Lincolnshire Sustainable Services Review

A Blueprint for Future Health and Care Services in Lincolnshire

FINAL DRAFT FOR CONSIDERATION BY ORGANISATIONAL BOARDS

November11th 2013

Prepared for Dr. Tony Hill LSSR Board Chair (on behalf of leaders of the Lincolnshire health and social care system)

By the Programme Management Office
Lincolnshire East Clinical Commissioning Group
NHS Lincolnshire East Clinical Commissioning Group
Cross O'Cliff
Bracebridge Heath
LN4 2HN
Tel: 01522 513355
Mob: 07808105895

Document details

Version history

Version	Date	Changed by	Nature of amendment	Issued to	Issued By
V1.0	29/10/2013	LSSR PMO	Inclusion of amendments following review by Dr Tony Hill (Chair) & Annette Laban (Programme Director) including; grammar and formatting checks; updates to IM&T slides / “MTD" changed to "neighbourhood team"); tweaks in slide title in 147 (contracting slide); consistent rounding down of decimal points in finance slides; updated map and text on slide 47 to reflect 101 GP practices / removal of some slides to avoid duplication of messages.	LSSR Programme Board	LSSR PMO
V1.1	07/11/2013	LSSR PMO	Inclusion of Change Management section; amendments subsequent to Informal Health & Well Being Board 29/10/11and LSSR Programme Board meeting on 06/11/2013 specifically; consistent use of “voluntary sector “ rather than “third sector” throughout; updated information about Mental Health Services in Exec Summary; changes to Proactive Care Model Diagram ; additional references and additional reading added.	LSSR Chair	LSSR PMO
FINAL DRAFT	11/11/13	LSSR PMO	Inclusion of amendments subsequent to LSSR Programme Board email responses specifically; A&E Local Description; Inclusion of statement outlining need for intervention detail to be defined by local population needs; addition of consideration for childhood obesity intervention programme in next phase; inclusion of consideration of development of Institute of Elderly Medicine to support blueprint delivery; inclusion of development of multi-organisational leadership development programme to support blueprint delivery; inclusion of estates slide within enablers section following discussions with NHSE Area Team representative; removal of travel time slides within current position report.	LSSR Chair prior to circulation to Programme Board & presentation to Health & Well Being Board for December 10th 2013	LSSR PMO

Approval History			
Final Draft Version reviewed	Approver Name	Title / Position	Date Approved
11/11/2013	Dr. Tony Hill	DPH & Programme Chair	

At a glance

If you are primarily interested in:	*Read:*
Overall objectives of this blueprint and the proposed future model of care	Foreword, Executive Summary and Background & Approach from page 4 to 34
Proactive interventions	Executive Summary from page 8 to 26, the Proactive Current Position section from page 44 to 49 and the Proactive interventions section from page 85 to 97
Urgent interventions	Executive Summary from page 8 to 26 and the Urgent Current Position section from page50 to 53 and Urgent Care interventions section from page 98 to 102
Elective interventions	Executive Summary from page 8 to 26, Elective Current Position section from 54 to 58 the Elective care interventions section from 103 to 112
Women's and Children's interventions	Executive Summary from page 8 to 26, Women's and Children's Current Position section from page 59 to page 62 and the Women's and Children's interventions section from 113 to 126
Financial implications	Executive Summary from page 8 to 26, the Interventions Summary from page 69 to page 80 and the Financial Summary from 127 to 134
What happens next	Executive Summary from page 8 to 26 and the Transition / Change Management section from 156 to 160

Foreword

This document sets out a vision for sustainable and high quality health and social care services for Lincolnshire. It is focussed on:

- how the people of Lincolnshire can achieve the best health and social care outcomes from the substantial (but ultimately finite) resources available
- what care should look like in 3 to 5 years' time

Why is this review necessary?

Health and social care services are currently commissioned and provided by a number of separate organisations. Service models have developed and evolved based on these partial views of the system – with services being fragmented by organisation boundaries, traditional professional distinctions and separate funding, regulation, physical locations and IT systems.

Care professionals across Lincolnshire have strived to deliver the best possible care within this framework – but it has led to duplication, "hand-offs" of people between organisations, and a lack of clear end-to-end accountability for people's health and social wellbeing. To many patients and members of the public this brings confusion and uncertainty.

The current configuration not only constrains care professionals, but through duplication and uneven distribution of resources is not financially sustainable – either in the short term, and particularly not given the expected growth in the population and increasing older people. Some recent service quality issues also indicate a system under pressure – and that reform is required.

What does this document represent?

The leaders of health and social care across Lincolnshire have agreed to temporarily set aside the interests of their individual organisations, and come together to focus on defining the right services for Lincolnshire – services that the population will value and care professionals can be proud of.

To achieve this, they set some very specific objectives:

- To understand how services are currently being delivered, how they are experienced by patients, citizens and their carers – and to understand the true of cost providing these services
- To liberate 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 – structured around the needs of patients and citizens, and by delivering the best value (outcomes per pound spend) make them affordable
- To then commit to supporting the commissioning and provision of these services in a way that is sustainable in the long term

How has the Blueprint been developed?

The primary focus of the professional and managerial teams in the Care Design Groups (CDGs) has been in maintaining the highest standards of public and patient safety, and on delivering the best possible outcomes. At all stages, care professionals have confirmed that the proposed changes either improve safety and outcomes, and at a very minimum maintain them. There is a growing body of evidence indicating that significantly better outcomes for patients can be achieved by the combination of earlier interventions, co-ordinated care and reduced hospitalisation. The CDGs have used this national and international evidence in their design sessions.

Foreword

This involves not only improving clinical outcomes, but social outcomes including maintaining independence and dignity, as well as patient and citizen experiences of the care they receive.

The models of care described have also been welcomed by care professionals as allowing them to work more freely across professional and organisational boundaries in the interests of their patients and the public.

What does it find?
When aggregated together, these interventions create a strategically different model of care, with a greater proportion of care provided out of acute hospital settings, with care professionals working across organisational and professional boundaries.

This Blueprint is only a first step – but will act as a unifying guide against which the planning and performance of each constituent organisation will be held to account

(Please note – some of the service options proposed may be subject to consultation, and this document is without prejudice to the outcome of any such consultation).

Commitment to deliver
This 'Blueprint' is supported by local health and social care professionals, with the leaders of the health and social care organisations in the area committed to supporting its delivery.

The Blueprint does not fully close the affordability gap, but the interventions described and the benefits they will deliver are intentionally realistic. There is significant opportunity for the benefits realised to go beyond what is described in this report. In addition it is anticipated that the implementation phase will allow for identification of new possibilities that will help to further close the financial gap.

"Most of us have been through numerous reviews of health services in our careers. Often the results have been unpalatable and have been swept under the carpet only to recur in a few years. This time is different for a number of reasons: The imperatives are greater than they have been before and we can't hope they will just go away; If we don't sort this situation then people from outside will sort it for us and the locus of control will move from within Lincolnshire making closer working ever more difficult; The health service changes may have created fragmentation but they give us some advantages we haven't had before, for example, a Health and Wellbeing Board which can agree a way forward drive it through and speak with one voice if there are barriers outside our county; elected members involved in the review from the start with a community leadership responsibility for health and care; the clinical leadership of the health commissioners and providers; involvement of social care as well as health care."

Dr. Tony Hill LSSR Chair

We, the Lincolnshire Sustainable Services Review Programme Board, agree with the direction of travel of this Blueprint, with further work to be done in the detailed design phase. We commend it to our organisations.

ICTP Board Members	Role	Organisation	Signed
Dr Tony Hill	LSSR Chair (SRO)	LCC	
Annette Laban	LSSR Director	Independent Consultant	
Dr. Brynnen Massey	Clinical Leader and Chair	LECCG	
Gary James	Chief Officer	LECCG	
Dr. Miles Langdon	Chair and GP	SLCCG	
Gary Thompson	Chief Officer	SLCCG	
Allan Kitt	Chief Officer	SWLCCG	
Dr. Vindi Bhandal	Acting Chair	SWLCCG	
Dr. Sunil Hindocha	Clinical Chief Officer / AO	LWCCG	
Sarah Newton	Chief Operating Officer	LWCCG	
Jane Lewington	Chief Executive	ULHT	
Dr. Suneil Kapadia	Medical Director	ULHT	

ICTP Board Members	Role	Organisation	Signed
Chris Slavin	Chief Executive	LPFT	
Dr. John Brewin	Medical Director	LPFT	
Ellen Armistead	Chief Executive	LCHS	
Dr. Phil Mitchell	Medical Director	LCHS	
Glen Garrod	Director of Adult Social Services	LCC	
Debbie Barnes	Director of Children's Services	LCC	
Richard Henderson	ADO	EMAS	
Andy Swinburn	Consultant Paramedic	EMAS	
Sarah Fletcher	CEO	Healthwatch	
Dr Brian Wookey	Director	Healthwatch	
Andy Learie	Finance Director	NHS England (Leicestershire & Lincolnshire Area)	

Contents

SECTION 1
Executive Summary

This section introduces the Lincolnshire Sustainable Services providing a high level review on the programme background and approach taken, an overview of how health and care services are currently delivered in Lincolnshire and the potential future model of care. It also highlights the impact of this programme on the system and enablers required to implement future change.

