experience	Maternity survey e-referral data	2020
	The development of a robust maternity dashboard which provides information on both the quality and outcomes of the services on a routine basis	Improved benchmarking and outcome data available to improve the quality and outcomes of the services	Maternity Dashboard	2017
	Implementation of the digital maternity tool that provides women with unbiased information to help them make their decisions and develop their care plan drawing on the latest evidence, and assessment of their own individual needs, and what services are available locally.	Improved decision making information	National Information Board	2020

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Care pathways will be strengthened to ensure that women have a flexible pathway and can access specialist services when required, including obstetric services in hospital, and in more specialist centres, perinatal mental health services, foetal medicine, and neonatal and paediatric services if they are needed once the baby is born.	The maternity transformation board has been established that brings together both commissioners and providers to establish a shared understanding of the maternity system and to develop a shared set of standards and protocols that all providers use to ensure standardization of care across this maternity system.	Standardization of care across the system and improved quality and outcomes for women and their babies	CCG assessment	2017
	Development of rapid referral protocols between professionals and across organisations to ensure that the woman and their babies can access more specialist care when they need it.	Improved patient safety	Maternity system governance	2017/2018
	Provision of services that will support women be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit after full discussion of the benefits and risks associated with each option.	Women will have greater choice about their type and place of birth decreasing intervention rates and improving patient safety and experience	Maternity survey, E-referral data CCG Assessment	2020
There will be a focus on providing continuity of care for women by establishing multi-professional teams, that are working together within community settings, with a direct link to a consultant obstetrician.	The development of community based midwifery teams who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.	Improved continuity of care for women and their families	Maternity survey CCG assessment	2017-2020
	The development of community hubs that enable women to have access to care in the community from their midwife and from a range of other services, particularly for antenatal and postnatal care.	Improved continuity of care for women and their families		2020
	Development of an identified obstetrician who can work with midwifery teams to ensure that they get to know and understand their services and can advise on issues as appropriate.	Improved communication	Staff Feedback	2020

Paediatrics Vision

To develop care pathways which ensure safe care as close to home as possible

Objective	Description Key Initiatives	Impact on care and quality	Metric	Delivery date
Provide high quality safe care for children and young people with acute illness	Consolidate paediatric surgery on a single site subject to full public consultation	Improve quality by making best use of resources	Reduction in readmissions following surgery	Dependent on LHAC consultation
	Co- located paediatric assessment units and urgent care centres on acute sites will impact on the number of admissions for assessment to secondary care		Reduction in emergency admissions	Dependent on LHAC consultation
Deliver integrated evidence based care for long term conditions and non-acute illness	Develop the Neighbourhood Team concept for children and young people, including commissioning of an integrated child health programme and early years public health offer	Evidence based early identification and prevention and care through increased targeting	Performance against mandated elements of the 0 -19 healthy child programme	September 2017
	Deliver minor illness and injuries in Neighbourhoods	Increased local access and reduced demand on acute care	Reduced attendance at A&E	April 2018
	Develop all age pathways for autistic spectrum disorder and attention deficit hyperactivity disorder which deliver NICE recommended care for children and young people	Improved access times and implement best practice for transition to adult services	NICE Pathways implemented Reduction in waiting times for community paediatrics Reduction in admissions to acute care	September 2017 April 2018 April 2018
	Implement a crisis service for young people with challenging behaviour	Manage young people in crisis in the community thereby avoiding disruption to their lives	Reduction in admissions to inpatient CAMHS services	Jan 2017

Operational Efficiencies

Vision

All provider and commissioner healthcare organisations working at maximum efficiency

Objective	Description Key Initiatives	Impact on care and quality	Quantify Impact on Finance (and any associated activity/ capital)	Metric	Delivery date
Right Care Prescribing	All CCGs prescribing activities reflect Rightcare best practice	Nil	**£16.2m**	Reduced spend, Lincs CCGs in top performing range	2020/21
Reduced use of agency, locum and other variable pay costs	Improved staff attendance through reduced sickness and return to work schemes, improved recruitment and retention rates. Assume ULHT reduce agency spend to 5% of paybill (currently 6.7%)	Potential improvement	**£5.8m**	Staff absence levels, percentage spend of paybill, staff turnover %	2020/21
Achieve non pay efficiency in line with Carter recommendations	Carter Recommendations- Estates rationalisation (assume 3% saving on premises costs), Hospital Pharmacy transformation (reduce drugs spend by 5%), reduce clinical supply spend by 10%, pathology efficiency through procurement	Nil	**£11.3m**	Reduced spend per agreed metrics	2020/21
Reduced management and back office costs in Trusts and CCGs	Reduce CCG management & admin overhead by 50%. Carter recommendations 7- Providers achieve 6% back office costs as % of income. Additional £5m saved from shared services, VAT efficiencies	Potential negative impact on quality and performance management	**£4.3m**	Reduced spend per Carter metrics	2020/21
Achieve workforce efficiency in line with Carter recommendations	Implementation of Patient Level Information Costing Systems, Care portal, e-rostering, Model hospital etc. reduces frontline costs by 2.5%	Potential negative impact on quality	**£21.0m**	Reduced spend per Carter metrics, reduced clinical variation	2018/19
Other Provider Savings	Business as Usual		**£2.2m**		
			TOTAL £60.8m		

Operational Efficiencies - Implementation Plan

Implementation Plan												
KEY 1 Initiative approved 2 Initiative resourced 3 Implementation 4 Saving starts 5 Saving fully released												
Timeline	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	2019/20	2020/21
Rightcare-Prescribing	1		2	3	4							5
Reduced use of agency, locum and other variable pay costs	1		2	3	4							5
Achieve non pay efficiency in line with Carter recommendations	1		2	3	4							5
Reduced management and back office costs in Trusts and CCGs	1		2	3	4							5
Achieve workforce efficiency in line with Carter recommendations	1				2	3	5					

Capacity Optimisation

Vision

Repatriation of Lincolnshire activity currently undertaken outside of the county primarily to ULHT.

Objective	Description Key Initiatives	Impact on care and quality	Quantify Impact on Finance (and any associated activity/ capital)	Metric	Delivery date
Repatriation of elective activity provided out of STP area back to ULHT	Change in GP referrals out of area to ULHT.	Improve patient experience by localising their acute treatment.	**£12.0m**	Increased market share for ULHT by specialty.	2020/21
Reduction in diagnostics testing activity levels	Reduce duplicate diagnostic testing including radiology and pathology.	Improve patient experience by removing current practice of duplicate diagnostic testing.	**£1.9m**	Reduce diagnostic tests.	2020/21
			TOTAL £13.9		

Capacity Optimisation - Implementation Plan

Implementation Plan												
KEY 1 Initiative approved 2 Initiative resourced 3 Implementation 4 Saving starts 5 Saving fully released												
Timeline	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	2019/20	2020/21
Initiative												
Repatriation of elective activity provided out of STP area back to ULHT	1		2/3/4									5
Reduction in diagnostics testing activity levels	1		2/3/4									5

Workforce

Vision

Workforce pay restraint

Objective	Description Key Initiatives	Impact on care and quality	Quantify Impact on Finance (and any associated activity/ capital)	Metric	Delivery date
Reducing pay increase down to 1%.	Reduce pay costs to 1%.	Nil	**£18.3m**	Staff costs contained within 1% uplift.	2020/21
			TOTAL £18.3		

Workforce - Implementation Plan

Implementation Plan												
KEY 1 Initiative approved 2 Initiative resourced 3 Implementation 4 Saving starts 5 Saving fully released												
Timeline	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	2019/20	2020/21
Initiative												
Reducing pay increase down to 1%.	1		2/3/4									5

Commissioning Priorities / Right Care

Objective	Description Key Initiatives	Impact on care and quality	Quantify Impact on Finance (and any associated activity/ capital)	Metric	Delivery date
Cease procedures of low clinical benefit	Restriction of procedures that are of limited value and will therefore not be funded.	Rationale is to fund only those treatments for which there is an evidence base of clinical effectiveness.	**£1.2m**	Cease spend on procedures of low clinical value New policy incorporated into all 2017/18 contracts	2018/19
Best value transitional care commissioning	Decommission NHS Community Wards Re-commission private sector	Improved integrated care	**£0.2m**	Best value impact assessment	April 2021
Reviewing services and ceasing provision e.g. MSK	Avoid excess supply and duplication	Standardisation of evidence based practice. Reduced unwarranted variation	**£1.1m**	Rightcare dashboard	March 2018
Reducing Estates and facilities costs e.g. branch surgeries, void space reduction, moving activity to alternative settings	Co-location of primary/community/urgent care hub and spoke models	Delivery of new models of care Keeping the fabric of health facilities safe	**£3.1m**	Reduced void space Space utilisation	April 2021
			Total £5.6m		

Commissioning Priorities / Right Care - Implementation Plan

Implementation Plan												
KEY 1 Initiative approved 2 Initiative resourced 3 Implementation 4 Saving starts 5 Saving fully released												
Timeline	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	2019/20	2020/21
Initiative												
Cease procedures of low clinical benefit		1	2	3	4							5
	3	4					5					5
Best value transitional care commissioning		1										5
Reviewing services and ceasing provision e.g. MSK		1	2	3	4					5		
Reducing Estates and facilities costs e.g. branch surgeries, void space reduction, moving activity to alternative settings		1										5

Impact of our work streams

The high level dashboard below shows the expected impact of our workstreams on 12 Critical Measures of Success. The programme management office will oversee performance against a full dashboard consisting of critical measures of success, finance and activity metrics, National Minimum Data Set, and workstream metrics.

Critical Success Measure	Impact of Workstreams
Mortality rate from causes considered preventable (all persons)	**1% annual reduction (300 lives saved in 2021)**
People with long term conditions supported to manage their condition	**70% 2021**
Delayed transfers of care attributable to NHS and social care per 100,000 pop	**Top quartile 2021**
Divert A&E attendances	**244,063 diverts – 235 per day 2021**
Length of stay - emergency admissions LOS by 2021.	**At least 3.8 day length of stay or top quartile in the country (which ever the greater) 2021**
Increased investment in primary care	**+ 10% increase in investment in Primary Care by 2021**
Development of Multispecialty Providers	**Multi-Speciality Providers established across Lincolnshire by 2020**
Centralisation of fragile services and specialties to achieve critical mass and resilience	**Centralisation by 2020**
Delivery of integrated care	**38,434 people by 2021 (5% of the population)**
All professionals in all NHS and LCC organisations have access to single care record	**Access to Single Care Record by 2021**
Staff engagement results in the NHS Staff Survey	**NHS Staff Survey will be in the top quartile of the country by 2019 for all our NHS organisations.**
Reduction in whole time equivalent staff	**Circa 750 reduction in whole time equivalent staff by 2021**

Closing the Finance and Efficiency GAP – impact by year

	2016/17	2017/18	2018/19	2019/20	2020/21
	£m	£m	£m	£m	£m
Financial Gap (do nothing)	-72	-145	-160	-184	-182
Clinical service redesign Including PH	0	13	27	30	36
Provider efficiencies Including EMAS	0	17	49	60	61
Workforce - Pay Restraint	0	5	8	10	18
Capacity optimisation	0	13	13	13	14
Right Care	0	5	5	5	6
Adjustment to profile for delivery	0	23	4	4	0
Specialised Commissioning savings	0	8	13	18	24
Confirmed & assumed STP Contribution	18	17	17	0	52
Investment in Developments	0	-13	-21	-22	-28
Subtotal (As per submission)	-54	-57	-45	-65	0
Five Year Forward View funding	0	15	15	15	0
TOTAL SYSTEM (DEFICIT)	-54	-42	-30	-50	0

Impact of work streams on closing the financial gap

- STP financial plan shows a balanced plan by 2020-21
- Assumes STF is available in 2020-21 at £52m
- Financial plan is compliant with CCG business rules and the NHS trust control totals
- In the three years from 17-18 to 19-20 the do something financial gap exceeds the advised control total by £14.9m which equates to Lincolnshire's fair share of the national transformation funding

Deficit position
2016-17 £54m Including STF funding of £18m
2017-18 £57m Including STF funding of £17m, reducing to £42m if national transformation funding is received
2018-19 £45m Including STF funding of £17m, reducing to £30m if national transformation funding is received
2019-20 £65m Excluding STF funding, reducing to £30m if national transformation funding is received
2020-21 £0m Assumes STF funding of £52m

Overall solutions savings plan totals £130m

Lincolnshire East CCG carried £5m unmitigated risk in its reporting to NHS England at Month 5. This is represented by the combined total deficit of £5m across the CCG surplus and the Primary Medical Care surplus in 2016/17. This differs from the financial plan but is consistent with the recognised control total.

Specialist Commissioning

NHS England commissions specialist services through a network of regional hubs. Lincolnshire forms part of the East Midland Hub alongside Derbyshire, Leicester, Leicestershire and Rutland, Nottinghamshire and Northamptonshire. NHS England Commission the following specialist services

- Internal medicine
- Cancer
- Mental Health
- Trauma Head and Spine
- Women and Children
- Blood and Infection

There are 6 services that account for the 50% of the growth in spend to 2019/20; chemotherapy, secure mental health, renal dialysis, neurology, neonatal intensive care, neurosurgery. Specialist commissioners and Lincolnshire partners will work collaboratively at the STP footprint level using a strategic framework of locally agreed clinical and service priorities.

- NHS England and STP to collaborate on future provider landscape to deliver service priorities within the collective spend of the NHS
- Spectrum of service commissioning responsibility to be considered e.g. partnering, delegating, devolving or delisting a specialist service
- New contracting models to be considered e.g. lead provider for whole pathways
- New payment methods to be considered e.g. linked to outcomes for whole or targeted populations
- Commissioning intentions set out collective approach and spectrum of models STP partners will use

Impact of our work streams on service delivery – new models of care

Simplified landscape and governance

Our governance vision: A radically different governance and organisational structure, in time extending across the whole of Greater Lincolnshire

- The organisational form of Lincolnshire will evolve rapidly in the next 2 years as form follows function
- **Neighbourhood Teams:** the initial building block providing services to a geographically based population of between 30,000 and 50,000 people and linking a GP Federation with other primary care professionals, prevention services, community health services, community mental health services, pharmacy, therapies and social care. Community involvement will be essential. They will have lead clinicians and managers.
- **Multispecialty Community Providers** the MCP framework and principles are the vehicle for delivering its vision for integrated neighbourhood working. The exact number will be determined in partnership with local providers and communities balancing localism with the need for scale; it is expected that at a minimum scale each MCP will host 6 or 7 neighbourhood teams. There will a real shift of responsibility from CCGs to MCPs as they increasingly take on decision making around how resources are used to deliver care better.
- **A more efficient way of working** which reduces transaction costs and overheads
- **Partnerships out of county:** An acute hospital sector with links to a number of larger specialist hospitals out of

county; there is acceptance that Lincolnshire can never be totally self-sufficient in terms of expertise

- **Working together to plan and deliver services:** A more integrated strategic commissioning arrangement for health and social care with appropriate clinical support and advisory arrangements; we are on a journey to develop a single strategic commissioning body which will develop as MCPs develop in the next few years to take on increasing levels of responsibility around funding for groups of patients
- **An ongoing commitment to work with patients and the public** to design and provide the services they need

Delivering Multi speciality Community Providers (MCP)

Based on the learning from the Vanguard programmes there are 5 key steps to us delivering successful clinically led MCPs:

1. Building Collaborative System Leadership around a shared vision for the population: we have been working with clinicians and the people of Lincolnshire through LHAC building the concept of Neighbourhood teams and the need to move care closer to home and further away from Hospital

2. Developing system-wide governance and programme structure to drive the change; we have established our System Executive team including the Local Medical Committee who represent the Lincolnshire GP federations and we have established and MCP work stream reporting to the System Executive Team

3. Undertaking the detailed work to design the care model, the financial model and the business model, we have already completed much of the work on the Neighbourhood team model design and roll out is well underway; we are currently working through the new contracting model needed for successful MCP operation

4. Developing and implementing the care model in a way that allows it to adapt and scale; whilst we accept 80% of neighbourhood teams will be similar we accept that local needs and the variation of communities in Lincolnshire from concentrated town populations to dispersed rural population may need different models to be able to access services.