Executive Summary

Programme Background

"Commissioners are encouraged to focus on 3 things

- *Develop 5 year plans and engage local people*
- *Strengthen your local partnership arrangements*
- *Identify the things that will make the greatest difference to patients and keep a relentless focus on putting them into action"*

***Planning for a sustainable NHS: responding to the 'call to action' David Nicholson 10th October 2013**

The health and social care system in Lincolnshire faces significant challenges. The Keogh review identified some key areas of concern over the quality and safety of some services with particular patient outcome challenges in Reactive (Urgent) care. In addition, there is evidence:

- from patients and service users of services being fragmented
- that service models do not reflect published clinical evidence that some elements of care can be better provided closer to home
- that workforce structure, IM&T, incentive arrangements and other factors are not supporting transformational change.

Like many other Lincolnshire employers we find it difficult to recruit the workforce required. For our services to be sustainable we will need to change them to make recruitment easier and this will require a huge increase in the flexibility of working approaches especially for senior clinical staff.

All four Lincolnshire CCGs have above average disease prevalence for the majority of the disease categories investigated. This coupled with the impact of growth in demand for services (growth in the elderly population and children) is outstripping growth in funding.

Increasing demand and expectations from patients; users and carers, and politicians around local access (made more complex by rurality) and time and type of care delivered, place additional pressures on this health and social care economy.

Whilst it is acknowledged that Lincolnshire has been impacted by historical below average investment levels it is clear that current models of care are neither delivering best health outcomes or sustainable now or in the future. The cost of making current services safe and viable would add to existing cost pressures. With a current system wide (health and social care) deficit of £20.8 million if current services were continued, we would have an annual overspend of just over £105 million in five years' time. These issues can only be addressed by the whole health and social care community.

Within Lincolnshire there are some examples of ways of delivering services, which are more appropriate and successful than others. A radical and innovative approach is needed to develop sustainable solutions adding scale and pace to how we collectively manage this challenge.

Integration is national policy and it is essential we get services working together, especially community care, social care, primary care and prevention and early intervention. In light of this, the organisations involved in the delivery of health and social care in Lincolnshire have agreed to work together to design a blueprint for the future delivery of services that would meet the needs of the population both now and in the future, and do so whilst operating under the financial constraints that exist to make the right choices for sustainability, particularly where these choices are difficult and contentious. The organisations are;

Lincolnshire East CCG, Lincolnshire West CCG, South Lincolnshire CCG, South West Lincolnshire CCG, NHS England (Leicestershire and Lincolnshire Area), Lincolnshire County Council, Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Services NHS Trust, United Lincolnshire Hospitals NHS Trust and East Midlands Ambulance Service and HealthWatch Lincolnshire.

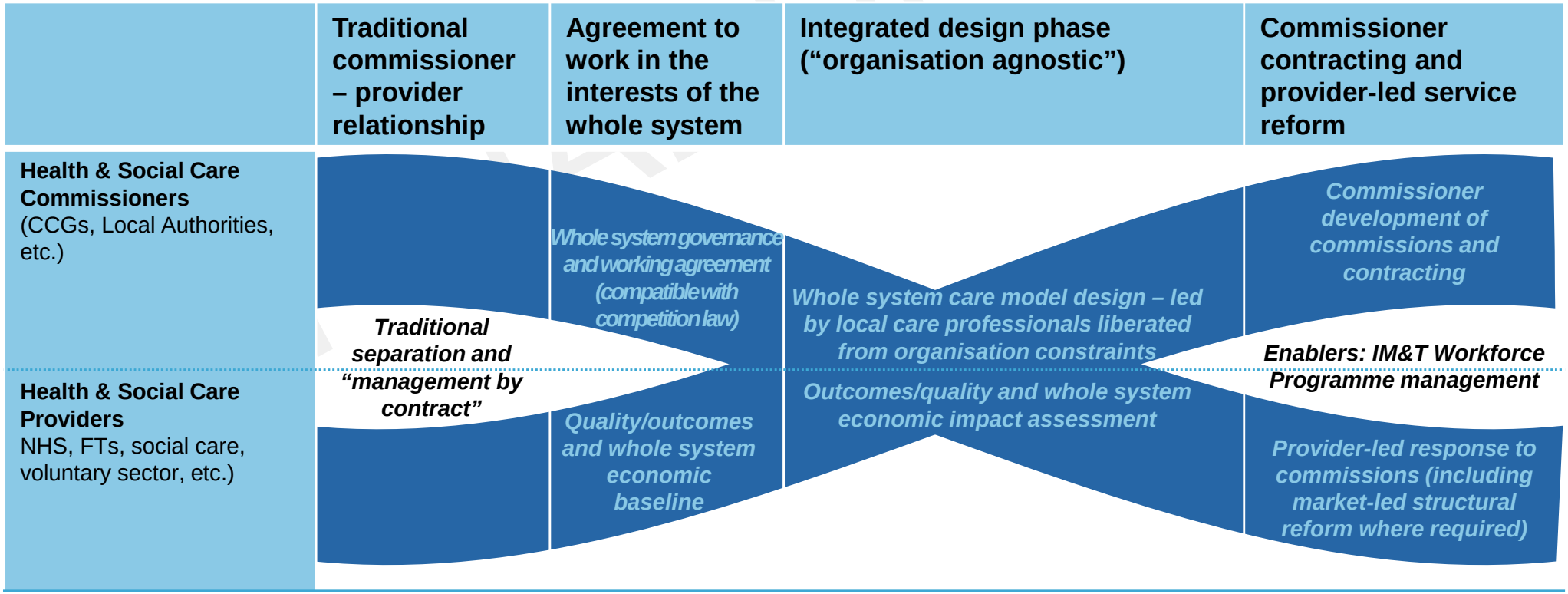
Executive Summary

Programme Approach

The approach used (shown in the diagram below) is what is termed as a "market reset". This allows the development and validation of a "single version of the truth" for the whole system and genuinely co-created design solutions which are organisation agnostic before commissioners develop their clear specifications for delivery and providers are invited to respond. It is important to acknowledge that the challenge of developing a system wide organisation agnostic future model is beneficial but complex.

At a recent Westminster Health Forum three key factors were outlined by a successful integrated system in New Zealand as being critical to the success of delivering such an integrated model of care; creating the vision; sustained investment in staff and skills needed to innovate and supporting them to do so; alliance contracting. "one budget one service". All of these factors have been discussed throughout the development of this blueprint and will continue to be worked through in more detail during phases two and three of the LSSR.

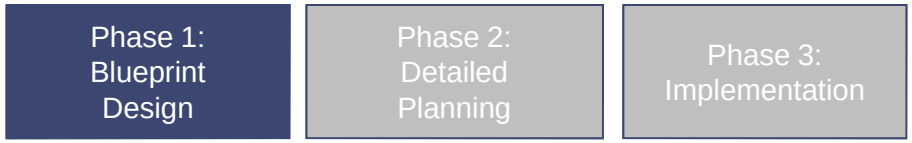
Market Reset



Executive Summary

Programme Approach

- The LSSR involves three phases of work. This report focuses on Phase 1 of the programme, carried out between July and October 2013.



Phase 1: Blueprint Design focused on 4 main areas:

- Establishing a vision and objectives, mobilising the team
- The current model of care: agreeing a baseline for how the health and social care economy currently operates:
- The future model of care: engaging clinicians, health and social care professionals and patients and carers in four Care Design Groups to develop design options, followed by modelling to understand the financial and activity impact of the proposed changes.
- The creation of a roadmap to deliver the changes proposed for consideration.

- The blueprint design was facilitated by a more strategic review of how services should best be configured. Rather than “tinkering at the edges”. different models of provision which offer greater levels of safety, higher quality and efficiencies brought about by economies of scale and innovative approaches to care have been included in the blueprint.

- A key objective was to build upon what is already in-train and what works within Lincolnshire but may require scale and pace to positively impact sustainability.

- Extensive stakeholder engagement with clinicians, managers, social care professionals , councillors and patient representatives has been undertaken during this phase to achieve the “buy in” and “bottom up” design required if sustainability is to be achieved. Formal consultation processes within Phase 2 will be outlined within the delivery roadmap on Section 7.

- During Phase 1 potential options have been “sense checked” by both HealthWatch representatives on the Programme Board and by patient and carers representatives who have actively participated in the design process.

- The programme governance process facilitates alignment with the Health and Well Being Board and therefore the Joint Health and Well Being Strategic Priorities for the county.

Executive Summary

Lincolnshire Health and Social Care Overview

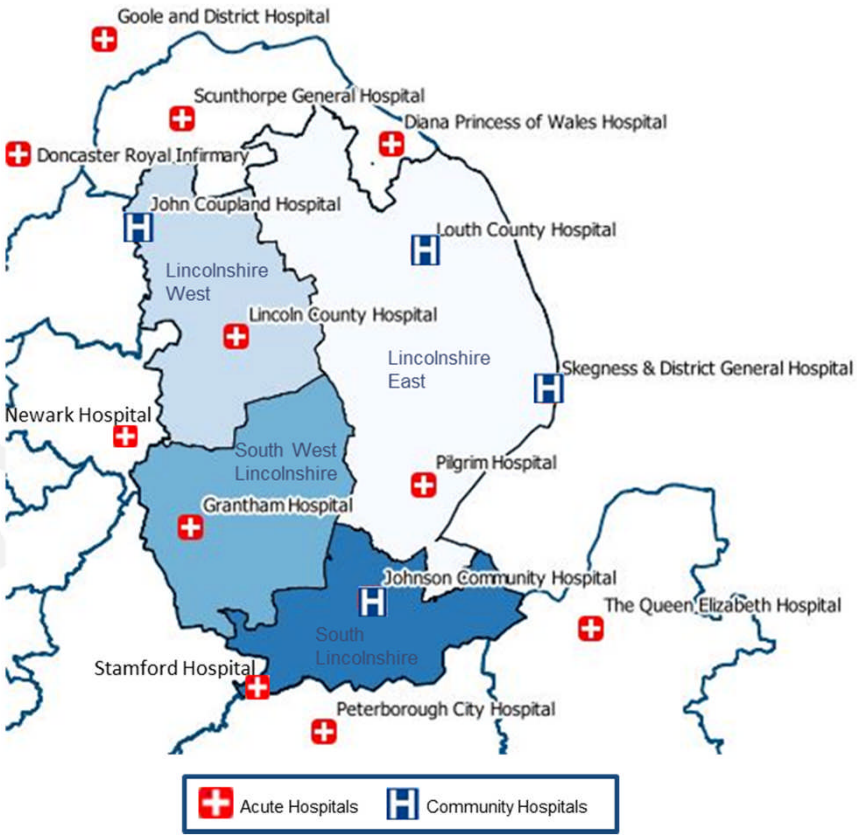
The map on the right shows the county of Lincolnshire and its main health and social care providers. The shaded areas are the CCGs of relevance for this report. There are over 715,000 people living in the four CCG areas, equating to almost half of the overall Lincolnshire county population of 1.4m inhabitants.

Primary Care Services Provision:

Lincolnshire has 5.7 GPs and 4.8 GP practice nurses per 10,000 people. There are 101 main GP practices across Lincolnshire with 30 in Lincolnshire East, 37 in Lincolnshire West, 19 in South West Lincolnshire and 15 in South Lincolnshire. The primary care budget in FY 2012-13 was equal to £111m.

Acute Services Provision:

The main acute provider in Lincolnshire is United Lincolnshire Hospitals NHS Trust, with sites in Lincoln, Boston and Grantham. The Trust's income for FY2012-13 was equal to £422.8m and it offers over 1,300 beds. Lincoln Hospital is the largest hospital, with over 88,000 inpatients and 65,000 emergency cases last year.



Community Care Services Provision:

The community provider, Lincolnshire Community Health Services NHS Trust, runs John Coupland Hospital in Gainsborough, Skegness and District General Hospital, Johnson Community Hospital in Spalding and County Hospital Louth. In FY 2012-13 the Trust's income totalled £107.7m and offered 155 beds.

Social Care Services Provision:

Adult Social Care Services are mainly provided by Lincolnshire County Council. In FY2012-13 £132.8m were spent on the provision of adult social care and the Council supported 3, 992 people in residential and nursing care.

Mental Care Services Provision:

Lincolnshire Partnership Foundation Trust provides mental care services, with 256 beds across hospitals and placements in the county. In FY2012-13 it recorded an income of £102m and registered 314,000 community contacts and 24,318 IAPT referrals.

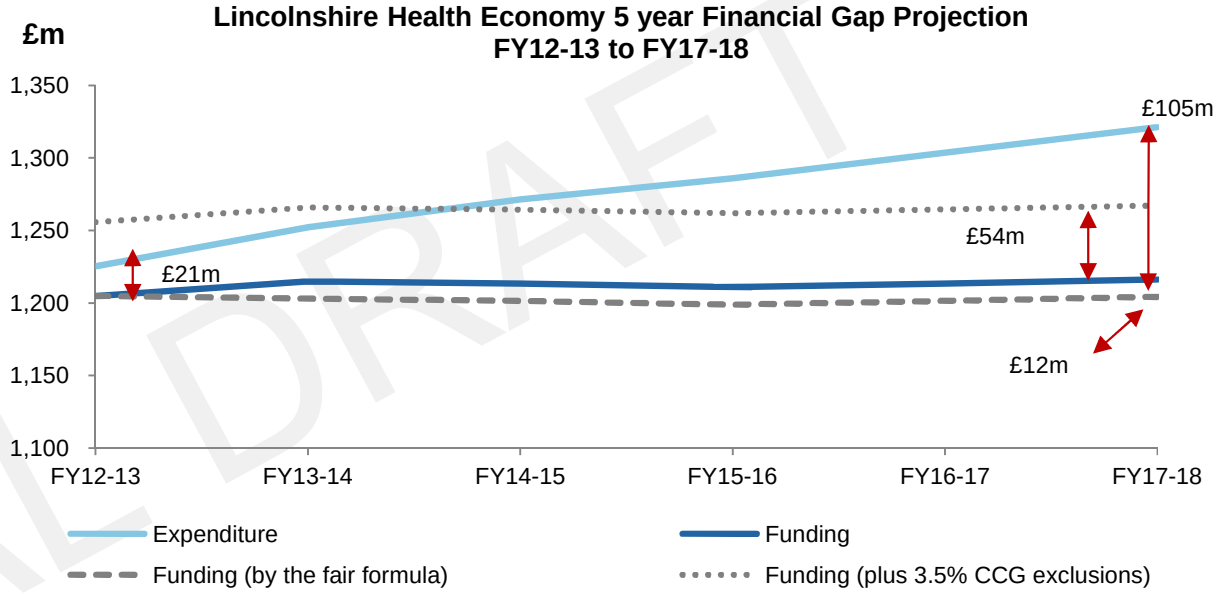
Executive Summary

The overall financial challenge:

There is already a multi-million pound recurrent gap and this is projected to rise to over £100 million in FY17-18. There is no rescue fund and only radical rearrangement of the way health and care are provided will achieve financial sustainability

The Current Model of Care

Through engagement with key stakeholders, data analysis and document review, a current financial position for the current health and social care economy was established.



Notes:

1. The financial gap in FY12-13 was £20.8m, which comprises of provider net surplus / deficit adjusted for net non-recurrent income, and the net deficit of LCC.
2. Healthcare funding is frozen in real terms for the next 5 years from FY13-14.
3. Healthcare expenditure increases in proportion to demographic change. 40% of cost is incurred from treating people aged 65 and older. The 65 and over population grows at 2.5% per year on average and the under 65 population grows at 0.7% per year on average (source: ONS forecasts).
4. CCGs share the PCT surplus from FY12-13 (little over £9m) in FY13-14. This is non-recurrent for FY13-14 and is hence excluded from our baseline.
5. Adult social care funding and expenditure is based on a 5 year forecast provided by LCC. Children's Social Care and Public Health funding and expenditure is assumed to be frozen and remain at breakeven.
6. The long-term temporary population in Lincolnshire is usually excluded from population estimates used in the funding formula. If this population was included it has been estimated that an additional £22m funding may be provided (Seasonal impact on local health services, East Lindsey District Council Report, 2007).
7. In a different scenario (dotted line), the allocation to 3 out of 4 CCGs falls from FY13-14, based on the draft NHS England "fair formula".
8. Of the total CCG allocation, 96.5% of the allocation is available to spend on healthcare. 3.5% is required to be retained as headroom (2%), planned surplus (1%) and contingency plan (0.5%).
9. In our third scenario, this 3.5% is made available to the health and care economy. Even in this case, the financial gap would still be £54.0m by FY17-18.

Executive Summary

Future model of care

The overall objective of this phase of work has been to design a future model of care that will allow the Lincolnshire health and social care system to deliver high quality services within a sustainable financial model. In order to develop this future model of care, the programme created four Care Design Groups. Divided into the core delivery areas, these groups were then tasked with agreeing an overall vision and then developing a series of interventions that, if implemented, they believed would make this vision achievable. The four Care Design Groups (CDGs) were:

Proactive ideas

Urgent Care (Reactive)

Elective Care

Women's & Children's

To provide a structure for understanding the future model of care developed by the CDGs, the programme team have considered the future model of care in terms of:

1. The overall goal – sustainability in Lincolnshire's health and care economy
2. The principles of how the overall goal will be delivered
3. The assets needed to achieve these outcomes
4. The brave ideas required to achieve the future blueprint

1. The overall benefit

A sustainable and safe health and social care economy for Lincolnshire.