5. Implementing the appropriate commissioning and contracting changes that will support the delivery of the new care model. There is system wide agreement that the historic transactional contracting model has not been successful for Lincolnshire; the strategic direction is to move to an alliance contracting model where risks and benefits are shared across the system and enable resources to flow to where they can be used to best effect. The output of the LHAC contracting work stream which was supported by PWC who have worked with a number of vanguards (Appendix 6 – Contracting Section LHAC draft) proposes that in consulting with the public we consider a number of potential footprints for our MCPs/Alliances. The expectation will be that all contracts will move to a more collaborative basis including those for Acute Care. This work will take place in the coming months; early steps to move in this direction will be included in the 2017 to 2019 contracting round.

6. Phase	Year	
Phase 1	2016/17	Emergent MCP footprints – organic development – accept variation and different paces of change across Lincolnshire. Dedicated "engine room" to drive / support this work. Building on principles of the NTs and developing federations Analysis of diverse populations that make up the developing MCP footprints Develop a "logic model" that shows complex chains of reasoning for what and how of the developing MCPs.
Phase 2	2017/18	Establish a "Value proposition" for each developing MCP
Phase 3	2018/19	Shadow delivery structures start to emerge alongside further design of clinical pathways, building on LHAC Shadow capitation budgets are available Commissioning of MCPs could start for early adopters
Phase 4	2019/20	Commission and contract MCPs Change management teams in place for each MCP Double loop learning / evaluation loops in place to assess and adapt quickly
Phase 5	2020/21	Formally established new models of care

Service Reconfiguration

In order to enable the modelling of quality, activity and finance, we have constructed a theoretical model for the "do something" case based on some of the options which will be debated and agreed through the public consultation; this scenario is purely theoretical and does not constitute a preferred option nor a definite course of action; it was not practical to model every scenario in the time available. It has been used in order to assess the impact of our plans objectively. The work to finalise the options on which we will consult is ongoing and will not be complete until after the STP has been submitted. Therefore this range of options is one of several potential options possible; however it is considered by the NHS to be a realistic option to model. Our composite options appraisal event is scheduled for 8th December 2016 following which our preferred options will be reviewed by the Clinical Senate. All options where significant change is required are subject to full public consultation and until this process is complete options will not be finalised. Following the assessment of our Plans by the National Arm's length Bodies who regulate the local NHS we will be formally developing our options and moving to a full, open and genuine public consultation process

Theme	Service	Location	Redesign Option	Quality Impact	Workforce Impact	Financial impact	Are multiple options considered viable?	Included in Modelling "do something" base case?	Evidence Base
Urgent Care	A&E	Lincoln	New urgent Care centre in front of A&E	A&E access standard met	Reduction in dependence on scarce A&E doctors	Reduction in non-elective spend and locum medical A&E staffing spend	no	yes	National A&E review and guidance
	Critical Care	Lincoln	Relocate HDU level 2 beds from Grantham	HDU level 2 standards met medium term	Rotas for HDU meet national standards	neutral	no	yes	National standards guidance on Critical Care; D16
	Surgery	Lincoln	Relocate Vascular surgery from Boston	Clinical quality improvements due to collocation on " hottest site"	Sustainable rotas in place; reduction in locum staff	neutral	no	yes	Recommendation from Network Review in 2014
	Stroke	Lincoln	Consolidate Hyper Acute stroke services to Lincoln; "The Lincolnshire Stroke Unit"	Improved clinical outcomes from service which meets national standards, reduction in length of stay 80% 0f stroke patients admitted to specialist stroke unit	Single sustainable rota	Reduced provider costs from multiple rotas	yes	yes	Network to support and Clinical review of current delivery model in 2017
	Stroke	Lincoln and Boston	Establish single team across two sites	Improved compliance with national standards, improved joint working between two units 80% of stroke patient's admitted to specialist stroke unit, reduction in length of stay	Improved joint working due to rotation	none	yes	no	Network to support and Clinical review of current delivery model in 2017
	A&E	Boston	New urgent Care centre in front of A&E	A&E national standard met	Reduction in dependency on Locum A&E medical staff	Reduced Non Elective spend and reduction in locum staff costs for providers	no	yes	National A&E review and guidance
	A&E / Medicine/ Critical Care	Grantham	An Urgent Care Centre (UCC) backed up by a medical take providing ambulatory care services and bed based selected medical admissions supporting the neighbourhood teams. Model not yet fully developed but will have a strong focus on frailty and rapid turnaround into community support. UCC likely to be led by the MCP working in partnership with acute provider(s).	Local delivery of the bulk of " walk in urgent care" Appropriate referral to specialist services; development of a local model of care that keeps " care close to home" Reduction in Clinical risk	Reduced dependence on locum medical staff in A&E New roles to be developed including advanced level nurses; less dependency on locum medical staff	Reduction in A&E and NEL commissioner spend, reduced provider Locum spend Medicine - Neutral unless volumes fall	no	yes	National A&E review and guidance
Women and Children	Paediatric Emergency Surgery	Lincoln	Centralise all Emergency Paediatrics on Lincoln Site	Best practice standards met; volume of surgery and anaesthetics give assurance of safety	Single rota in place	neutral	no	yes	Clinical senate recommendation
		Boston	Develop Paediatric Assessment Unit on Pilgrim site	Local service available for majority of children who " walk in", only 2 children per day would require transport to Lincoln	Development of new roles for advanced nurses; reduction in temporary medical staff	neutral	no	yes	
	Neonatal	Lincoln and Boston	Develop single team across both sites	Improved compliance with standards;	Improved experience through rotation through level 1 and level 2 services	Service remains high cost to commissioners and providers	yes	yes	National Maternity review, review of Cumbria maternity services

Theme	Service	Location	Redesign Option	Quality Impact	Workforce Impact	Financial impact	Are multiple options considered viable?	Included in Modelling "do something" base case?	Evidence Base
		Lincoln	Centralise all neonatal services on Lincoln site	Level 2 service meets all standards, reduced transfers out of Lincolnshire	Viable rota in place on single site	Reduced staff costs; potential for reduction of commissioner costs, savings from fewer neonatal transfers	yes	yes	National Maternity review, review of Cumbria maternity services
	Maternity	Lincoln and Boston	Develop single team across both sites to deliver Consultant led Obstetrics services with co-located midwifery led units on both sites	Improved compliance with standards	Limited impact on rotas	No costs released	yes	yes	National Maternity review, review of Cumbria maternity services
		Lincoln	Centralise Consultant led Obstetrics service on Lincoln site alongside MMU at Lincoln	Improved maternal experience and lower level of intervention		Neutral	yes	yes	National Maternity review, review of Cumbria maternity services
		Boston	Develop standalone MMU and relocate Obstetric services to Lincoln site	Improved maternal experience and lower level of intervention	Greater levels of Midwife led care	Reduced rota costs	yes	yes	National Maternity review, review of Cumbria maternity services
Planned Care	Cancer	Grantham	Develop single " The Lincolnshire Breast centre" on Grantham site	Breast Cancer access standards met	Scale of service is more attractive to potential recruits	Reduced costs on locum and agency staff	No	yes	Network led review to be conducted in 2017
Learning Disabilities	Assessment and Treatment	Lincoln	Replace permanently the inpatient service with a community based model	Transforming care ambitions delivered fewer hospital placements and current patient cohort is supported in a move to community	Redeployment of inpatient staff into a new model	none	no	yes	

Option shaded in **GREEN** have been used to populate the "do something" base case scenario; these remain subject to the final prioritisation process for the development of the public consultation; this is not a preferred option but one thought to be realistic for modelling purposes; final options will be developed and agreed by the week commencing 5 December 2016.

It is our plan to have a health and care composite options event week commencing 5 December 2016. After this event, a Pre Consultation Business Case will be reviewed by the Regional Clinical Senate in January 2017. Once the feedback has been received from the Regional Clinical Senate and NHSE, Lincolnshire can then go to public consultation. This is anticipated to be in May 2017. These dates are subject to change depending on assurance from NHSE and sign off from local decision making bodies.

Enablers

Estates

There are 3 key themes for our capital requirements over and beyond the life of this plan. A number of projects have had detailed options appraisals (feasibility studies) carried out utilising health care planners working with our clinicians, quantity surveyor etc. and a range of options and estimated costs have been produced. However each one will be subject to the usual business case process. The cost described in the spreadsheet below is the mid-point of these estimated costs:

1. Delivering the service reconfiguration agenda (takes in to account a variety of potential options)

- ULHT Clinical strategy capital requirements £52m
- Reconfiguration of Women and Children's if approved £13-35m

2. Delivering the new care model and MCPs

- Lincoln County Hospital- Urgent Care centre "at the front door" £8-14m
- Pilgrim Hospital Boston – Urgent Care centre "at the front door" £9.5-13.5m
- Sleaford/Grantham Integrated primary and urgent care centres £7-29m
- Lincoln South Primary Care Hub (PCH) £10-25m
- Lincoln North Primary Care Hub £10-25m
- Lincoln City Primary Care Hubs £10-30m x 2
- Gainsborough developing John Coupland Hosp. as a Primary Care Hub £10m
- Re-provision of community facilities at Louth and Skegness Hospitals with single site £25-35m

3. Keeping the fabric of our Hospitals safe and reducing unplanned estates costs

- Backlog Maintenance ULHT £59m, for critical infrastructure only. Work is ongoing to determine the full extent and will be completed in February 2017. In addition, backlog maintenance costs for LPFT £23m, NHS PS and LCHS estimated at £15m.
- Relocation of Acute Mental Health services to St Georges site £20m, to be funded from own resources.

The total capital requirement of circa £200m is in a very constrained capital situation and any national capital funding is likely to be limited. We are therefore exploring other sources of capital including third part developers, Public Private Partnership (project Phoenix), County Council funding etc. Capital Investment priorities will be based on maximising delivery of STP objectives and critical success factors, alongside closely monitoring capital risks and mitigating actions.

There will need to more detailed discussions on return for investment and release of revenue through capital schemes as business cases are developed further

These are estimates based on the best evidence available and the timetable for deployment needs further work.

Capital workstream	Location	Proposed by:	Proposed Owner/Lessee	Progress	£m low	£m high	£m STP	
1.Primary Care and Urgent Care	Lincoln South Primary Care Hub	Lincolnshire West CCG	Primary Care	Feasibility Study July 2016	10.0	25.0	17.5	Primary care hub for western city (with extended primary care) and reprovision of Richmond Medical Practice
	Lincoln North and City Primary Care Hub	Lincolnshire West CCG	Primary Care	Feasibility Study July 2016	20.0	60.0	40.0	Primary Care Hub for Monks Road with extended primary care to create capacity in surrounding areas
	Gainsborough including John Coupland Hospital as a Primary Care Hub	Lincolnshire West CCG	Primary Care	Feasibility Study June 2016	10.0	10.0	10.0	Reprovision of Caskgate Surgery within John Coupland to create extended primary care services - preferred option
	Urgent Care Lincoln County Hospital	Lincolnshire West CCG	Primary Care	Feasibility Study June 2016	8.0	14.0	11.0	No preferred option identified. CCG and ULHT progressing the SOC
	Urgent Care Pilgrim Hospital	Lincolnshire East CCG	Primary Care	Feasibility Study June 2016	9.5	13.5	11.5	No preferred option identified. CCG and ULHT progressing the SOC
	Sleaford/Grantham Primary Care and Urgent Care	SW Lincolnshire CCG	Primary Care	Feasibility Study June 2016	7.0	7.0	7.0	Hub and spoke model for Sleaford with extended primary care services
	TOTAL				64.5	129.5	97.0	
2. Additional clinical services at Community hospitals	Louth Hospital	Lincolnshire East CCG	tbc	SOC September 2016	25.0	35.0	30.0	No preferred model identified but recognised need to bring under a single provider. OBC to be developed
	Skegness Hospital, remodelling outpatients and Minor injuries	tbc	tbc	tbc	2.0	2.0	2.0	TBC
	TOTAL				27.0	37.0	32.0	
3. LHAC - clinical workstreams	women and children: new and upgraded maternity on ULHT sites	ULHT	ULHT	ULHT Clinical Strategy 2016-2021	13.0	35.0	24.0	
	TOTAL				13.0	35.0	24.0	
4. Provider Estates Strategy	ULHT (excluding maternity, urgent care)	ULHT	ULHT	ULHT Clinical Strategy 2016-2021	52.0	52.0	52.0	excludes backlog maintenance, investment maternity (in section 3) and urgent care (in section 1)
	TOTAL				52.0	52.0	52.0	
Summary					**£m low**	**£m high**	**£m STP**	
1. Primary Care and Urgent Care					64.5	129.5	97.0	
2. Additional clinical services at Community hospitals					27.0	37.0	32.0	
3. LHAC - clinical workstreams					13.0	35.0	24.0	
4. Provider Estates Strategy					52.0	52.0	52.0	
					156.5	253.5	205.0	

See Appendix 8 – national Estates Template for further detail

To support the ambitions for the Lincolnshire health system, capital scheme prioritises for investment have been agreed as below. The criteria used to prioritise were whether the scheme contributed to our vision, supported care in the community and delivered a "shift" in activity.

1. Urgent Care Centres in Lincoln and Boston
2. Primary care hubs in Lincoln, Gainsborough and Sleaford
3. ULHT's clinical strategy
4. Women and children's services in ULHT estate
5. Louth Hospital Capital Requirements

Technology

The Lincolnshire Local Digital Roadmap is firmly grounded in the strategic ambition of the Lincolnshire Sustainability and Transformation Plan. In five years' time the health and care system in Lincolnshire will be offering a radically different experience to patients. The balance between hospital and out of hospital care will have moved significantly; care in the community rather than admissions to hospital will the norm for all but those for whom it is essential. The boundaries between services that obstruct care will have been eliminated, and patients will have a single relationship with their care provider – not many separate relationships as happens today – there will be a single view of the patient.

The overarching vision for the roadmap is:

- To deliver an integrated, single view of the patient and make silos of information a thing of the past. This will extend to the patients and carers themselves, who will be active partners in their own care and participating in their care narrative. Patients will be empowered to help themselves and make informed choices about their care and services. Improved information will drive better decisions about patients and support care in the most appropriate setting
- System navigation (self- help and signposting) will become a core part of the NHS, with simpler choices for patients relating to all aspects of their care. Our services will be working from a single, shared understanding of the service model, encompassing the capacity and capability of every part of the health and care system.
- Meanwhile care providers and leaders will have an integrated view and understanding of system demand, capacity and availability. We will be more proactive as a service, assessing and anticipating demand on an individual and system basis and intervening earlier.

STP Enabler TECHNOLOGY		
Objective	**Description of Initiatives**	**Key milestones and dates**
To empower patients to self- care and make more informed choices about how they use services by 1. providing patient access to records, enabling them to self-serve across the system where possible 2. supporting social prescribing 3. making it easier to find information, people and services 4. enabling patients to access services remotely 5. providing technology to enable patients to self-monitor 6. enabling patients and carers to contribute to their own electronic care plans	1. The Patient Portal will enable patients to participate in their care and to view their assembled health records in one place. 2. Development of Self Care apps 3. Community Directory of Services (DoS) 4. Develop remote consultation technologies for patient to clinician interaction with all parties able to see view of the patient record through the Care Portal. 5. Deployment of near patient test technologies linked to the Analytics Module of the Care Portal. 6. Deployment of Care Planning module of the Care Portal.	1. The design and build of the patient portal will commence 2016-17, with development and rollout to patients in 2017-18. 2. By 2018 a suite of self-care apps for specific conditions will have been developed as part of a Lincolnshire social prescribing offer. 3. Development of Lincolnshire's Community Directory of Services by Q4 2016. 4. By 2018 patients will be using e-consultations and video conferencing for consultations and clinical advice. 5. 2018/19 Deployment of Analytics Module of the Care Portal. 6. 2019/20 Deployment of Care Planning Module of the Care Portal.
Develop shared infrastructure to support efficient, integrated mobile working by 1. Providing integrated patient records to improve clinical decision making, reducing duplication and releasing time to care enabling staff to work seamlessly with the same access to information irrespective of location or organisation 2. automatically alerting staff to significant patient events such as A&E attendances, admissions, discharges, contact with crisis teams or missed appointments 3. providing clear vision of system capacity, patient flows and pressure points. 4. improving access to expertise and reducing wasted time spent travelling across a large rural county	1. Implementation of the Care Portal, providing health and care professionals with a single integrated view of a patient's record. 2. Develop advanced system analytics to support more proactive models of care using 'smart programmes 'of patients automatically identified by our care portal technology based on clinically configured triggers. Use smart algorithms to monitor patient indicators, automate alerts and make appointments based on predetermined indicators or combination of indicators. 3. Whole System Capacity Management Technology 4. Develop remote consultation technologies to allow clinician to clinician interaction in virtual environments, with all parties able to see the same view of the patient through the Care Portal.	1. Care Portal will Go Live Q3 2016, with continuing roll out to staff and further development in 2017. 2. By 2018/19 the Analytics Module of the Care Portal will be deployed. 3. By 2018/19 Lincolnshire will have whole system view of capacity and patient flow is tracked digitally in real time across the system. 4. 2016/17 Development of telephone advice services between primary and secondary care. Primary and Secondary care clinicians will begin using e-consultations and video conferencing to contribute remotely to discussions about patient care with colleagues.

Workforce and Organisational Development

Workforce, activity and finance – an integrated approach

The approach in Lincolnshire has, from the start, been one that seeks to integrate the key themes of activity, workforce and finance in a clear and linked process. The adoption of control totals in each of these three interlocking themes has been critical, i.e. identifying a consistent set of assumptions for activity shifts, a clear workforce baseline and the system wide financial control total.

Delivering the transformation is, however, fundamentally dependant on re-shaping the workforce, something that requires a close alignment with population health needs and the care functions consistent with achieving improved health and wellbeing. However, achieving service transformation at the scale envisaged to meet the quality, inequalities and financial gaps identified in the Five Year Forward View requires a fundamental shift in thinking. This has been facilitated by the adoption throughout this strategic workforce plan of the ***SWiPe*** approach, facilitated by the Whole Systems Partnership but now being adopted widely in the local system.

> ***SWiPe*** stands for the Strategic Workforce integrated Planning and evaluation framework developed by the Whole Systems Partnership.

The Lincolnshire ***SWiPe*** approach builds on the LHAC workstreams, which in turn reflect the needs of key population groups. It adopts a skill-mix approach, with a focus on the future, whilst mapping the journey from the 'as-is' over the planning period. Working with broad workstreams, and at skill level, provides the flexibility to take into account local supply side factors and the development of new roles, whilst remaining true to the end goal of ensuring a workforce that has the right skills, in the right place, at the right time.

The 'Whole Lincolnshire' workforce

This plan is underpinned by an approach to identifying the 'whole Lincolnshire' workforce that incorporates:

- A detailed dataset from each of the three main provider organisations that could be analysed using the skill mix and workstream methodology outlined above;
- The use of HSCIC data on primary care to inform this part of the workforce;
- Skills for Care data to inform the broader community workforce;
- Ambulance Trust workforce intelligence, which is reflected in the urgent care workstream and other sources such as hospice staffing.

Whilst the STP is focussed specifically on the NHS employed staff system transformation will be not be realised without collaboration and greater integration with social care, wider Council services and a strong partnership with the independent and voluntary sector. There is strong engagement in workforce strategy implementation programmes from these sectors.

The NHS Trust provider data for the three main providers also now underpins a data visualisation portal that has been used to enable workstream leads to review and validate the overall workforce baseline. There are plans to refine this approach and incorporate other non-ESR workforce costs such as locum and agency costs, an approach that will further strengthen the links between financial and workforce planning.

The patient-facing NHS workforce employed by the three main Trusts plus primary care is shown in the following table.

The table below details the baseline whole time equivalent (wte.) workforce.

Baseline workforce (patient facing healthcare staff):						
Workstream:	**Skill level:**	**Foundation**	**Core**	**Enhanced**	**Advanced**	**Total**
Primary care		**291.1**	**208.4**	**35.7**	**434.8**	**969.9**
Diagnostics	Pathology	17.7	0.6	20.8	4.0	43.1
	Phys measurement	12.4	5.4	36.5	7.8	62.1
	Physiology	12.9	0.0	8.2	0.0	21.1
	Radiology	111.3	56.1	95.5	19.0	281.9
	TOTAL	**154.3**	**62.1**	**161.0**	**30.8**	**408.2**
LD		**30.5**	**6.6**	**22.6**	**3.7**	**63.4**
MH	Adult	292.6	144.4	264.2	145.2	846.4
	Elderly	101.7	45.6	55.7	15.5	218.5
	Intensive	36.6	40.1	18.7	10.9	106.3
	Primary care	9.5	5.0	14.3	1.6	30.4
	TOTAL (MH&LD)	**470.9**	**241.7**	**375.5**	**176.9**	**1,265.0**
Planned	Cancer	83.4	57.3	68.9	63.0	272.6
	Community	91.4	45.5	41.2	43.3	221.4
	Medical	336.6	214.5	201.9	144.8	897.8
	Palliative	3.5	10.1	38.6	3.0	55.2
	Surgical	558.4	532.0	224.8	491.8	1,807.0
	TOTAL	**1,073.3**	**859.4**	**575.4**	**745.9**	**3,254.0**
Proactive	Community	643.6	472.8	568.4	140.1	1,824.9
	Transitional	75.5	27.3	11.8	0.0	114.6
	TOTAL	**719.1**	**500.1**	**580.2**	**140.1**	**1,939.5**
Urgent	Front door	171.1	129.8	86.4	107.6	494.9
	Intensive	36.4	102.6	49.3	21.0	209.3
	Medicine	178.3	118.0	93.0	64.8	454.1
	TOTAL	**385.8**	**350.4**	**228.7**	**193.4**	**1,158.3**
W&C	CAMHS	40.4	17.8	45.4	10.2	113.8
	Community	47.8	32.3	137.0	13.2	230.3
	Maternity	85.2	26.8	212.3	80.0	404.3
	Other	81.8	68.8	61.6	86.0	298.2
	TOTAL	**255.2**	**145.7**	**456.3**	**189.4**	**1,046.6**
Grand total		**3,380.2**	**2,374.4**	**2,435.4**	**1,915.0**	**10,104.9**
	EMAS scaled to Lincs	173.8	156.0	30.2	0.0	360.0
Mgt & Admin		**1,201.6**	**151.3**	**256.4**	**151.3**	**1,760.6**

Workforce implications of STP 'solutions'

The overall STP programme of transformation is underpinned by a series of 'solutions'. Solution 4 is defined as clinical redesign and contains the costed workforce interventions that will act as the catalyst for wider system transformation. The savings anticipated from this solution are estimated at circa £33M. Building on assumptions for displaced activity, and associated costs, local system leaders have developed proposals for costed interventions for Solution 4 that include workforce requirements. The workforce associated with these interventions will, in large part, already be employed in the local system, but these new or enhanced interventions will form a critical part of the initial workforce strategy, enabling the overall reductions in workforce and therefore costs attributed to this part of the STP.
The interventions that need to be developed from within the existing workforce, for each of which an appropriate future skill mix has been identified thus enabling them to be costed, consist of:

For urgent care: a Clinical Assessment Service, enhancements to the Urgent Care Centres, a Mobile Rapid Response service and extended access to Primary care.
For Pro-active care: additional capacity within Transitional (intermediate) care, additional case management functions for LTC and frailty in Neighbourhood Teams and support to self-care.

In Planned care: a range of interventions including 'Right Care', shifting work into primary and community settings and referral management.

For Mental Health services: input to neighbourhood teams to support alternatives to general acute hospitals and specific support to shift specialist mental health care from hospital to community settings.

In addition, a new workforce for primary prevention is envisaged plus an additional workforce for repatriated mental health services, for example in the development of a Lincolnshire Psychiatric Intensive Care Unit.

The Lincolnshire SWiPe roadmap (October 2016)

Focussing on getting these interventions right early on in the transformation journey will give confidence to reshape the wider workforce and realise an overall reduction in workforce. This reduction is consistent with the assumptions about activity displacement, and map back to the overall financial control total. The following table sets out the approach to achieving the Workforce Futures at a strategic level consistent with realising the benefits of the early investment from the targeted interventions above.

The table right details the costed workforce futures based on workstream and skill mix arising from the Clinical Redesign workstream

Workstreams:	Current workforce	Demand pressures	Do nothing FTE	Displaced activity	New (Primary Prevention & MH Repatriation)	Change in FTE	Future FTE	
Women & Children's	1,047	0.00%	1,047	0.00%	0	0	1,047	
Primary Care	970	0.00%	970	9.90%	0	96	1,066	
Proactive Care	1,940	0.00%	1,940	-21.00%	206	-201	1,738	
Urgent Care	1,158	0.00%	1,158	-10.00%	0	-116	1,042	
Planned Care	3,254	0.00%	3,254	-15.00%	0	-488	2,766	
MH/LD	1,328	0.00%	1,328	0.00%	160	160	1,488	
Diagnostics	408	0.00%	408	0.00%	0	0	408	
	10,105		10,105			-549	9,556	
			0.0%			FTE change:	-5.4%	
Current skill mix:	Foundation	Core	Enhanced	Advanced	Check			
Women & Children's	24.4%	13.9%	43.6%	18.1%	100.0%			
Primary Care	30.0%	21.5%	3.7%	44.8%	100.0%			
Proactive Care	37.1%	25.8%	29.9%	7.2%	100.0%			
Urgent Care	33.3%	30.3%	19.7%	16.7%	100.0%			
Planned Care	33.0%	26.4%	17.7%	22.9%	100.0%			
MH/LD	37.2%	19.1%	29.7%	14.0%	100.0%			
Diagnostics	37.8%	15.2%	39.4%	7.5%	100.0%			
Change in skill mix:	Foundation	Core	Enhanced	Advanced	CHECK ZERO			
Women & Children's	-3.2%	-2.2%	5.7%	-0.3%	0.0%			
Primary Care	0.0%	-2.0%	1.0%	1.0%	0.0%			
Proactive Care	3.0%	-5.0%	2.0%	0.0%	0.0%			
Urgent Care	-4.2%	1.0%	-0.3%	3.5%	0.0%			
Planned Care	0.0%	0.0%	0.0%	0.0%	0.0%			
MH/LD	3.0%	-4.0%	1.0%	0.0%	0.0%			
Diagnostics	0.0%	0.0%	0.0%	0.0%	0.0%			
Future skill mix:	Foundation	Core	Enhanced	Advanced				
Women & Children's	21.2%	11.7%	49.3%	17.8%				
Primary Care	30.0%	19.5%	4.7%	45.8%				
Proactive Care	40.1%	20.8%	31.9%	7.2%				
Urgent Care	29.1%	31.3%	19.4%	20.2%				
Planned Care	33.0%	26.4%	17.7%	22.9%				
MH/LD	40.2%	15.1%	30.7%	14.0%				
Diagnostics	37.8%	15.2%	39.4%	7.5%				
Workforce costs:	Foundation	Core	Enhanced	Advanced	Modified Advanced	Current total	Future total	Difference
Women & Children's	£24,219	£32,530	£40,889	£85,918	£82,528	£45,850,971	£45,828,797	-£22,174

Workstreams:	Current workforce	Demand pressures	Do nothing FTE	Displaced activity	New (Primary Prevention & MH Repatriation)	Change in FTE	Future FTE	
Primary Care	£23,877	£32,530	£42,524	£90,225	£87,821	£54,472,743	£59,412,758	£4,940,015
Proactive Care	£23,578	£32,530	£42,947	£71,710	£71,070	£68,188,188	£60,926,078	-£7,262,110
Urgent Care	£24,300	£32,530	£42,333	£83,459	£79,517	£46,596,081	£43,294,248	-£3,301,833
Planned Care	£23,213	£32,530	£43,792	£91,262	£90,280	£146,141,383	£123,597,211	-£22,544,172
MH/LD	£24,169	£32,530	£42,080	£85,872	£84,052	£52,753,076	£58,497,023	£5,743,947
Diagnostics	£23,780	£32,530	£43,103	£82,733	£81,884	£15,177,085	£15,150,927	-£26,158
						£429,179,527	£406,707,042	-£22,472,485

The change in wte arising from this reshaping is shown in the next table. From a total of just over 10,100wte patient facing staff in the three main Trusts and Primary Care there is an anticipated reduction of c.550wte over the full five year period. Whilst no detailed modelling of turnover has been undertaken as yet an illustrative 6% turnover in staff each year (c.600wte) and a requirement to reduce overall staffing levels by c.550wte over the full five year period would mean an approach to staff replacement that sought to ensure that for every four wte capacity lost an approach to ensuring that three replacement wte were consistent with the new service models and establishments consistent with the transformed services.

The table below also identifies where changes in wte by workstream and skill levels are required. The mix illustrated here emphasises the need for partners to work collaboratively across organisations and workstreams. The greatest reduction in wte is shown in Planned care, with pro-active care being balanced somewhat by increases in primary care. The greatest reduction in skill level is seen in Core staff, although a strategy that defaults to growing local talent will mean that the rate at which people progress from core to enhanced skills will balance off some of the reduction in recruitment at this level. A dynamic modelling tool will be developed to explore this early in the next phase of work underpinning the development of operational plans.