2. The principles

1. People are engaged and informed
2. From fragmentation to integration
3. Prevention is better than cure
4. Shared decision-making

3. The assets

The Future Model of Care will include ten assets designed to drive our four principles and overall benefits:

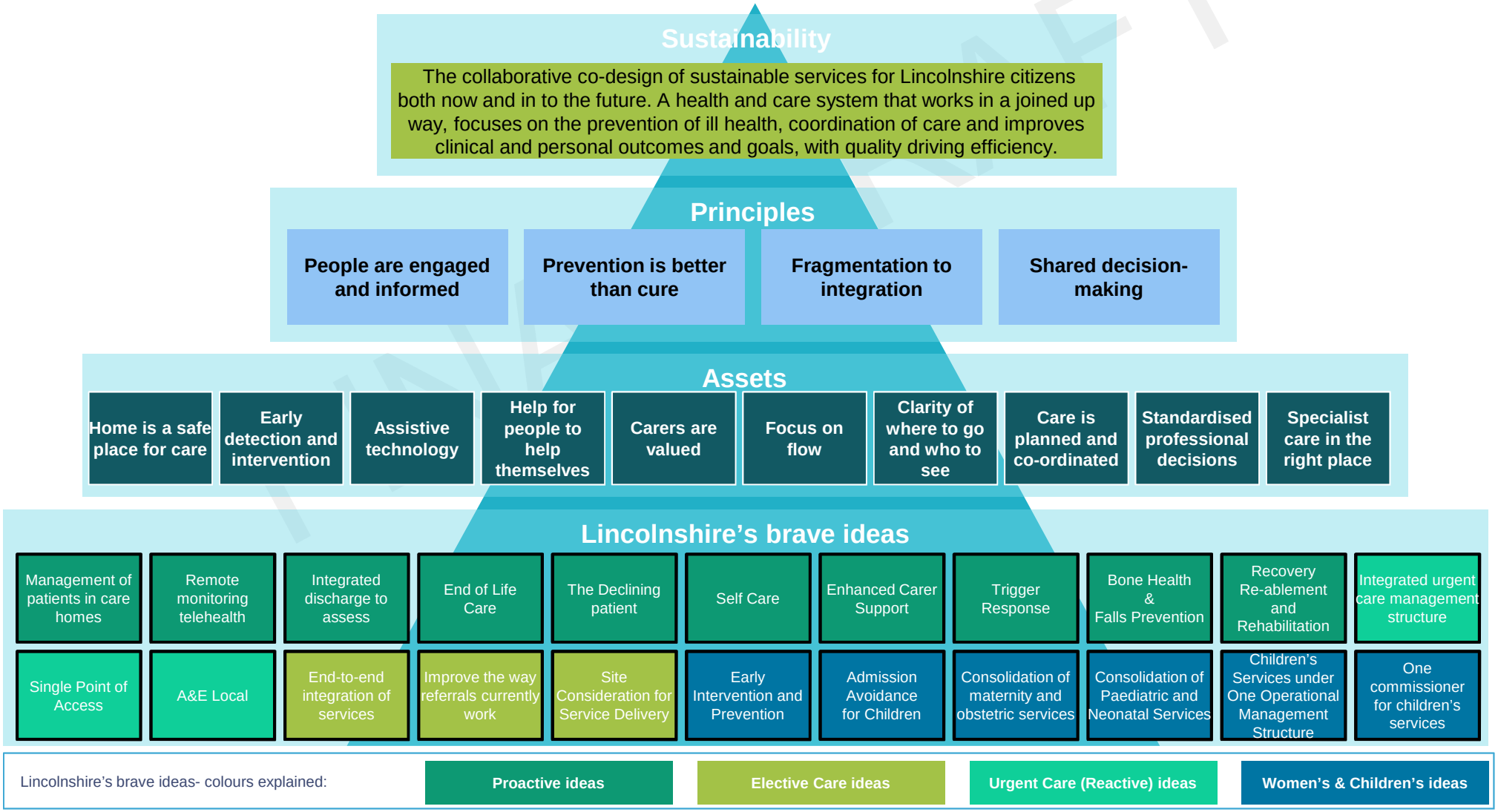
1. Home is a safe place for care
2. Early detection & intervention
3. Assistive technology
4. Help for people to help themselves
5. Carers are valued
6. Focus on flow
7. Clarity of where to go and who to see
8. Care is planned and co-ordinated
9. Standardised professional decisions
10. Specialist care in the right place

4. The interventions

In order to achieve the future model of care and the proposed capabilities, twenty-two interventions (as proposed by the Care Design Groups) have been proposed (see next page). These will be supported by some key enablers, such as: estates, IM&T, contracting and workforce planning.

Executive Summary

The diagram below provides on one page the golden thread between Lincolnshire's goal of the design of sustainable services in the future model through key principles, use of assets and brave ideas:



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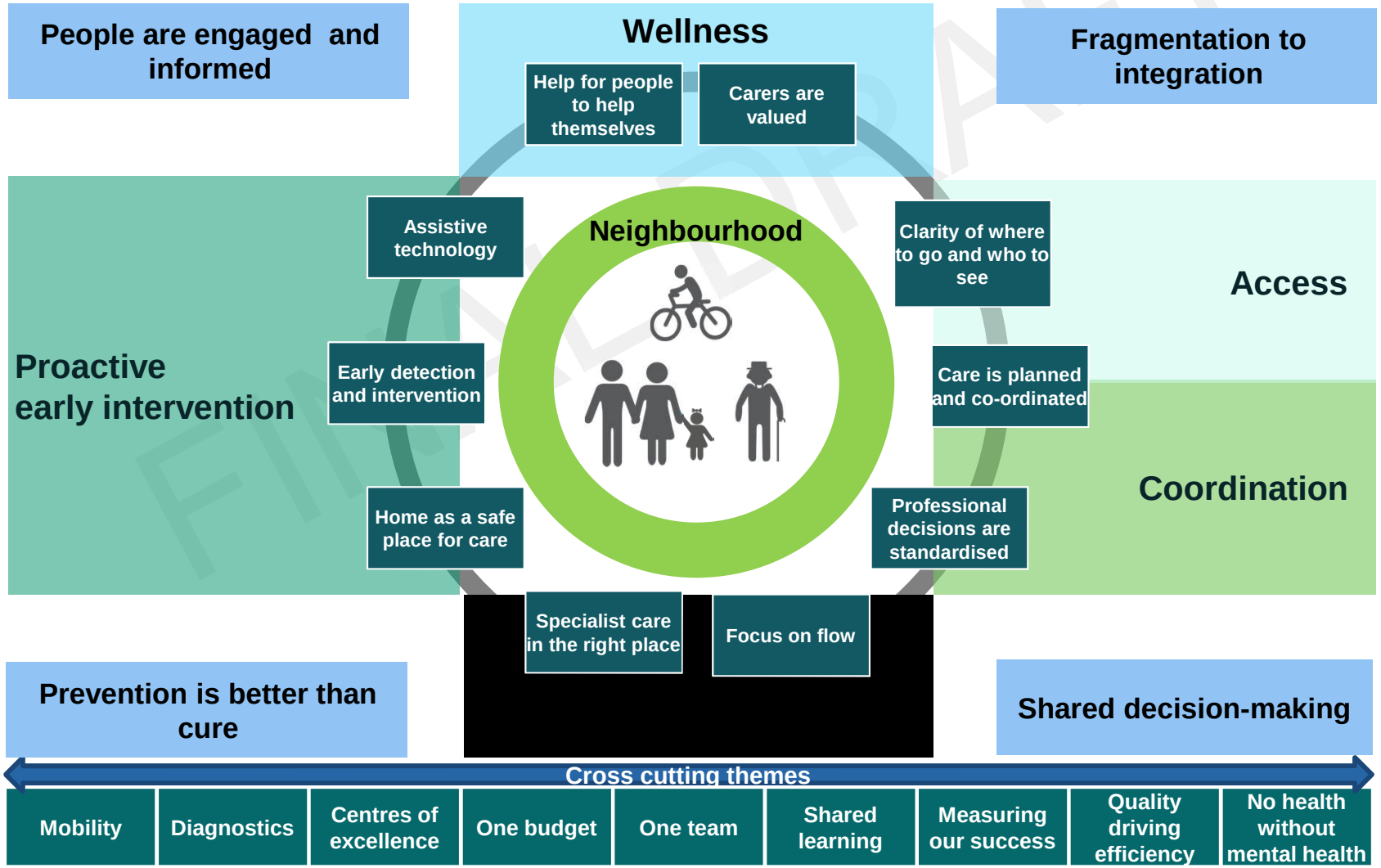
The diagram below details, on one page, the elements which have been described across all four care design groups and reviewed by the Programme Board to form the proposed future model of care. This model is intended to encompass the full spectrum of physical, mental health and social care services across Lincolnshire.



Executive Summary

The Future Model of Care

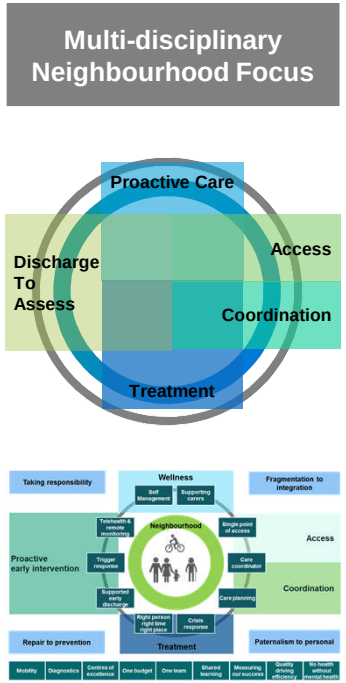
The model on the previous page is intended to provide a vision for the delivery of sustainable integrated care services in Lincolnshire. Detailed within the model are a number of key elements:

1. **Building the assets–** the core delivery method of the future model of care will be through the assets identified. In the majority of circumstances these already exist within the whole system but will require detailed discussion regarding optimal design and configuration for improved safety, quality and efficiency. The development of seamless patient / citizen journeys through connections into other parts of the system to ensure an integrated operational model.