The table right details the shift in wte by workstream and skill mix arising from the clinical redesign workstream

	Foundation	Core	Enhanced	Advanced	Total
Baseline workforce	3373.3	2379.9	2431.6	1920.1	10104.9
Workforce FTE change:	Foundation	Core	Enhanced	Advanced	Total
Women and Children's	-33.5	-23.0	59.7	-3.1	0.0
Primary Care	28.8	-0.7	14.2	53.7	96.0
Proactive Care	-22.5	-138.8	-25.5	-14.5	-201.3
Urgent Care	-82.4	-24.6	-26.0	17.1	-115.8
Planned Care	-161.0	-128.9	-86.3	-111.9	-488.1
MH/LD	104.2	-29.0	62.4	22.4	160.0
Diagnostics	0.0	0.0	0.0	0.0	0.0
Total	-166.3	-345.0	-1.5	-36.3	-549.2
Change on base	-4.9%	-14.5%	-0.1%	-1.9%	-5.4%

The specific workforce strategies to manage this process are described elsewhere in this document, but will include both a reshaping and a managed downsizing consistent with the impact of the clinical redesign. This will ensure that Lincolnshire retains, grows and where necessary secures the workforce that is needed. Detailed plans will be developed at an organisational level (and across organisations where necessary) to ensure that future establishments map to new service models.

Whilst the above focusses on patient-facing NHS staff further work will be undertaken to identify the contribution made by non-patient facing staff as well as how we partner with other agencies to achieve the long term sustainable care systems described in the Five Year Forward Review.

Workforce and finance leads are working closely to ensure continued alignment of these objectives, recognising that there are potentially additional factors yet to be fully incorporated. These include the workforce implications of repatriation consequent on released capacity in local Trusts, whilst respecting individual patient choices, and wider workforce challenges associated with non-patient facing staff reflecting their important contribution to service delivery and their potential as recruits into direct patient care giving roles.

Workforce Themes and 'big ticket' items

Workforce transformation themes

The approach to identifying the Lincolnshire Workforce Futures outlined above has led us to identify the following key themes for the workforce strategy:

1. That we will need to achieve a workforce 'cascade' that reflects the activity displacement from acute to community and primary care settings, i.e. securing and developing the skills of professionals to work in different settings.
2. That we will need to manage an overall reduction in wte in the order of 550wte over 5 years (from c.10,000).
3. Within this, that skill mix changes will need careful management to ensure both 'throughput' and opportunities for personal development alongside delivering a new pattern of care.
4. That all staff, not just those in community settings, will need to work pro-actively.
5. That outside the clinical redesign workstream, but critical to future service models and closing the financial gap, will be a significant reduction in locum and agency staff by ensuring future establishments are fit for the future service model.

'Big ticket' items

As well as the service interventions noted above, and the themes that provide the back-cloth to the overall service transformation, we have identified a number of important roles that will need to be developed or enhanced. These are not additional to the service interventions noted above, but will make a critical contribution to new ways of working. Many are also already in evidence but need to be developed 'at scale' in the context of local ambition.

In General Practice: there is a continued effort to recruit to GP posts, but with a focus on salaried positions, including 25wte being recruited from overseas. Our modelling (see later section) also suggests a significant increase in ANPs in primary care, in the order of c.20wte a year over the planning period.

In Neighbourhood Teams: working closely with GP practices, but located in 13 geographical footprints, a Lincolnshire-wide estimate of 26wte community pharmacists, 52wte primary care mental health workers, 162wte case managers for people with complex needs and 69wte care navigators supporting people to self-care.

At scale in selected clinical hubs: working to reduce pressure on the acute hospital through alternative provision and rapid response/transitional care the enhancement of the existing Transitional Care workforce by c.98wte, the enhancement of existing services by c.27wte clinical assessment and associated pre-hospital urgent care staff.

Three further areas are being explored and will contribute to future 'big ticket' items:

- Subject to the resolution of configuration options changes in maternity services workforce, likely to require additional enhanced skilled level staff, could emerge.
- Consolidation of services at scale in selected clinical hubs from shifts in planned care are also being explored.
- There are ambitions for the development of integrated community children's services working alongside social care.

LWAB Programme Boards:

The previous Lincolnshire LETC focused work in a number of workforce transformation areas, and this work has not been ceased by the LWAB, although there is acknowledgement and a piece of work occurring to refine the programmes of work, to ensure better alignment with the workforce elements of the STP. These areas are:

- Lincolnshire Talent Academy
- Lincolnshire Attraction Strategy
- Workforce Supply, Demand and Retention
- Workforce Transformation
- Culture and Organisational Development.

Once refined, these programme boards will be the vehicle by which the workforce themes and big ticket items detailed above will be realised. Each programme board has representation from health and social care organisations within the footprint, as well as education providers, PVI's, public health and ALBs where appropriate, in order to have the necessary intelligence to drive the agendas of work. In the Programme Boards, some key progress has already been made towards achieving the "big ticket items":

Development of the first integrated post – Health and Care Apprentice, which will rotate to acute, community service, mental health services and social care, and align to clear career pathways, so there is a route from apprentice to advanced clinical practise. This aligns with growing your own strategy, and moving staff at a rate from foundation through to enhanced and advanced skill levels. (Talent Academy).

Advanced Clinical Practise – The LWAB invested some of its funding in the provision of MSc courses in Frailty at University of Lincoln, in order to support system wide roles in this area at an advanced level. Further investment has been made into advanced clinical practise education with UoL for the current workforce in order to make a "head start" in generating the marked increase in this level of skill required in the footprint, although acceptance that the course content may have to be tweaked during the course duration to meet the requirements of the system. (Workforce Transformation)

Attraction strategy – The programme board has developed a Lincolnshire Healthcare brand and logo, website, marketing material for the whole NHS system. Planning of careers fairs, events and marketing campaigns with the media has been scheduled for calendar years. This approach has already generated recruitment of GPs from within the UK. The international recruitment campaign for GPs was established with LETC/LWAB funds, but has received further support from NHSE, and as such is going to generate 25 WTE GPs to commence in 2017, supporting the increase in GPs required in the system. (Attraction Strategy).

Culture Change - Lincolnshire Health and Care leaders have developed an OD Strategy(Appendix 9) and five-year plan to support the STP which is summarised in section below. This sets out how we will deliver our transformational vision of truly integrated health at scale and pace. We recognise that those leading that change need support in terms of time and head-space to work through the challenges, supported by individual and system wide interventions to enable them to develop the mind-set and skills required to lead in new ways.

Those who are leading this seismic shift in how we provide health and care in Lincolnshire must:

- Go out of their way to make new connections.
- Adopt an open, enquiring mind-set, refusing to be constrained by current horizons.
- Embrace uncertainty and be positive about change – adopt an entrepreneurial attitude.
- Draw on as many different perspectives as possible; diversity is non-optional.
- Ensure leadership and decision-making are distributed throughout all levels and functions.
- Establish a compelling vision which is shared and promoted by all partners in the whole system.
- Promote the importance of values – invest as much energy into relationships and behaviours as into delivering tasks.

Wellbourn et al (2012, p4)

We must start to work and act as one system. This will require everyone adopting and demonstrating the behaviours above to ensure real collaboration and genuine partnership working, setting aside organisational differences, hierarchies and demands along with desire to always be in control and personal vested interests.

And we must actively challenge ourselves and our colleagues when we fail to demonstrate these behaviours.

We need to encourage, allow and make courageous decisions, taking some risks and learning from them when things don't go well.

Delivering our vision requires us all to work differently – different teams, different locations, different systems. The importance and value of co-locating teams in support of systems working cannot be under-estimated.

This change requires role redesign across the system. We need new roles which are innovative, work across boundaries and professions, provide job enrichment and enable us to have the right staff, at the right time, in the right place and the right cost.

Innovation and transformation will support a system to promote independence, build resilience at both individual and community level delivering a step change in self-care and moving care provision away from buildings and closer to home.

We will create new ways of working with the use of improved technology, which allow for individuals to be agile and flexible and mobile, increasing patient facing time whilst also allowing patients to manage their own health needs

General Practice is a necessary enabler in transforming healthcare delivery into a locally focussed integrated system. GPs within their emerging federations need to be able to consider new models of care which are GP led but not GP first. Developing Federation leaders as ambassadors for new ways of working, building trust with colleagues and new team members to further this ambition.

Building capacity into the strategic vision and the day job is an essential component to enable primary care to not only work differently but to provide differently. General practice must see this vision as an attractive way of working, reducing workload, bureaucracy and thus enabling them to focus on those most in need. Co-location and integration of full healthcare teams need to be able to demonstrate this as a reality to achieve pace in the scale of change required.

As providers of health care, health and wellbeing applies as much to our employees as it does to the local population. We want to do as much as we can to enable our employees to be at their best, motivated and committed to their work.

The Five Year Forward View also highlights the importance of workplace health and the opportunity for the NHS to set a national example – supporting its staff to remain healthy and to serve as 'health ambassadors' in their local communities.

We must take our staff with us on this journey. We need to ensure that every one of them is clear about this vision, the steps along the way to deliver it, what is changing, and what isn't changing, what that means

to them and what they need to do differently both in terms of task and behaviour, with support, to help them to make that shift.

And most importantly of all, we must have an absolute and overt focus on putting our patients at the centre of every decision made and ensure that they or their representatives are integral to the process.

To deliver our vision, we have identified six OD strategic priorities. Three of these focus specifically on systems leadership:

- Developing and sustaining systems leadership and systems
  Developing system wide talent management & succession planning leaders
  Building strong, supportive, trusting relationships

STP OD Plans – Year 1

Each of our OD priorities is supported by specific plans for the next five years.
To build collaborative systems leadership, the actions we will be undertaking in Year one include:

- We will adopt the NHS Improvement Culture and Leadership programme as a system-wide cultural diagnostic tool to inform our Collective Leadership Strategy.
- We will work with East Midlands Leadership Academy to commission, deliver and evaluate a series of Systems Leadership Laboratories which enable leaders to explore how productive partnership and systems working can be developed and sustained within their own context.
- We will design, commission and implement system wide leadership development programmes with a focus on developing leaders who can influence and persuade beyond their organisational hierarchies and without necessarily "being in charge". This will start with the offer of an STP based Mary Seacole programme.
- We will develop a Leadership Charter which clearly sets out the behaviours required to deliver our vision.
- We will agree a plan for SET team development to include quarterly development sessions
- We will establish a Lincolnshire Coaching network and train coaches to work with leaders to enable them to have different conversations outside their traditional hierarchical boundaries. a Lincolnshire Coaching Charter.
- We will address observed behaviours which do not support our vision and our Leadership Charter.

LWAB OD and Culture Programme Board

This work is overseen by the LWAB Culture and OD Programme Board. The Board, which meets regularly supported by HEE, has active representation from all stakeholders including adult social care, all three NHS Trust providers, East Midlands Ambulance Service and St Barnabas Hospice. The Programme Board has a designated Senior Responsible Officer who is the Director of HR & OD at United Lincolnshire Hospitals NHS Trust.

Health and Wellbeing

Lincolnshire also has a joint Health and Wellbeing Group which takes a collaborative system wide approach to all health and wellbeing strategy and actions.

Staff Engagement

All following NHS organisations take part in the annual NHS Staff Survey and are working towards improving staff engagement scores.

Lincolnshire Community Health Services NHS Trust	3.85
United Lincolnshire Hospitals NHS Trust	3.68
Lincolnshire Partnership NHS Foundation Trust	3.62
Lincolnshire West CCG	4.09
Lincolnshire East CCG	4.11
South West Lincolnshire CCG	4.28
South Lincolnshire CCG	*head count too small to participate

The 2016 staff survey is currently underway and results will be available early 2017. This is one of our key critical success factors. (Culture & OD).

Return to Practice – Work has taken place with UoL to develop as RTP course. The first cohort commenced summer 2016 with 19 returnees. Another cohort will take place in March 2017. Again, this is part of Lincs grow your own strategy due to the historical recruitment issues, to return registered nurses to the system, to upskill to enhanced/advanced level, and to replace the core skill where due to turnover, retirement, vacancy and upskilling this group of staff is depleted. (Workforce Supply, Demand and Retention).

Workforce modelling to support service transformation

Approach

With support from WSP, Lincolnshire has adopted the SWiPe framework for strategic workforce planning, which combines local engagement with the use of systems modelling tools. Whilst the SWiPe framework has informed the 'total workforce' reshaping exercise that sits alongside the activity and finance submissions of the STP the systems modelling work has been targeted at key priority areas.

SWiPe combines data sourcing, analysis and systems dynamic modelling in a way that provides a strategic modelling tool. The tool adopts an integrated modelling approach bringing together both planning for service change and workforce planning so that the interdependencies between these are always recognised. The incorporation of a system dynamics model means that it provides the opportunity to ask 'what if' questions, which enables participants to learn from the process in an iterative way.

It combines:

- Population health needs for a specific population cohort;
- Strategic service transformation and redesign;
- The requirements, opportunities and constraints when these are applied to the size and shape of the existing and future workforce.

Based on local engagement the approach is being used in Lincolnshire to support the STP process by helping to answer critical questions, including:

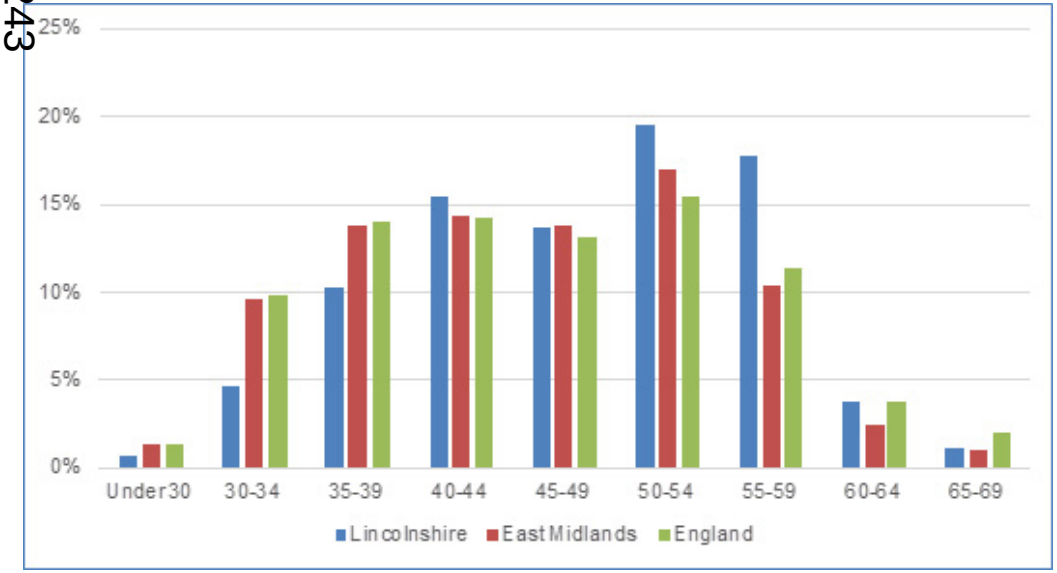
- What is the size and shape of the current workforce (across all organisations) available to support a particular set of care functions, for example 'pre-hospital' urgent care;
- What is the impact of local demographic projections for increases in need;
- What is the impact on this workforce if planned service transformation is achieved?

GP workforce

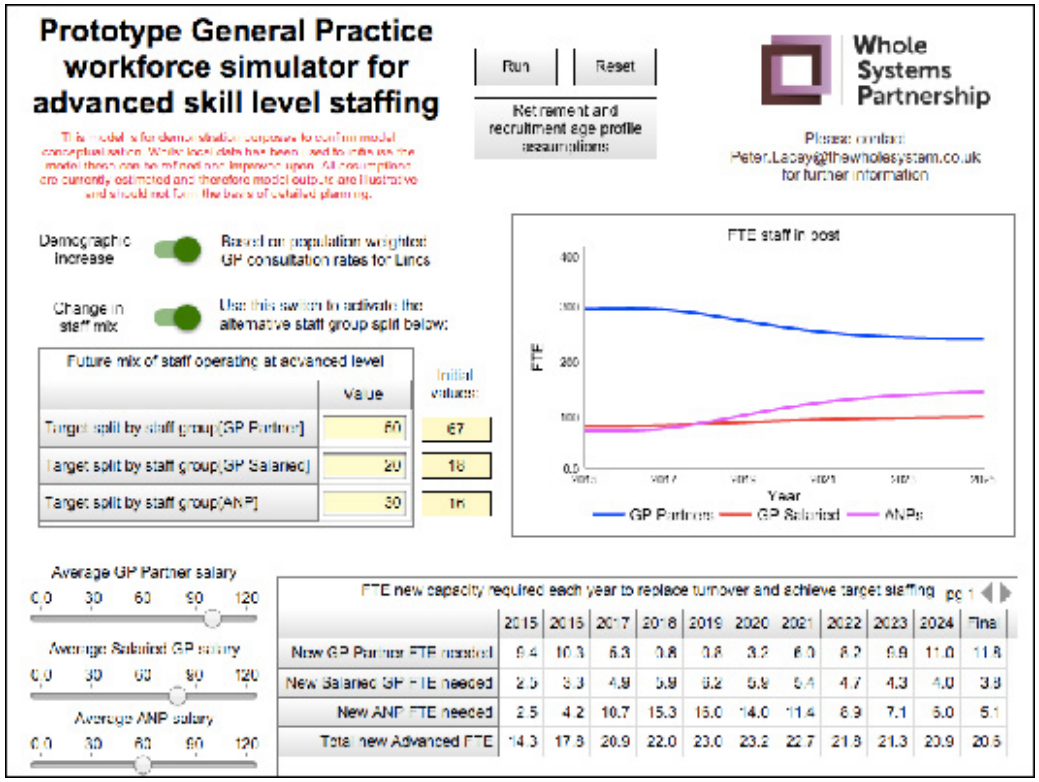
Lincolnshire has particular challenges in recruiting to GP vacancies, particularly in respect of taking up a Partnership. However, it recognises the attractiveness of Lincolnshire as a 'second-move' destination for professionals. Concerns over the age profile, and therefore the likelihood of increased retirement numbers in the near future also need to be factored in.

Through engagement with the local GP lead a systems model has therefore been developed to reflect the current age structure of the workforce as well as the anticipated rates of retirement and age on taking up a post in Lincolnshire. By exploring an alternative mix of GP Partners, Salaried GPs and Advanced Nurse Practitioners, we have been able to identify annual recruitment numbers for each that ensures an appropriate rate of replacement plus meeting growing demand. In addition, we have explored the impact of changing the mix of 'advanced level' skills between GP Partners, Salaried GPs and ANPs. Our modelling has demonstrated the ability of the local system to remain within its current cost envelope whilst meeting increased demand from underlying demographic change, through the change in the mix of this advanced skill workforce.

The graph below details the age profile of GPs in Lincolnshire compared with East Midlands and England average illustrating high numbers in the >50 age group



The diagram below demonstrates the annual FTE recruitment and replacement numbers for the future shape of GP and ANP workforce to meet growing demand and reflecting current age profile



This stimulation modelling gives the confidence to local plans to:

- Target GPs in the local attraction strategy;
- Recruit 24wte Salaried GPs to strengthen this part of the workforce;
- To factor the growth in ANP capacity to be factored in to the over-arching STP programme for increasing this skill level as a 'big ticket' item, with a focus on developing the local workforce.

Proactive and Urgent Care

In 2015, through a process of local engagement, the SWiPe modelling approach was applied to proactive and urgent care. In this instance the system changes considered were in relation to the delivery of major reductions in A&E attendances and unscheduled admissions. These included the development of Neighbourhood Teams, a Clinical Assessment Service and enhancement of Urgent Care Centres. The outputs were an understanding of the current workforce by skill mix, the quantum and skill mix required over the next ten years and a 'route map' to achieve this.

As part of the STP process the modelling is being refreshed. This reflects updated workforce and activity data, revised targets, and a review of core assumptions. Through engagement with local stakeholders a redefinition of the system boundary for Proactive Care has been undertaken to make it 'tighter' and clearer. The boundary now reflects more closely where strategic workforce change will be required to deliver integrated neighbourhood team working.

For urgent care the modelling identifies a shift in workforce to increase the proportion with higher levels of skill particularly in assessment.

Together this modelling has supported a number of the 'big ticket' items including:

- A significant investment in Transitional Care to support 'step-up' options as an alternative to hospital;
- The development of enhanced practitioners with skills in case management to support the on-going needs of people with complex needs;
- The recruitment of additional mental health, pharmacy and care navigator capacity and roles in line with the primary care FYFV at the interface of primary care and neighbourhood working;
- The development of skills in urgent care response across the pre-hospital urgent care pathway including, for example, paramedics, clinical decision hub staff, urgent care centres and 111.

Adult Mental health

Work is in progress to apply the approach to the adult inpatient mental health pathway. The impact on activity and workforce of a number of proposed service changes is being explored. Key scenarios include:

- Development of a Lincolnshire Psychiatric Intensive Care Unit – male;
- Development of a Lincolnshire Psychiatric Intensive Care / High dependency Unit – female;
- Expansion of crisis response and intensive home treatment;
- Development of a community rehabilitation function;
- Development of a psychiatric decision unit.

The impact of these potential changes on key indicators is being tested, including:

- Out of area placements;
- Demand for inpatient care;
- Length of stay.

The implications of this service transformation for the future workforce required over the next five years are being explored through the modelling both in terms of the overall quantum and 'ideal' skill mix. When compared with an assessment of the current workforce a 'route map' will be developed, through the modelling tool and informed by local input, on how the workforce changes can be achieved on a year by year basis over the next five years e.g. up skilling, in area and out of are recruitment and so forth.

Planned Care

For planned care the approach is being adopted in two identified priority areas. Firstly, for a cluster of specialties where service change is proposed, predominantly with regards to outpatients. These include orthopaedics, ophthalmology, dermatology, urology, cardiology, ENT, gastroenterology, clinical haematology, respiratory medicine and rheumatology. Considered individually the modelling is looking at the impact on workforce of system changes that include:

- Development of community surgical schemes;
- Pathway redesign;
- Development of referral management systems and introduction of thresholds for referral and intervention based on NICE Guidance.

The modelling is looking at the impact of these changes on patient flows (both outpatient and inpatient) in the hospital and activity shifts to the community and primary care. It will assess the impact of these changes on workforce requirements by quantum and skill band and relate these to the current workforce.

Neurology is the second area of planned care modelling with a focus on the workforce providing support to people with a progressive, degenerative diseases. The work will model the system of support (across hospital and community services) for individuals at different stages in their journey, proposed changes to this and the associated workforce implications.

The baseline analysis of the current workforce indicates that for staff in planned care who are 'community facing' c50% are in the enhanced or advanced skill level. Whilst the modelling is not yet completed the indication is that implementation of the system changes identified would result in:

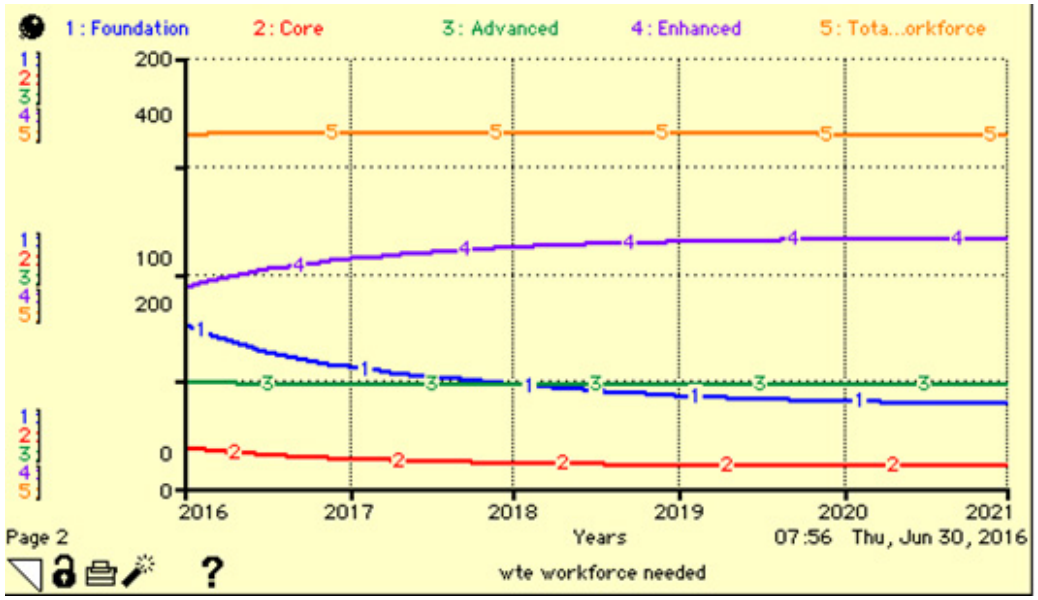
- A degree of shift within the advanced skill level from consultants to GPs;
- An increase in staff in the core and foundation skill level as some current outpatient activity is undertaken by Integrated Neighbourhood Teams as part of their remit in chronic disease management;
- Some limited increased in staff with enhanced skills to provide advice and guidance to Integrated Neighbourhood Team staff.

Maternity services

A model has been developed to inform the overall reshaping of the workforce that would be required were national best practice achieved in the provision of choice to mothers in respect to place of birth. Lincolnshire maternity services currently support below the expected number of home births and no options for mid-wife led or co-located units. There is also an aspiration to provide a larger proportion of births to Lincolnshire mothers from the local provider.

We have engaged with senior local stakeholders to conceptualise the systems model and agree the baseline assumptions. This has provided an initial 'direction of travel' for the workforce and scaled the extent to which the number of midwives in the system needs to be expanded to meet a combination of options for the service model. A parallel exercise to consult on the actual location of maternity services is also underway, and it is expected that once resolved the strategic workforce model can be used to refine the initial direction of travel identified.

The graph below illustrates the emerging picture of greater numbers of enhanced skill level staff to deliver the new service model.



For further details see Appendix 10 Lincolnshire Workforce Strategy

Transport

Lincolnshire is a large, and predominantly rural shire county covering 5921 square kilometres (2286 square miles) representing some 4.5% of England. Its population of 714,800 (ONS 2011 mid-year estimate) is contained within some 307,000 households (2011 Census). Consequently, the county is relatively sparsely populated at just 1.21 people per hectare, less than a third of the equivalent figure for England of 4.07 people per hectare. This varies across the county from the relatively densely populated City of Lincoln (26.08 people per hectare) to East and West Lindsey (just 0.78 and 0.77 people per hectare respectively).

Due to the extent of the county, the highway network is extensive at some 8,905 kilometres (5,534 miles) – the 5th largest of any local highway authority. However, within this total, there are no motorways and just 66 kilometres (41 miles) of dual carriageway of which the vast majority are made up of the A1 and the A46.

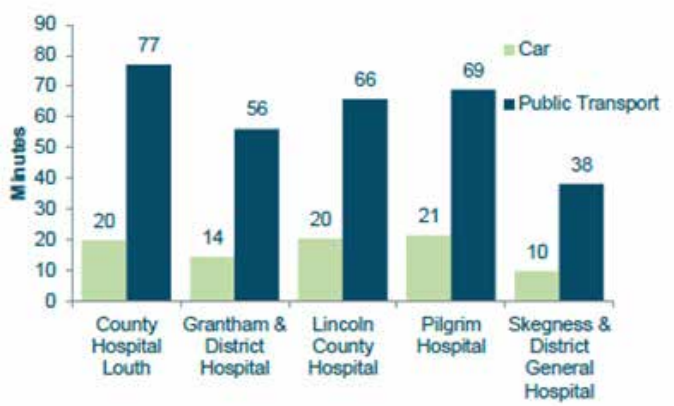
With four CCGs and four providers spread out over this large county there is a significant interdependency with the transport infrastructure and development set out in the Lincolnshire Local Transport Plan (2013) http://www.lincolnshire.gov.uk/residents/transport-travel-and-roads/transport-planning-and-development-control/local-transport-plan/4th-lincolnshire-local-transport-plan/102070.article

The plan references schemes which aim to deliver accessibility through improved public transport to hospitals etc. but acknowledges services remain limited in the evenings and at weekends in some areas.

The position of the main acute hospitals means that each serve a population group for all care available on those sites. The current average travel time by car for all services across all sites is 20 mins (period covered : April 12-March 2013) In 2013 a high level impact assessment was carried out to understand the current travelling times of the patients to the different hospital sites and to identify the potential changes after a service reconfiguration. This can be found in the Phase 1 Blueprint on http://www.lincolnshire.gov.uk/lincolnshire-health-and-care.

Current travel times and modes of transport

Analysis has been undertaken to understand the current travel times and patterns for patients. This has been done on both private and public transport



Patient travel times by car to the three main sites in Lincolnshire County

There is a marked difference in travel time for patients travelling by car and by public transport between sites as shown below. Patient travel times vary greatly between sites, with the minimum average travel time being 10 mins by car up to approximately 21 mins. Public transport (walk, bus or rail) times are at least 3 times longer.

During phase 2 of work for Lincolnshire Health and Care (LHAC), the impacts were analysed in more detail. A tool was developed that explored how average and maximum travel times were affected by the emerging options at that time. The following four areas were modelled.

- Emergency patient transport included the issues and challenges facing current provision of services by EMAS.
- Staff transport included as understanding of the impact on staff travel time in particular as a result of site reconfiguration
- Non-emergency patient transport included the utilisation of current infrastructure to find innovative options for patient transport services that move people across the county, not just too and fro from hospitals.
- Impact of the Geographical characteristics of Lincolnshire, i.e. large geographical area covered within the county and a road network consisting of many single lane carriageways which are speed restricted, resulting in travel times between towns and villages being relatively high.

The Transport Enabler Group will be relaunched in November and the following three areas will be addressed;

- All Site reconfiguration scenarios will be modelled in terms of understanding the impact on emergency transport, patient transport, voluntary and private transport.
- The Digital impact; how do electronic solutions reduce the need for patient and staff to travel and identify the consequences.
- The "Human Story"; equality impact assessments will be completed to understand the impact of potential options on our population.