2. **Optimising a cyclical process**– it is acknowledged that the health and social care process should not be seen as linear but as cyclical; with patients going through a pathway from proactive care settings to access and coordination stages, treatment, discharge and returning to proactive care settings once more. Whilst it is accepted that not every patient / citizen journey will experience every point in this process, it provides a useful lens through which to view the operation of the system as a whole.

3. **Driving integration** – the future model of care has at its heart a commitment to support a more integrated health and social service in the coming years. Throughout the blueprint design process, the Care Design Groups have kept in mind the linkages between the different care settings, with the interventions proposed and the consequent model of care aimed at improving these links.

4. **Focus on delivering the outcomes** – the delivery model being proposed is closely linked to the key principles pulling the programme together. Each part of the model, and the interventions proposed in order to meet it, is therefore focused on delivering one of the four principles proposed opposite.



People are engaged and informed	Fragmentation to integration
Prevention is better than cure	Shared decision-making

Thinking behind Lincolnshire's "Big Brave Ideas"

Underpinning the future model of care are the interventions put forward by the Care Design Groups. The table below outlines a high level summary (by care category) of the thinking behind Lincolnshire's "Big Brave Ideas" identified by the Care Design Groups and presented to the LSSR Programme Board. These changes are transformational in nature, though considered to be both realistic and achievable. The integration of previously separate services to meet local needs (including primary, community and mental health care and social care supported by the voluntary sector) will be defined by local population needs.

Proactive	• Clinical evidence is increasingly demonstrating that **proactively managing people** – and particularly those with long terms conditions and the frail elderly – delivers better health and social outcomes, and through **avoiding unnecessary hospitalisation** – can be more affordable • Lincolnshire will establish a **properly resourced proactive care** service – drawing on the best of primary care, community and mental healthcare, social care and with support from hospital expertise and delivering them in a way that does not perpetuate these categories of care.
Urgent	• When people experience a crisis, they should expect a **clear, simple response** appropriate to the needs they have. • Rather than lots of services run by different organisations without single co-ordination – from out of hours primary care to A&Es – Lincolnshire will **align all of the urgent care response services under a single operational management** – with simplified ways to access these services. • By drawing together all urgent care services under one umbrella, Lincolnshire **will** be able to **have a safe service**, and **afford to preserve the geographical access points** to urgent care services and make best use of the workforce available.
Elective	• Access to urgent care will be made **more consistent** and based on evenly applied criteria – **protecting the specialist services** for those whom clinical evidence shows are most likely to benefit. • In hospital services **will no longer be set up in competition with community services** – and decisions about how people can best be supported will be made by the care professionals across these settings working together based on value to patients. • Work with others to recruit high quality staff e.g. joint posts with other acutes, specialist and tertiary centres
Women's & Children's	• **Safety and quality** have been the **main focus** of the care design group, with consolidation options considered for different Women's and children's services • **A careful balance** to be considered **between improved quality through centralisation and increased volumes of care / efficiency** through rationalisation of services across sites and patient safety including access and travel times and should include detailed risk benefit and equality impact analysis.

Lincolnshire's "Big Brave Ideas"

Care Category Dashboards

Underpinning the future model of care are the interventions put forward by the Care Design Groups. The table below outlines a high level summary (by care category) of the interventions identified along with the associated cost avoidance estimated in 2017-18. These changes are transformational in nature, though considered to be both realistic and achievable. In addition to these opportunities, it is envisaged all organisations in the system will continue to make traditional cost improvements over the next few years.

Proactive (see Urgent)	• Ten different ideas were considered: Self Management, Trigger response, Telehealth & remote monitoring, Supported carers, Single point of access, Right person right time right place, Care coordination, Care planning, Neighbourhood teams, Integrated crisis response, Supported early discharge • The financial impact of Proactive ideas has been combined with that of Reactive ideas, as Proactive will have a financial impact on Urgent activity through, for instance, the reduction in acute beds, lowering A&E presentations and shorter length of stay
Urgent £36-43m	• Eight initiatives were considered and grouped into three design options by the Urgent care design group. These are: • A Single Integrated Urgent Care Service under a Single Management Structure • A Single Point of Access that has access to Directory of Services which includes community, social care and other intermediate care options and coordinates direct patients with urgent care need to the right services. • An A&E Local (branding to be discussed) is an integrated multi-disciplinary service comprising traditionally separated acute, primary and other care professionals of an A&E (primary care currently approximately 40-50% but could increase in the future model). 7 day service.
Elective £11-26m	• The elective care design group identified the need for a single end-to-end service commissioned for a particular patient group, service or specialty, including all of the acute and community aspects of the service. The group specifically considered how such initiative would apply to fifteen specialties. • An overall referral structure was identified as needed to support referring clinicians to decide the appropriateness of referrals, together with simple guidelines developed community-wide to aid GPs and feedback loops between GPs and specialists • High-level site considerations on the principles that need be considered when analysing where services should be provided • These initiatives are estimated to lead to benefits in the region of £10-26m.
Women's & Children's £2-6m	• The design options within this CDG were primarily focused on the provision of safe, quality services around 7 key interventions promoting proactive early intervention, coordinated multi-disciplinary teams working in neighbourhoods and drawing in specialist support where required, admissions avoidance and models of commissioning and provision to reduce fragmentation of services. • The group considered options around the consolidation of consultant led and midwifery led units on the same site (24/7 consultant available at all times) or consultant led and midwifery led unit on separate sites (24/7 Consultant cover at one site). Consolidation was also discussed around paediatrics and neonatal services, including acute care, ambulatory care / paediatric assessment services, surgical units and neonatal support. The interventions discussed are estimated to create benefits of between £2-6m

Executive Summary

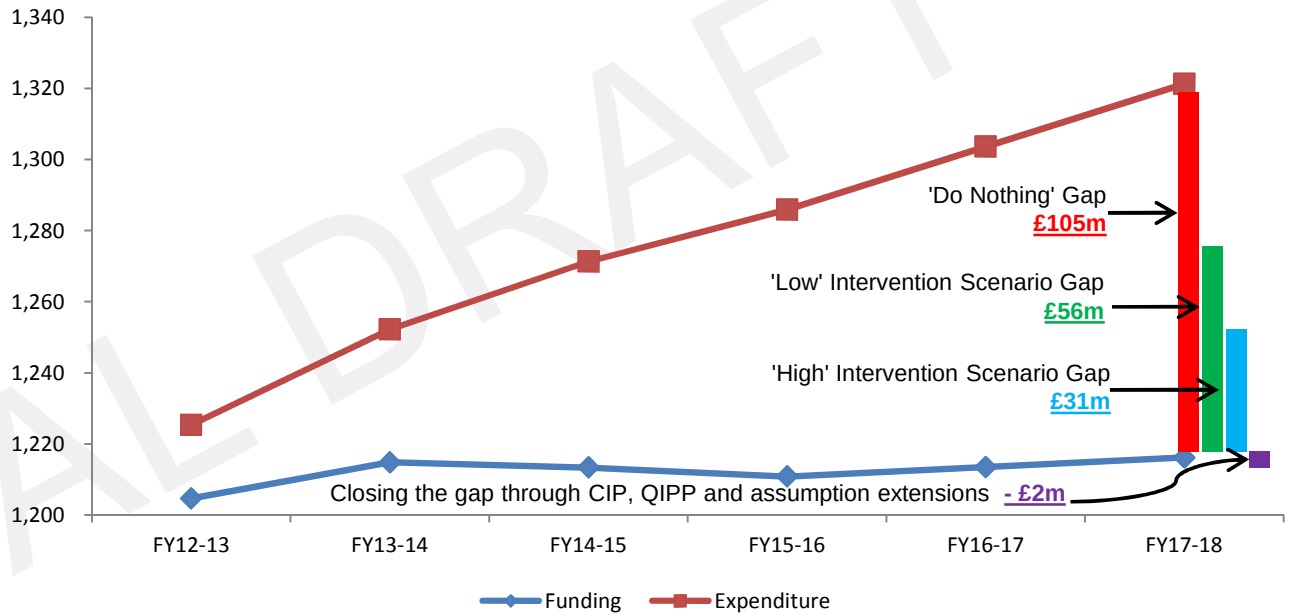
Narrowing the Financial Gap

The diagram to the right shows the financial gap explained on Page 13. If the new model of care is taken forward and the interventions are adequately implemented, high-level data modelling suggests that the estimated financial gap of £105m could be significantly reduced by between £74m and £49, depending upon which interventions will be undertaken and the extent to which they will be implemented.

To achieve these benefits, significant effort and collaboration will have to take place across all the stakeholders in the health and care economy and some radical changes will need to occur. It is our view that both scenarios are achievable, although the outcomes will be contingent upon how the implementation of initiatives will be prioritised and co-ordinated.

The remaining gap of between £56m and £31m can potentially be closed through CIP, QIPP and further assumption extensions, as discussed on slide 22.