Implementation

The system(s) of care that are being proposed are very different from the way that Lincolnshire health services are currently organised and therefore will require new rules to guide the way we work. The Kings Fund (2015) describes a set of design principles to guide the development of place-based systems of care in the NHS. Two of these principles are essential to getting our resources / infrastructure fit for purpose.

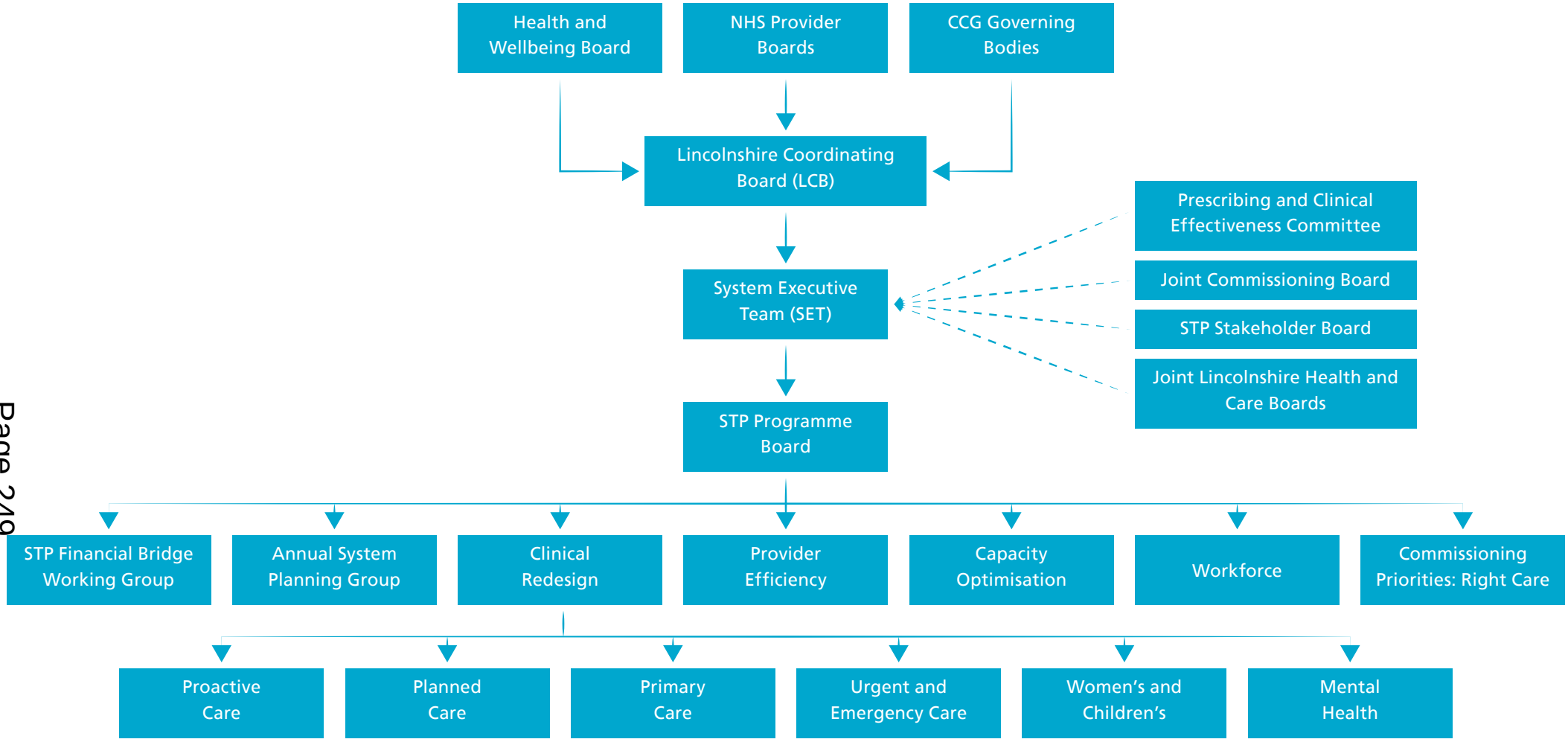
Principle 5 - Identify the right leaders to be involved in managing the system and develop a new form of system leadership.

Principle 8 - Create a dedicated team to manage the work of the system.

System Governance

We have implemented a new governance to ensure we can maximise the benefit of our collective vision and get ready to deliver the changes; establishing:

- Lincolnshire Coordinating Board; bringing together the chairs of all organisations together to bring oversight to the system. This Board meets monthly.
- System Executive Team all Chief Executives and Officers working together with senior Local Authority leaders and the Local Medical Committee. This team meets weekly.
- Joint Commissioning Board brings together health and care commissioners. This Board meets monthly
- STP Programme Board; senior directors from all organisations leading across boundaries. This Board meets weekly.
- Programme Management Office to make delivery easier and accountability clear.
- Annual System Planning Group brings together commissioners and providers to collectively translate the STP into two year operational plans. This group meets weekly until January 2017 and will then be reviewed.



Enablers:

- IMT
- Estates
- OD and HR
- Comms and Engagement
- Transport

For further details on roles and responsibilities see Appendix 11 for Terms of Reference for the above STP boards and groups.

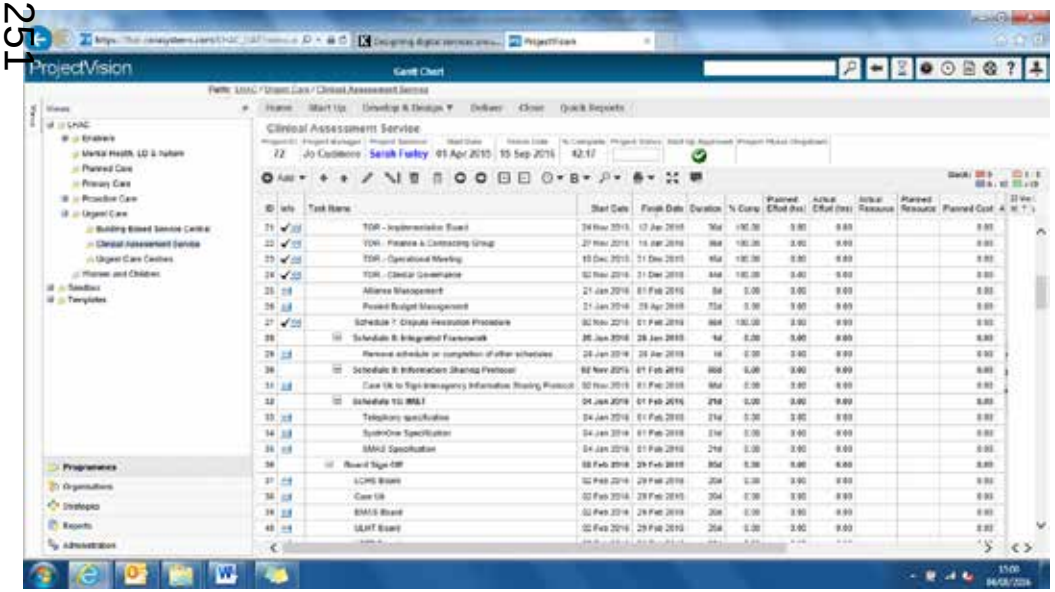
Programme leadership and support structure

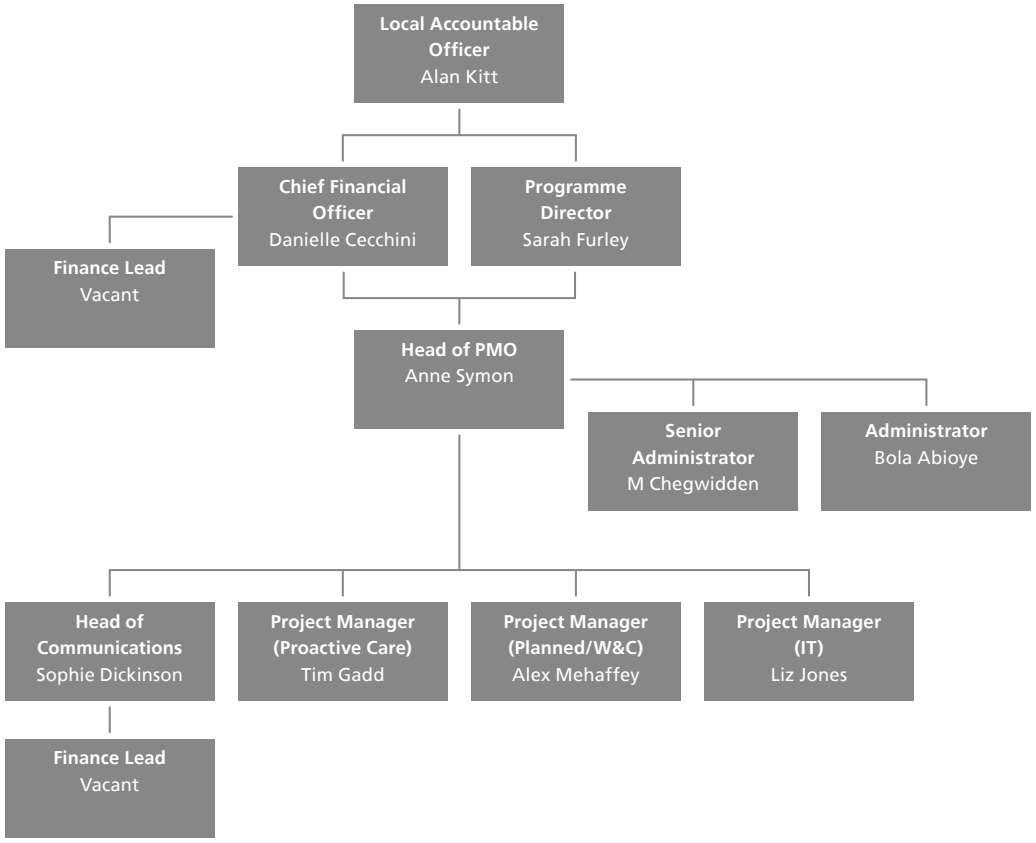
The above governance structure and our five workstreams are supported by the following programme leadership and support structure.

Programme	SRO	Programme Director	Clinical Lead	Commissioning Finance lead	Provider Finance lead	Provider lead	Project Manager
STP and LHAC overall programme	Allan Kitt CO SWL CCG	Sarah Furley Programme Director	NA	NA	Dani Cecchini DoF LCHS		Anne Symon Head of PMO
Primary Care	Dr Sunil Hindocha CCO LWCCG	TBC 23rd November 2016	NA	NA	TBC 23rd November 2016	Dr Kieran Sharrock MD Lincs. LMC	TBC 23rd November 2016
Proactive Care	Andrew Morgan supported by Glen Garrod DASS LCC	Carol Cottingham LWCCG with Pete Sidgwick AD LCC	Dr Vindi Bhandal Chair SWLCCG/ Dr Sunil Hindocha CCO LWCCG	Rob Croot CFO LW CCG	Dani Cecchini DoF LCHS	Dr Carol Brady Dir of Strategy LCHS	Tim Gadd LHAC PMO
Urgent Care	Gary James CO LE CCG	Ruth Cumbers Programme Director LE CCG	Dr Yvonne Owen LECCG Dr Dave Baker SWCCG	Rob Croot CFO LW CCG	Dani Cecchini DoF LCHS	Julie Pipes AD strategy ULHT	Sarah Stringer LECCG
Planned Care	Dr Sunil Hindocha CCO LW CCG	Sarah-Jane Mills Director of Development LW CCG	Dr Kevin Hill Chair SL CCG	Steve Hanson CFO SL CCG	John Barber DoF ULHT	Julie Pipes AD ULHT	Alex Mehaffey LHAC PMO
W & C	Gary James CO LE CCG	Obstetrics - Tracy Pilcher Chief Nurse LE CCG Children - Sally Savage AD LCC	Dr Vindi Bhandal Chair SWL CCG	Sandra Williamson CFO LE CCG	John Barber DoF ULHT		Alex Mehaffey LHAC PMO
MH & D	Dr John Brewin CEO LPFT	Clair Raybould Chief Comm. Mgr. SWLCCG supported by Justin Hackney AD LCC	Dr Dan Petrie SL CCG Dr Sue Protheroe LWCCG	Jo Wright CFO SWL CCG	Karen Berry DoF LPFT	Obstetrics - Sue Bennion Head of Midwifery ULHT	TBC 23rd November 2016
Prevention	Tony McGinty Acting DPH LCC	Dr Isabel Perez Consultant in PH LCC	NA	David Laws Financial Advisor LCCD	N/A	Jane Marshall Dir Strategy LPFT	Emma Marshall / Phil Garner PH LCC
Financial Bridge Workgroup	Dr John Brewin CEO LPFT	Danni Cecchini DoF LCHS	NA	NA	NA	N/A	Being recruited
Provider Efficiency	Andrew Morgan CEO LCHS	TBC 23rd November 2016	NA	TBC 23rd November 2016 ?	Karen Berry DoF LPFT	Kevin Turner	TBC 23rd November 2016
Capacity Optimisation	Gary James CO LECCG	TBC 23rd November 2016	NA	TBC 23rd November 2016	John Barber DoF ULHT	TBC 23rd November 2016	TBC 23rd November 2016
Right Care	Dr Sunil Hindocha CCO LW CCG	TBC 23rd November 2016	TBC 23rd November 2016	Sandra Williamson	TBC 23rd November 2016	TBC 23rd November 2016	Arden GEM CSU
Workforce & OD	Jan Sobieraj CEO ULHT	Maz Fosh Deputy CEO LCHS(supported by Amy Beeton HEE)	NA	NA	Dani Cecchini DoF LCHS	TBC 23rd November 2016	LWAB
Enablers	SRO	Programme Director	TBC 23rd November 2016	TBC 23rd November 2016	TBC 23rd November 2016	TBC 23rd November 2016	Liz Jones LHAC PMO
Technology	Gary James CO LE CCG	Dave Smith LHAC PMO	NA	NA	NA	NA	John Harness LHAC PMO
Estates	Sarah Newton COO LW CCG	NA	NA	NA	NA	NA	John Harness LHAC PMO
Transport	John Turner CO SLCCG	TBC 23rd November 2016	TBC 23rd November 2016	TBC 23rd November 2016	TBC 23rd November 2016	TBC 23rd November 2016	TBC 23rd November 2016
MCP development	John Turner CO SLCCG	Carol Brady Jane Marshall	Dr Peter Holmes Dr Sunil Hindocha Dr Peter Hill Dr Vindi Bhandal Dr Sue Elcock Dr Phil Mitchell				

Current PMO

The current PMO is supporting the above programme leaders. In practice, there is routine monthly reporting via Project Vision for each workstream with the escalation route through each Programme via their SRO into the Programme Board and then to Strategic Executive Team for exception only.





Finance Lead interviews are taking place on 21st October 2016

High Level (single) critical path for mobilisation

A high level critical path for the five workstreams has been developed and is below and starts to set out the scale of the change programme. It should be noted that public consultation will be required before finalising elements of this critical path; however it is considered by the NHS to be a realistic option for planning purposes.