Lincolnshire Health Economy 5 Year Financial Gap Projection FY12-13 to FY17-18



'Low' Intervention Scenario Gap: cautious modelling assumptions

'High' Intervention Scenario Gap: achievable but ambitious modelling assumptions

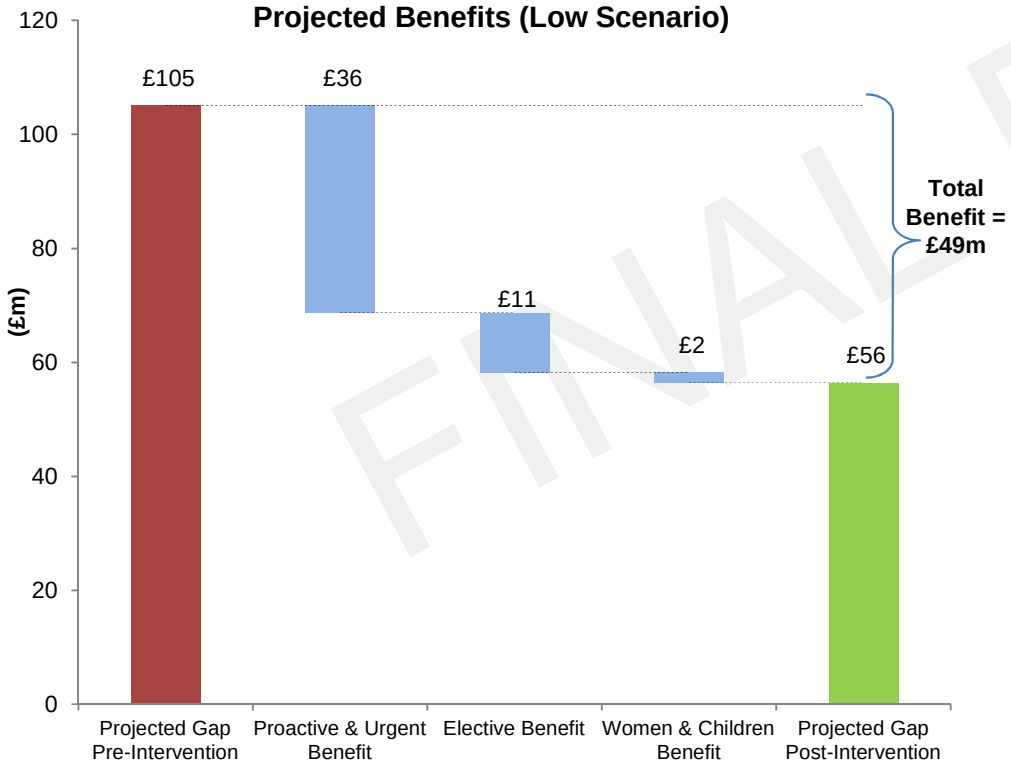
Scenario modelling approach

- The modelling has been undertaken against the counterfactual that no action is taken and services continue to operate as they currently do out to 2017/18.
- The modelled scenarios have been undertaken at a broad, system-wide level for the purposes of this report.
- High and low scenarios have been modelled with varying assumptions to provide a range of projected benefits.
- Assumptions have been collated from CCG workshop outputs, clinical input, published literature and experience from similar pieces of work.
- The modelled benefit scenarios are intended to provide insight into the possible costs that could be avoided through the interventions proposed, and demonstrate the need for action. More detailed analysis would need to be undertaken as part of a Business Case.

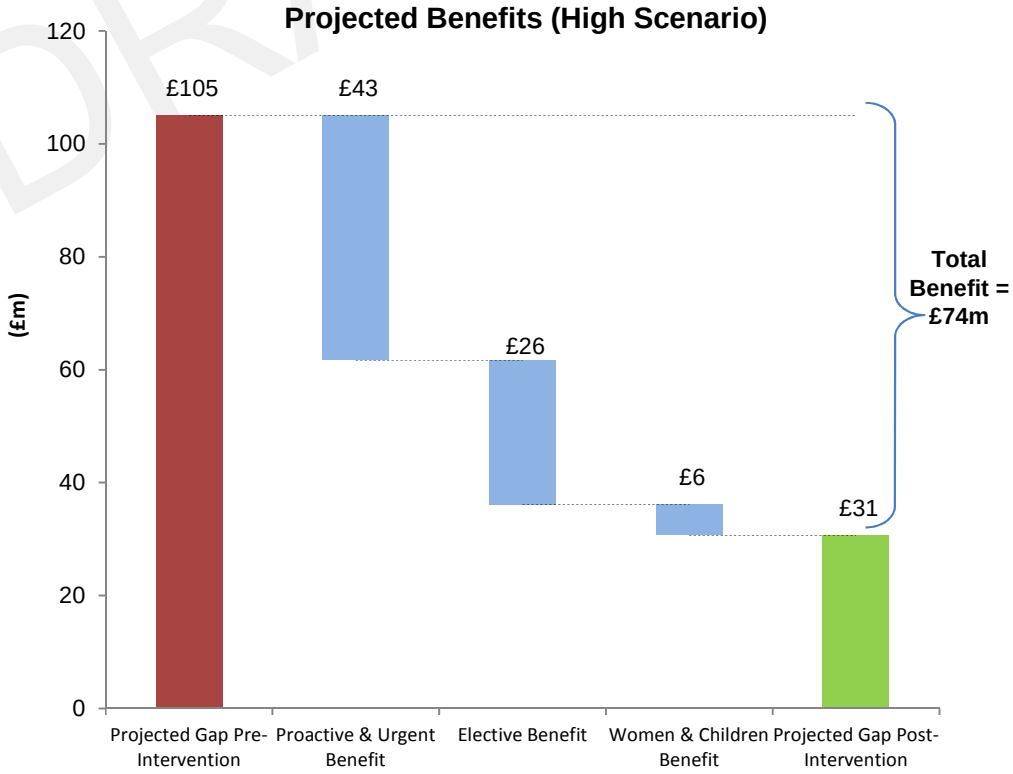
Executive Summary

Modelling the Care Design assumptions in the Future Model of Care

A high-level modelling was conducted on the likely impact of interventions on Lincolnshire's economy. As the impact depends upon how these and to what extent interventions would be implemented, two scenarios were modelled. It is worth noting that both scenarios are achievable. The combined modelled initiatives could potentially provide between £49m and £74m in annual benefits by 2017/18, with proactive and urgent care initiatives providing the largest share of projected benefits. Although the gap would not be closed, in the high scenario it would be reduced by 71%. Additional measures would be needed in order to completely close the gap. These are analysed in the following slide. Each Care Design's impact is explored further in Section 4.3.5.



'Low' Intervention Scenario Gap: cautious modelling assumptions



'High' Intervention Scenario Gap: achievable but ambitious modelling assumptions

Sources: HES 11-12; 2011-12 Reference Costs; ULHT, LPFT LHCS SLR 2011-12, Local Authority Personal Social Services Statistics, LCC

Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

Executive Summary

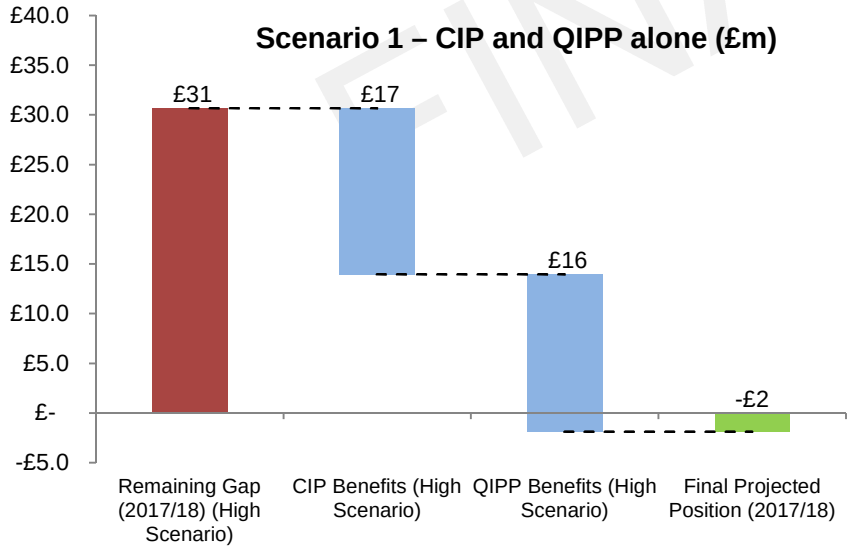
Closing the Remaining Gap Beyond the Care Design Assumptions