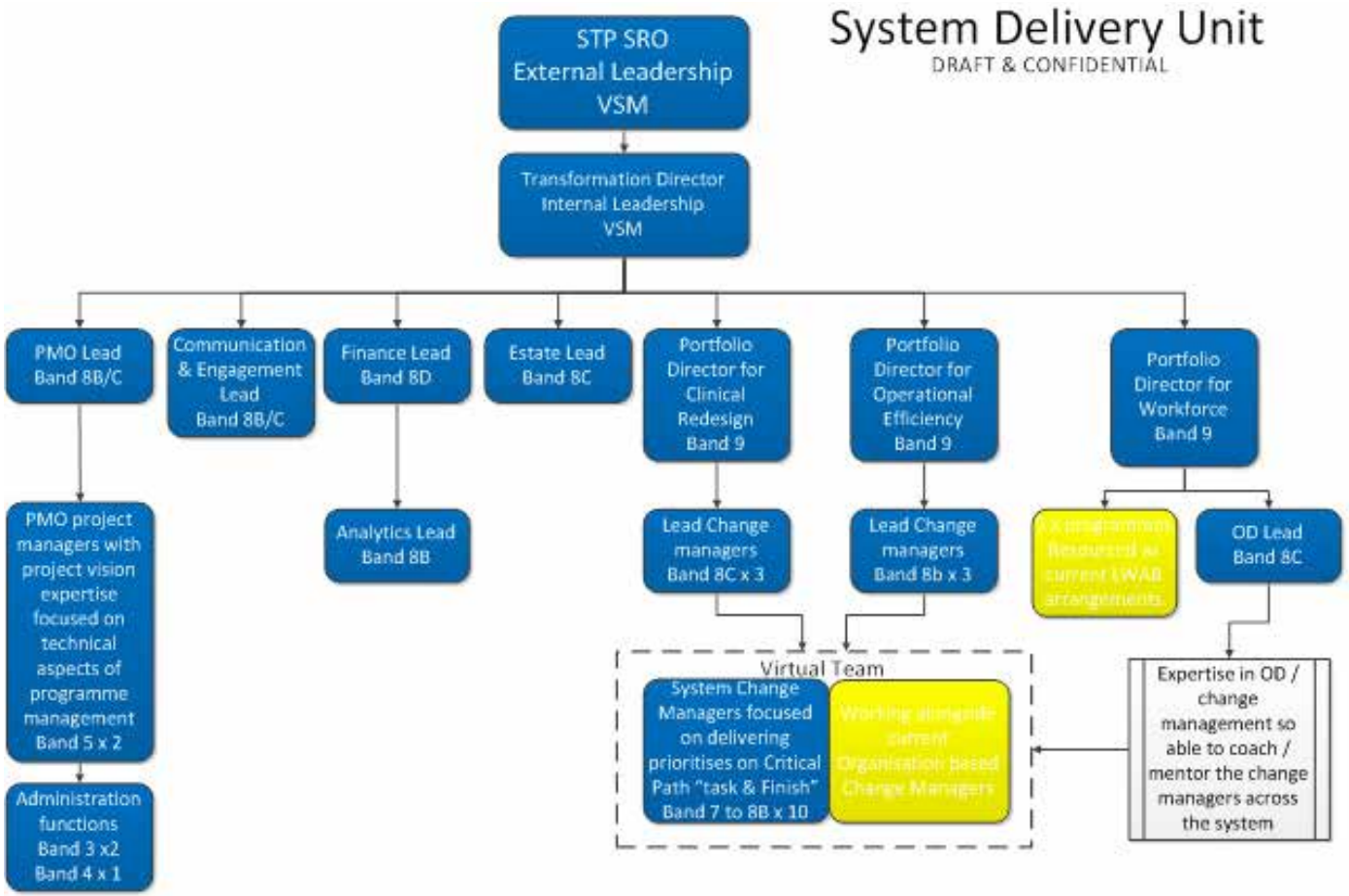
Workstream	2016/17	2017/18		2018/19		2019/20		2020/21	
	Q3	Q1	Q3	Q1	Q3	Q1	Q3	Q1	Q3
Clinical Redesign - Proactive Care	• Operating Framework for Integrated NTs agreed and signed off. • Countywide Risk stratification process agreed. • Decision on NT development support agreed e.g. Leadership roles, OD programme •Decision on investment in additional Transitional Care	•4 x Phase 2 Integrated NTs "testing" Operating Framework and on-going refinement. •Risk stratification process being tested via Phase 2 sites - Initially supporting top 2%, and developing process to support 5%. •Transitional Care (Care at Home Service) commences increasing capacity	•Self-Care Networks being developed around Phase 2 sites. • Implementation of Self Care DOS by Dec 2017 •Care Navigators operating • 50% of Neighbourhood Teams working within the agreed Framework.	•Risk stratification implemented within 50% of NTs using agreed management process for those patients identified. At least Top 5% •Transitional Care (Home Care) - full capacity. • 75% of NTs now working within agreed Framework	• Self Care Networks being developed for 75% of NTs. • Self Care and Prevention options fully operational for initial 4 Phase 2 sites • 100% of NTs operating within the agreed framework.	• 75% of NTs utilising agreed Risk stratification to identify and support top 5%. • Self Care and prevention Networks in place for 75% of NT sites. • Transitional Care fully operational.	• All NT sites working with agreed framework. • All sites utilising risk stratification process.	• All NT will be in place and embedded. • A full range of self-care and prevention options available and working with the Neighbourhood Teams	
Clinical Redesign - Primary Care	•GP 5YFV - CCG led programme of improvement developed. Aggregated plans "feed" MCP planning •Decision required for locality estate solutions for Lincolnshire	•International recruitment •GP Mentorship Programme •GPwSI Mentorship Programme •GP 5YFV - CCG led programme of improvement starts; implementation assuming collaborative working through federations or equivalent. Interdependencies with integrated NTs, e.g. pharmacists. Includes 'Releasing Time for Patients' Programme			Fully implemented GP 5YFV	NE locality Estate Solution •Gainsborough Estate Solution			

Workstream	2016/17	2017/18		2018/19		2019/20		2020/21	
	Q3	Q1	Q3	Q1	Q3	Q1	Q3	Q1	Q3
Clinical Redesign - Urgent Care	Decision on future of acute care reconfiguration (28-09-16	•CAS - fully operational •PUBLIC CONSULTATION on Grantham A&E long term solution and corresponding implications for emergency admissions •Direct booking from 111 and CAS into primary care • PUBLIC CONSULTATION on clinical community "hub" for the NE locality •Transitional Care (Crisis Service) building capacity •PUBLIC CONSULTATION on centralisation of stroke and vascular services	•UCC @ PIL and LCH (solution without capital)•Transitional Care (Crisis response) 75% capacity	•Additional urgent care capacity in Primary Care (7/7) through federated working - 50% coverage •Transitional Care (Crisis Care) - full capacity •Implementation of agreed option for Grantham Hospital A&E and emergency admissions •Implementation of agreed option for an UCC that is part of the NE locality consultation and implementation of the UCC at Spalding		•Implementation of agreed option for stroke and vascular services •Additional urgent care capacity in Primary Care (7/7) through federated working - 75% coverage		•Additional urgent care capacity in Primary Care (7/7) through federated working -100%coverage	
Clinical Redesign - Planned Care	•Decision on referral management infrastructure (buy in service or not) •Thresholds finalised and implemented •PLCV & prior approval agreed and implemented •Planned Care Programme of Transformation agreed by specialty - 80% to be delivered by end of 2018/19 •Decision on decommissioning of MSK CATs & Pain management	•Referral management complete full list of guidelines/thresholds (prioritised basis) • New pathways operational for headache and epilepsy •Pain management service manages "new" pain referrals differently. Current pain management service starts to discharge current patients on a rehabilitation programme. • PUBLIC CONSULTATION on consolidated inpatient and diagnostic services for certain planned care specialties on sites for quality, viability and scale	•Ophthalmology - Capacity and Demand modelling, post application of thresholds; decision made on configuration of service •Diabetes service - new model in place including reconfiguration •Dermatology - new model in place •e-referrals - full implementation by March 2018 •Transformation Review of OP services completed •End of Life delivery model completed	• MSK "new" service starts includes meeting orthopaedic pain management activity •Implementing new pathways for progressive neurological diseases, i.e. MS, Parkinson's, MND •Implement discipline of referral management •Pathway redesign completed •Community Surgical Schemes •Implementation of agreed option for consolidated inpatient and diagnostic breast service	•Urology - new service starts •ENT - new service starts includes single site reconfiguration			
Clinical Redesign - Mental Health	Decision required on investment in PICUs both male and female	•PUBLIC CONSULTATION completed for Long Leys and agreed option implemented • Male PICU opens	• Older Adult CMHTs redesigned• Adult Psychiatric Clinical Decisions Unit opens• Adult CMHTs redesigned• Enhanced Adult CRHT deployed	New MH Community Rehab service implemented	Female PICU Opens				

Workstream	2016/17	2017/18		2018/19		2019/20		2020/21	
	Q3	Q1	Q3	Q1	Q3	Q1	Q3	Q1	Q3
Clinical Redesign - Women and Children	Decision reached on maternity, neonatal and paediatric options to go to public consultation	•Implementation of rapid referral protocols •Development of community based midwifery teams •PUBLIC CONSULTATION on options for maternity, neonatal and paediatric options	•Implementation on agreed options for maternity, neonatal and paediatric options				•Development of community hubs •Obstetrician who can work with midwifery teams	•Implementation of a personalised care plan •Implementation of the digital maternity tool	
Clinical Redesign - Paediatrics		• Above PUBLIC CONSULTATION on options for maternity, neonatal and paediatric options will include whether to centralise emergency paediatric surgery in Lincolnshire	Develop NT concept for children and young people	•Co-locate PAUs with UCCs / A&Es •Implement all age pathways for autistic spectrum disorder and attention deficit hyperactivity disorder	Deliver more minor illness and injury in neighbourhoods				
Clinical Redesign - Prevention		•Smoking cessation services enhancement begins •Healthy Lifestyles programme developments •MECC e-forum to access up-to-date resources and information and MECC training to frontline staff •Commissioning of the Social Prescribing Programme	•Smoking cessation services enhancement implemented •National Diabetes Prevention Programme picked up by lifestyles developments •Healthy Lifestyles programme implementation •Community-based weight management support implementation •Recommissioning of the Wellbeing Service •Implementation of the Social Prescribing Programme		Full capacity of prevention services by end of quarter				
Operational Efficiency - Right Care Prescribing	Project initiatives approved - All CCGs reflect RightCare best practice	Project Initiatives resourced	Projects Implemented						20/21 Full savings released

Workstream	2016/17	2017/18		2018/19		2019/20		2020/21	
	Q3	Q1	Q3	Q1	Q3	Q1	Q3	Q1	Q3
Operational Efficiency - Reduced use of agency, locum and other variable pay costs	Project Initiatives approved - Improved staff attendance through reduced sickness and return to work schemes, improved recruitment and retention rates, Assume ULHT reduce agency spend to 5% of paybill (currently 6.7%)	Projects fully resourced across the system	Projects Implemented	Savings begin to be released					20/21 Full savings released
Operational Efficiency - Achieve non pay efficiency in line with Carter recommendations	Carter Recommendations- Estates rationalisation (assume 3% saving on premises costs), Hospital Pharmacy transformation (reduce drugs spend by 5%), reduce clinical supply spend by 10%	Project initiatives fully resourced	Projects Implemented	Savings begin to be released					201/21 Full savings released
Operational Efficiency - Reduced management and back office costs in Trusts and CCGs	Projects approved to Reduce CCG management & admin overhead by 50%. Carter recommendation 7- Providers achieve 6% back office costs as % of income. Additional £5m saved from shared services, VAT efficiencies	Project initiatives fully resourced	Projects Implemented	Savings begin to be released					20/21 Full savings released
Operational Efficiency - Achieve workforce efficiency in line with Carter recommendations	Carter efficiency projects approved -Implementation of PLICS, Care portal, e-rostering, Model hospital etc. reduces frontline costs by 2.5%	Project initiatives resourced	Efficiency projects implemented	Savings released					
Capacity Optimisation- Repatriation of Lincolnshire activity currently undertaken outside of the county primarily to ULHT	Project Initiatives approved -Repatriation of elective activity provided out of STP area back to ULHT -Reduction in diagnostics testing activity levels	Project Initiatives resourced, and implemented							20/21 Full savings released
Workforce efficiency	Initiative approved - Reduce pay increase to 1%.	Savings released							

The role of the current PMO is evolving to focus on driving the change cycle across the health economy and determining and managing the single high level critical path to deliver the STP. The PMO will become a System Delivery Unit (the evolved structure is below), some posts are already filled and currently we are "matching" individuals working in the current health and care economy to the remaining roles. This "matching" exercise is aimed at using our collective capacity and capability better. We recognise that for some areas of expertise and additional capacity (for some roles, this is underway), we will need to advertise externally to Lincolnshire. The "matching" exercise will be completed by 23 November 2016.



Matrix working will continue and the System Delivery Unit will become integral to and expand the current programme leadership and support structure detailed earlier.

As implementing the STP will take more than just a protected resource; it will also require a change in collective mind-set and a commitment to organisationally agnostic working. So, it is proposed that we will work within the following principles;

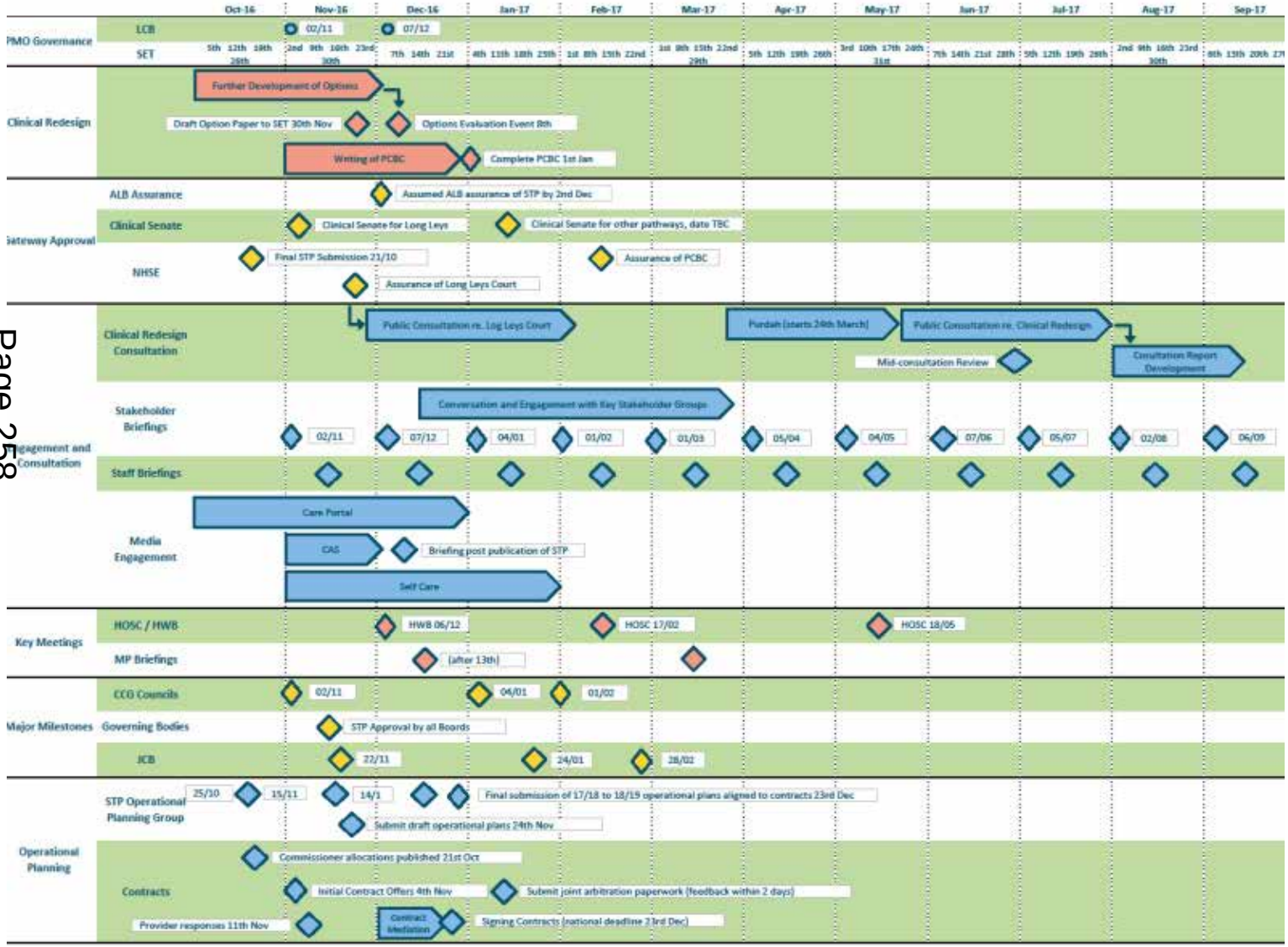
- When staff are released by their employing organisation into the STP infrastructure (System Delivery Unit), that the time will be protected to deliver Lincolnshire's STP objectives.
- Staff working in these system wide roles have the authority to act (as detailed in their job descriptions) within the agreed STP governance structure, drawn from the collective authority of SET. SET have agreed the single STP critical path and staff will be delivering those objectives. Achieving this principle is about creating a mind-set that individual organisations will interface / integrate.
  Individual organisations will align internal objectives and work programmes to the STP work programmes.
  The system will adopt agreed service improvement methodologies, e.g. Lean Thinking, Change Model for Health and Social Care, to support the delivery of change. These will not be used as management tool, but as frameworks recognising that any methodology is not an end in itself.
- The infrastructure for the STP requires stability and whilst will be evaluated for effectiveness, the structure has commitment for 3 years to summer 2018 as a minimum. After this period, it is anticipated that new organisation forms will be emerging.

Clinical Leadership is critical to our governance structures, system delivery unit and to realising benefits to patients and the wider population. Clinical leaders have been fundamental to the work completed to date and to the future work, yet to be done. See Appendix 1 – Communication and Engagement Plan that details clinical involvement in our pathway design work to date.

Medical leaders have met and are establishing a Clinical Cabinet to include medical directors, clinical directors and our most senior GP Leaders in both providers and commissioners. All the programmes within the clinical redesign workstreams have clinical leads – see page 105 and each expert reference group also includes clinical experts.

As we identify leads within our system delivery unit, it has been agreed that where appropriate, clinical leads will be appointed with project management support. Further work is required in this area as we "match" knowledge and competence correctly to responsibilities.

Critical Milestones in the next 12 month



Communications and Engagement

- The intention, post assurance, is to rapidly move to more open, transparent and meaningful engagement as we work to refine and finalise the detail of the Plan, get local input, buy-in and comment on the proposals and move to formal consultation where necessary. The first step will be to produce a public version of Lincolnshire's STP that builds on the Vision for Lincolnshire but describes the elements of the STP in more detail, along with an accompanying timetable for engagement.
- It should be noted that the STP as currently drafted includes some assumptions about changes to both in hospital and out of hospital services but these proposals will be subject to challenge and confirmation through a full public consultation process before a final decision is taken and implementation begins. We have had to work on an assumption in order to model activity over a 5 year period and cost our proposals, as required for the finance template of the Plan. We are fully committed to ensuring that no decision on major service change is formally agreed until the appropriate level of public consultation is undertaken. We have scheduled an options appraisal event shortly after we submit our draft Plan in order to ensure that we continue the work undertaken over the last 12 months to fully evaluate the acute changes, in the context of new out of hospital services. This appraisal will inform any consultation proposals planned for 2017.

Future engagement plans

The table below shows the future engagement plans with high level information on the subject for engagement, timing, audience and engagement approach. This may, potentially, be subject to change based on the feedback from the assurance process.

The information below is at a summary level. There will be detailed communications and engagement plans for each element of the STP development and implementation with strategies designed to ensure effective input and involvement from core stakeholder groups like clinicians, politicians and hard to reach groups. We will also look to use all channels, in particular social media and traditional media, to reach as wide an audience as possible

Date/timing	Engagement area	Audience	Approach
Oct-Dec 16	Prescriptions for over the counter medicines/goods	All public	Public consultation - CCG led
Oct-Dec 16	Care Portal roll out	Public, staff, stakeholders	Briefings, comms, videos, web-resources, leaflets, posters, media
Nov 16	Clinical Assessment Service	Public, staff, stakeholders	Briefings, comms, media
Nov 16	Options appraisal event for whole system reconfiguration	Core strategic stakeholders and clinicians	Discussion forum to agree proposals for public consultation
8th Dec 2016	Publish STP	All public/staff/ core stakeholders/ elected members	Public Boards, website, internal comms, networks, media, briefings with politicians and key stakeholders
Dec-Feb 17	Long Leys Court	All public; LD community	Public consultation – System led
Jan-June 17	Provider Efficiency priority changes	Staff	Internal engagement and consultation
Jan-June 17	Proactive care	Core stakeholders and staff	Face to face engagement and involvement to agree NT operating model
Jan 17	Primary care – GP mentoring and recruitment	GP community; all public	Media on GP international recruitment; Engagement with GP community on mentoring
Jan-June 17	Primary care – GP 5YFV improvement initiatives	GP community	Engagement and involvement of CCGs and GP on improvement initiatives, federations etc.
12 week period – likely to begin May 2017	Urgent and Emergency Care and Planned Care; Maternity, paediatrics and neonatal services; Out of hospital care	All public and stakeholders	Public consultation – system led

Commissioning and Contracting

Developing a new contractual basis for implementation

The contracting options have been developed through a process of five workshops with key internal stakeholders and providers to assess and define contracting routes and preferences. The workshops followed the structure below:

- Workshop 1 outlined the relationship between the contracting workshops and the development of this SOC, determined and confirmed the high level scope of this contract, and agreed the criteria for differentiating the various contract forms Workshop 2 included a granular discussion on scope, introductory discussions on capitated outcomes-based commissioning contracting and a high-level introduction to potential contracting form options
- Workshop 3 developed agreed contracting principles (including that the contract should have collective accountability, with a clearly defined transition and well-managed interim arrangements) and discussed citizen and workforce expectations, as well as LCC's position on integration and funding alignment
- Workshop 4 produced agreement that the preferred contracting model should place financial incentives on cost reduction, and discussed an appetite to break down organisational barriers and form alliances between commissioners and providers
- Workshop 5 provided an opportunity for feedback and input from both commissioners and providers on the contracting positions and options, discussion on what these options entail for providers and assessment of the deliverability of the presented options.
- A new work stream on the development of Multi-speciality Community Provider development will now begin the process of developing a road map to a new form of contracting

We have also considered

- Structural and organisational form considerations - considered in light of the system vision and the limitations inherent in the existing contractual arrangements
- The key principles and basis of a new contracting regime – including an outline and discussion of the proposed scope of services, affected stakeholders (including commissioners and providers), demographic segmentation options, the focus on outcomes and the possible implementation of capitation to promote health prevention and a change in behaviours

Developing organisational form that supports transformational change

The Lincolnshire System has a clear vision to develop a sustainable and safe health and social care economy for Lincolnshire:

- Liberating care professionals from traditional organisational and professional boundaries so that, together with representatives of the population, they can design services that deliver what is most needed
- Producing a framework that is structured around the needs of patients and citizens
- Commercially delivering the best value (outcomes per £ spend) to make the contract both affordable and sustainable
- A commitment to supporting the commissioning and provision of these services in a way that is sustainable in the long term
- Enabling a different way of working in Lincolnshire and helping to deliver transformational change to the system, in order to build an improved and sustainable model of care
- Implementing a clear and strong move towards Proactive Care, as an alternative to the current reactive, bed-based care model.

Emerging views of current contracting arrangements are that:

- The current contract form is not effective, as resources do not flow to the parts of the system where they are most needed
- There is a desire and need to move away from the current focus on inputs and concentrate on outcomes
- Current organisational boundaries between commissioning and provision of services are not helpful
- The challenges of redesigning delivery are beyond the capacity and capability of a single provider to resolve.
- There are excessive levels of duplication in the assurance processes for 7 NHS organisations in Lincolnshire
- Our capacity is diluted by both the number of organisations and the historical culture of contracting

Implementation issues have been identified below:

- Deliverability considerations must be at the forefront – the project needs to be realistically implementable by providers and manageable by commissioners Getting the right scale that balances economies of scale with manageability is critical.
- The complexity of the supply chain may be lost in some large-scale options, meaning that the supply chain may not be managed as robustly in larger scale contracts (e.g. single county-wide)
- The contracting options should promote economies of skill and scale (particularly from the workforce perspective) rather than fragment or dilute them
- Commonalities around interfaces should be sought to provide stability; there is little appetite for structural change that proves to be a distraction from genuine transformation

Next steps

- Contract negotiations for 2017 to 2019 to be underpinned by agreed STP assumptions on key service changes
- Decision on number of MCPs to be established by 30th November 2016 and scope of contracts
- Risk and benefit sharing arrangements agreed with alliance partners April 2017
- Shadow contracting arrangements for MCP October 2017
- Formal establishment of alliances April 2018
- Full transfer of alliance responsibilities April 2021

Risk and Controls

No.	Description	Owner	Initial Score	Post mitigation Score	Target Score	Mitigations and Controls in Place	Future Actions
Health and Well Being							
	Clinical and financial Failure to focus on preventative approach, lack of focus and participation from the public.	Director of Public Health	12 3x4	8 2x4	6 2x3	• STP outlines objectives • Investment identified in the plan (to be checked) • Public health direction incorporated into STP planning process	• Need to agree the delivery plan • Monitor objectives and track KPIs
	Clinical Failure of patients and carers with long term conditions to self care.	Director of Public Health	12 3x4	8 2x4	6 2x3	• Social marketing • Information • Identify population • Targeted theme- based campaigns • Lifestyle campaigns with LCC	• Implementation plan • Monitor objectives and track KPIs • Incorporate into specific care pathways
	Clinical Failure to support staff to change clinical practice and deliver the least intrusive intervention.	Chief Executives	12 3x4	8 2x4	6 2x3	• STP Organisational Development Strategy and Plan	• Implementation Plan • OD work engaging and supporting staff to deliver STP
	Clinical Failure to tackle known health inequalities.	Director of Public Health	16 4x4	12 3x4	8 2x4	• Known public health prioritisation through JSNA	• Implementation plan • Themed campaigns • Care pathways

No.	Description	Owner	Initial Score	Post mitigation Score	Target Score	Mitigations and Controls in Place	Future Actions
Care and Quality gap							
	Workforce Failure to redesign the workforce.	Chief Executive ULHT	16 4x4	12 3x4	8 2x4	• Workforce strategy • Attraction strategy • Recruitment and retention strategy	• Implementation plans
	Clinical, political and reputational Failure to secure support for clinical redesign / configuration.	Accountable Officer South West Lincolnshire CCG	20 4x5	16 4x4	8 2x4	• Clear options on service configuration for public consultation • Robust and owned public consultation plan • Robust clear process	• Single public consultation plan • Engage leaders • Agree timescales • Identify leads • Communication plan
	Clinical and reputational Failure to agree single approach on access and standards (Right Care).	Chief Clinical Officer West Lincolnshire CCG	12 4x3	12 4x3	6 2x3	• Emerging STP and ownership through regulatory/assessment process of agreed plan • Planned care, proactive care and primary care work streams	• Commitment to the STP • Commissioning and investment strategy • STP KPIs agreed
	Clinical Failure to modernise with appropriate technology	Accountable Officer, East CCG	12 3x4	8 2x4	6 2x3	• Lincolnshire Digital Roadmap • Care Portal implementation	• Information Governance agreed • Implementation Plan
Funding and Efficiency							
	Financial Failure to deliver financial efficiencies programme. Failure of organisation to deliver 2016/17 financial efficiencies on a recurrent basis.	Chief Executive, LPFT	25 5x5	20 4x5	8 2x4	• Savings programme is scoped • Do nothing and do something solutions identified • Solutions paper • Focus on operational efficiency plan	• Detailed delivery plans • Single Lincolnshire delivery plan
	Financial Failure to attract capital investment to support clinical redesign and maintain current assets and buildings.	Chief Executive, LPFT	25 5x5	20 4x5	8 2x4	• No mitigation available currently • No capital available • Combined provider estate plan needed for primary care and NHS	• Not known

No.	Description	Owner	Initial Score	Post mitigation Score	Target Score	Mitigations and Controls in Place	Future Actions
	Financial Failure to successfully secure Lincolnshire's fair share of the national transformation funding of £1.1bn	Chief Executive, LPFT	25 5x5	20 4x5	8 2x4	• No mitigation available	
	External Risk of not supporting flexible funding flows (outside of national tariff) and contracting arrangements	Chief Executive, LPFT	25 5x5	20 4x5	8 2x4	• Simplified contracting mechanisms across NHS providers in Lincolnshire	• Rules based commissioning policy from national sources • Model contract • Implementation plan for Lincolnshire
Leadership and capacity							
	Clinical and reputational Failure to operate as a single system	Chief Executive, LCHS	25 5x5	12 3x4	6 2x3	• Agreed single governance structure that includes SET and the LCB	• System wide leadership and organisational development programme
	Organisational Failure to identify and mobilise capacity and capability to deliver the STP work programme	Chief Executive, LCHS	25 5x5	12 3x4	6 2x3	• STP governance structure and people capacity structure currently being populated • Assessment of internal and external capacity and capability to deliver underway • Defined new roles aligned to the STP programmes • Programme Board and SET in operation	• Implementation Plan • Detailed work programme for STP delivery, reporting to Programme Board and STP • Business Cases to Programme Board
	Organisational Failure to achieve the organisational and cultural change necessary to deliver the STP	Chief Executive, ULHT and Accountable Officer, South Lincs. CCG	25 5x5	12 3x4	6 2x3	• STP Organisational Development Strategy and Plan for Lincolnshire	• Implementation plan

Appendices

1. Communications & Engagement Plan - List of clinical leads and members of expert reference groups including EIA
2. Lincolnshire Health Profile
3. Activity Model 26-6-16 (OPTUM)
4. STP Resource Maps
5. STP WF Workforce requirements
6. STP Prevention Plan
7. Contracting Section LHAC Draft
8. Estates template
9. OD Strategy
10. Workforce Strategy
11. TORs for all groups

Digital Roadmap – sent as a separate document
Finance template – sent as a separate document

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