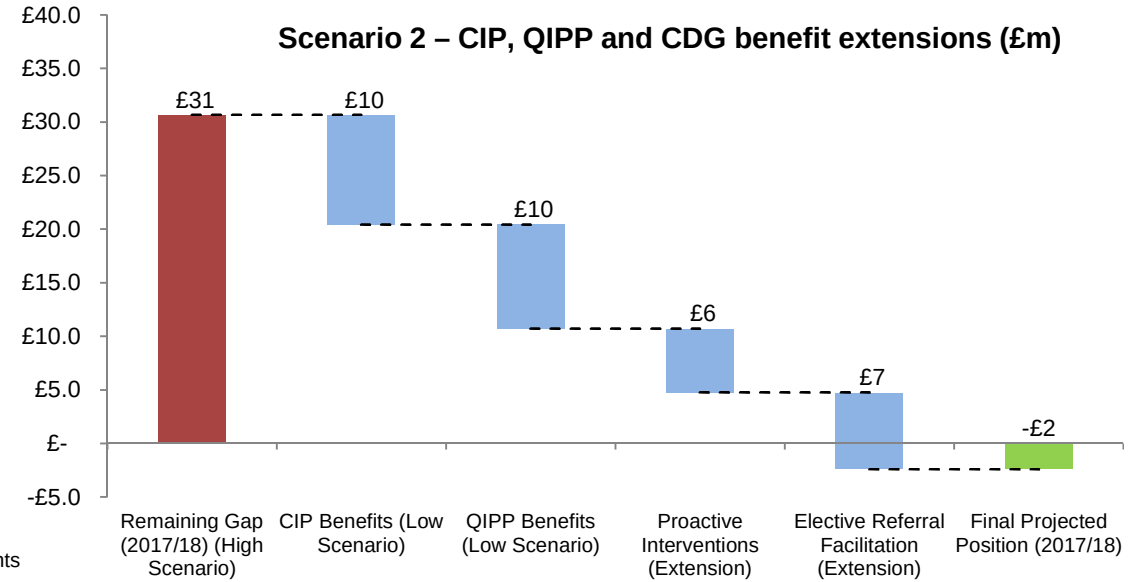
The interventions modelled across Care Design Groups could potentially provide annual benefits of between £49m and £74m by 2017/18. This alone would leave a financial gap of between £31m and £56m in 2017/18. We examined what it might take to completely close the high scenario gap (£31m) by considering two scenarios. The first scenario is one in which CIP and QIPP improvements alone are able to close the gap. The second is one in which a combination of CIP, QIPP and extensions to Care Design Group intervention assumptions.

In the **first scenario**, we include 40% of projected CIP and QIPP improvements, given that many of these align with proposed Care Design Group improvements, and so that we do not double count. In addition, past performance shows that approximately only between 47% and 76% of projected improvements are actually realised. In the first scenario we assume that 76% (of the included 40%) are realised to close the gap. This results in a positive net position of approximately £2m in 2017/18.

In the **second scenario**, we take 40% of the lower end of CIP and QIPP improvements realised (47%). To illustrate closure of the remaining gap, we project the benefits from extending the (high scenario) benefit assumptions for Proactive Interventions and Elective Referral Facilitation each by 5 percentage points. This results in a positive net position of approximately £2m in 2017/18.

Our baseline analysis had removed net non-recurrent funding. As such, if this is incorporated back in it could potentially improve the financial position even further. If CIP and QIPP initiatives are successful then there is a potential case for portions of this non-recurrent funding to become recurrent.





Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

Executive Summary

Implementation Critical Success Factors

In order to realise the benefits identified in this blueprint for the future model of care, there will be a number of critical success factors.

1. Clinical and Organisational Leadership with Executive sign up

- Leadership is the single biggest contributory factor to the success or failure of a complex change programme. In delivering high value care systems, it is essential. Everyone in the Health and Care economy needs to understand, believe in and support delivery of an integrated approach to care. This includes acute, community, mental health and social care providers, as well as health and social care commissioners and others such as housing associations and the voluntary sector.
- The only way to achieve real change is to build consensus around how care should be delivered. Established governance arrangements including the agreed Concordat between all key agencies will facilitate consensus agreement on the current sustainability and future blueprint to take forward for the implementation strategy.
- Developing effective networks will help to create sustainable services for the short, medium and long term. Focusing on the opportunities afforded by multi-disciplinary teams and primary care working together to promote prevention and self management, risk stratification and proactive assessment, crisis co-ordination and planned care with seamless transfer between settings

2. Strong and Deliberative Engagement

- Design services for people from the ground up – with meaningful engagement of patients, service users and their carers through a representative body. HealthWatch Lincolnshire are members of the LSSR Programme Board and the Care Design Process has included Lincolnshire Carers & Young Carers Partnership Ltd in addition to HealthWatch Lincolnshire
- Engagement with the public will be key for outlining the benefits of the LSSR, reducing the risk of opposition to the programme.
- Access to local teams and key stakeholders to help drive the programme forward, validate information and co-design the future blueprint.
- Consideration and interface with existing key initiatives and reviews both within and outside of Lincolnshire County (notably to include Commissioner-led reviews at Peterborough and Stamford NHSFT, Northern Lincolnshire and Goole NHSFT and Sherwood Forest Hospitals NHSFT) and impact on patient flows and on availability of services near our boundaries.

Executive Summary

Implementation Critical Success Factors

3. **Business Case & Benefits Lead Approach**
   - A key tool the system will use to underpin the change will be a robust detailed business case. This will enable the programme to be rigorous in it's pursuit of clinical outcomes and financial benefits. Further, a benefits management plan will be required, placing the target benefits of the programme at the centre of future work.
   - Avoid the risk of increasing complexity becoming a block to delivery. Simplify things – and allow the priorities to be the focus rather than get lost in detail liberating care professionals to do what they do best – provide the best care for their patients and citizens.
4. **Programme Management & PMO**
   - Rigorous programme management is essential to make sure that there is robust implementation plan, a delivery team is in place and that the change is effectively governed to enable decisions to be documented and risks and issues to be managed appropriately.
5. **An Integrated Delivery Team**
   - Resources in the delivery team may include representation from the major stakeholder groups, programme management, design, clinical leadership, IM&T, estates and workforce transformation.
6. **Innovative Finance and Contracting**
   - The system will consider how the key commissioners i.e. Clinical Commissioning Groups (CCGs) and NHS England (Leicestershire & Lincolnshire Area) can use contracting mechanisms to promote provider collaboration considering shared incentives to allow a more cost effective integrated delivery model that drives value for money and improved clinical and care outcomes. Joint Commissioning is key as is exploration of "one budget one service". National contracts will impact on the programme and changing working practices for GPs and the GP contract should be given due consideration
7. **Timely access to Data and Systems**
   - Sharing of data required for analysis to establish sustainability of existing services and to model future assumptions.
   - All of the interventions proposed in the blueprint require technology enablement. Implementing systems in line with the delivery plan and providing access to robust information will be critical for achieving outcomes and delivering financial benefits.

Executive Summary

Enablers for Change

IM&T

In order to enable the changes set out in the future model of care, information management and technology (IM&T) infrastructure will need to be addressed. The requirements for this will be:

- Information governance systems that allow better linkages between health and social care
- A single, coordinated point of access to services, across the appropriate channels;
- Access to comprehensive patient / service user information to allow informed decision making;
- Ability to record all actions taken and share this information with other professionals;
- Ability to provide appropriate urgent response quickly and effectively for both medical and social care episodes;
- Effective identification of candidates for early discharge processes to accelerate their discharge to a community setting;
- Ability to provide appropriate community medical and social care services and measure their effectiveness; and
- Access to appropriate risk stratification tools to support targeting of services.

Finance and contracting

Another key tool for enabling the changes set out in this blueprint will be an effective finance and contracting model. The contracting mechanism needs to promote provider collaboration to allow a more cost effective integrated delivery model that drives value for money and improved clinical outcomes. Example models presented in the report for consideration in the next phase of work include:

- The Prime-Contractor model – CCG or a Joint Commissioning body holds the commissioning contract with the Prime Contractor;
- The Joint Venture (JV) – Commissioning management board holds the commissioning contract with the Joint Venture Provider; and
- The Alliance Contract – All parties would share the Alliance agreement, with common objectives and outputs.
- The options appraisal for the preferred contracting model should be undertaken as part of Phase 2 of the LSSR.

Estates

- It is acknowledged that a significant amount of Lincolnshire's estate is in poor condition or unfit for its current purpose with significant cost implications assigned to maintenance backlog (not quantified during Phase 1);
- Models of care remain largely designed around buildings
- Consideration must be given in Phase 2 to how innovative estates management within Lincolnshire's health and social care economy can facilitate fundamental change, help to improve efficiency, move more care out of hospitals and exploit new technologies.

Executive Summary

Enablers for Change

Workforce

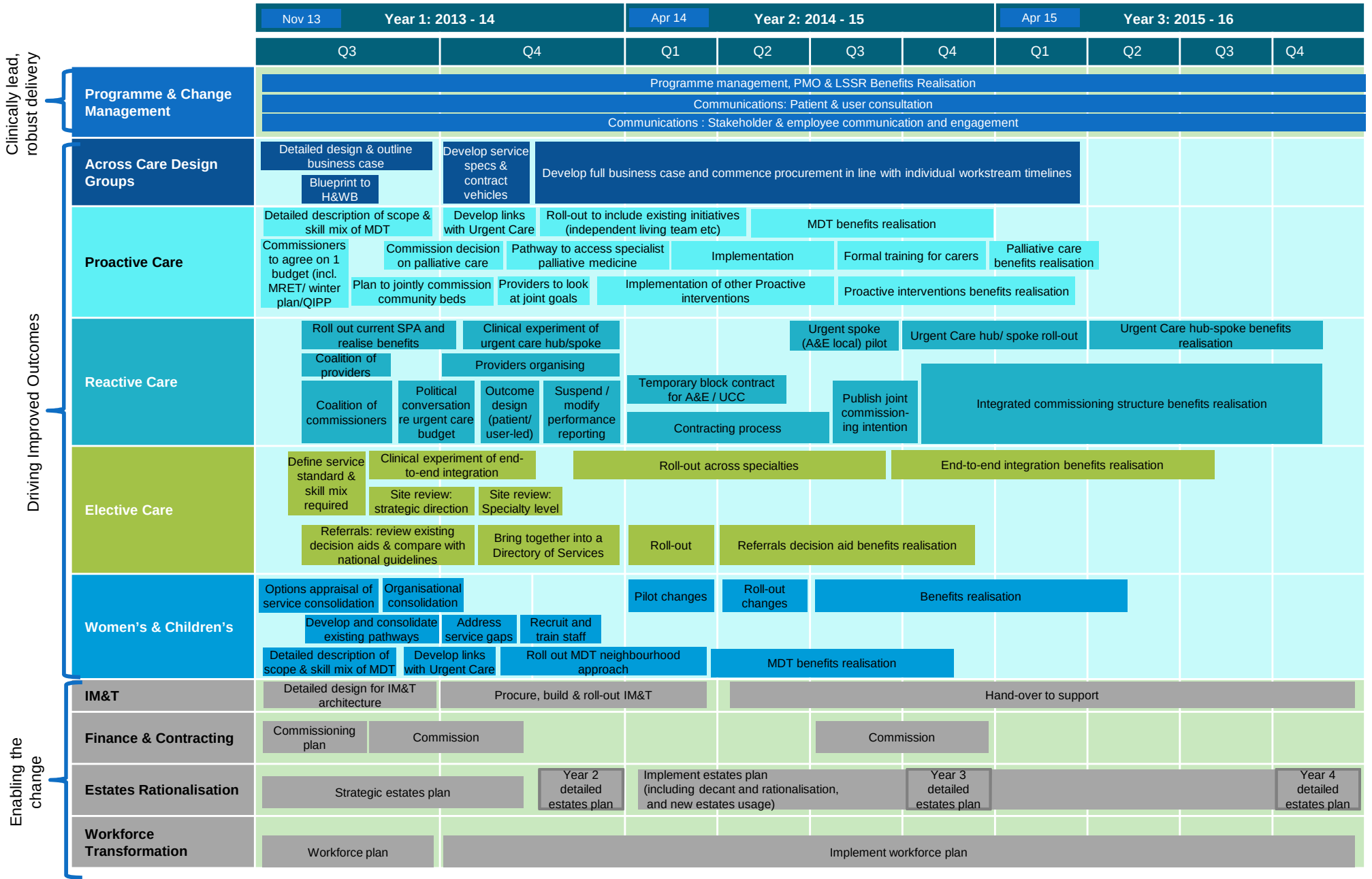
Sustained investment in staff, skills needed to innovate and supporting staff to do so is critical to the success of a sustainable future model of care. This will require a system wide workforce model which delivers optimum capacity, capability and flexibility, as well as maximising workforce efficiency and value for money.

Lincolnshire will need to address a number of key challenges , issues and opportunities for the development of future services, including:

- The 'big supply challenge' – inability to recruit adequate numbers of skilled and talented clinical staff, particularly medical staff and GP's, this is reflected in high temporary and locum expenditure;
- Optimising the deployment and utilisation of workforce capacity – productivity measures and metrics used highlight the opportunity to increase efficiency and associated "Return On Investment" across a range of staff groups based on the existing staffing models across Lincolnshire;
- Implementing new ways of working – traditional roles currently dominate the provider landscape, new roles and ways of working will be essential to enabling system transformation.
- This work stream will play a significant part in all future phases of work to co-develop detailed design and delivery of this blueprint.

Implementation Plan

Note: Individual work streams will be coordinated to ensure that they link to develop the detailed design for the whole system Future Model of Care



SECTION 2
LSSR Background and Approach

This section defines the context of the programme. It contains the programme background and objectives, the approach taken to undertake the programme, along with governance arrangements.

LSSR Background and Approach

LSSR Background

Lincolnshire Health and Care economy faces a number of complex challenges, particularly a fast growing ageing population, increasing expectations from patients; users, carers and the wider community, and great pressure to meet growing clinical standards and better outcomes for patients. Financial imbalances across the Lincolnshire economy already make it difficult to deliver services as desired and national budgetary pressures will make this increasingly difficult. These challenges need to be tackled and require a collaborative programme approach to the co-design of sustainable services for Lincolnshire citizens both now and in to the future.

For these reasons, the Lincolnshire Health and Care economy has embarked on a Sustainable Services Review (LSSR) in the county, covering health and social care. This is driven by a need to ensure that the quality and safety of services is maintained, that the substantial (but ultimately finite) resources are put to best use for our population, and that integrated services based on sound evidence and making best use of our skilled professionals are sustainable in the long term.

The constituent organisations have agreed to be driven by what delivers the best outcomes for the population of Lincolnshire, and the best value to the health and social care system as whole, rather than the impact on individual constituent organisations. This is a once in a generation chance to make the strategic changes required for long term sustainable services. Designing services around the patient / citizen / user creates opportunities for new innovative ways of delivering better outcomes and managing cost.

These organisations concurred that a sustainable health and social care system needs to deliver integrated, joined up services, investing more in early intervention and prevention on a long-term basis intervenes early where there is a case for doing so; maintains well-being and effectively reduces the need for more expensive, bricks-based or specialist services, in particular long term Social Care and Secondary healthcare.

The constituent organisations have tasked users and professionals across Lincolnshire to work together to co-design a proposed blueprint of a new model of care. This blueprint document presents the high level options that users and professionals have suggested through a collaborative effort. This blueprint document is the first phase in a longer process toward the delivery of a sustainable health and social care system in Lincolnshire.

The stakeholders involved in this Review are:

- Lincolnshire County Council
- Lincolnshire East CCG
- Lincolnshire West CCG
- South Lincolnshire CCG
- South West Lincolnshire CCG
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- NHS England (Leicestershire and Lincolnshire Area)
- East Midlands Ambulance Service NHS Trust
- HealthWatch Lincolnshire

LSSR Background and Approach

LSSR Background

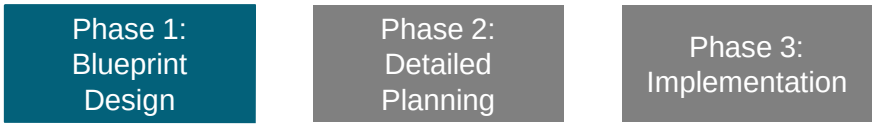
During the development of programme governance arrangements a number of key **themes** were identified:

1. For service users : we will create an experience of a health and care system that works in a joined up way, a system that focuses on the prevention of ill health and improves clinical and personal outcomes and goals.
2. For health and social care professionals: we will create a culture where a sense of collective responsibility exists for the whole journey through the system.
3. For health and social care providers: we will create a common vision where the needs of service users transcends the need to protect organisational form.
4. For commissioners: we will create a more productive and sustainable future for the health and social care system in Lincolnshire.

It was agreed that the main **objectives** of the Lincolnshire Sustainable Services Review were to:

- Critically review and assess the clinical operational and financial performance of the current Health and Social Care systems in Lincolnshire and comparison to what is known to be good practice in high performing systems.
- Identify specific service areas where there is a clear lack of clinical or financial critical mass due to scale or geography.
- Identify opportunities to make significant, quality and efficiency gains by the development and implementation of a whole system change programme.
- Develop a Health and Social Care service Blueprint with key milestones – based upon a process of discovery as opposed to a single and fixed solution for the future.
- Develop the likely footprint of services and patient and service user's flows in the new system and what the best, worst and most likely scenarios might be following implementation.
- Build upon what is already in-train and what works e.g. the Adult social Care Blueprint, the development of an intermediate care specification.

The programme of work involves **three** distinct **phases**.



Phase 1: Blueprint Design – this phase focuses on mobilising the programme team, understanding the current health and social care economy and services, and developing initial high level future design options as well as a roadmap for change.

Phase 2: Detailed Planning – this phase builds more detail into the design options identified in Phase 1 prior to implementation of the design options

Phase 3: Implementation – this phase involves the actual implementation of the detailed design options and the existence of the planned future sustainable health economy

This report focuses on Phase 1 of the programme carried out between July and October 2013.

LSSR Background and Approach

LSSR Phase 1 Objectives

At the outset, it was key that the organisations involved identified the overarching objectives of Phase 1 of the programme. These were established as the following:

- Critical review and assessment of the clinical operational and financial performance of the current Health and Social Care systems in Lincolnshire and comparison to what is known to be good practice in high performing systems.
- Development of a Health and Social Care service Blueprint with key milestones – based upon a process of discovery as opposed to a single and fixed solution for the future.
- Development of a change strategy incorporating an implementation plan.
- Assess the impact of proposed changes
- Build upon what is already in-train and what works.

Design Principles

Prior to undertaking any design work it was key that a set of overarching design principles were put in place that would guide the development of any design options and ultimately the blueprint. The design principles were agreed upon by the care design groups (comprised of health and social care professionals, voluntary sector and designated patient representatives). The principles are identified below:

1. Prevent illness or crises where possible – and transfer resources (people, physical assets and finance) from reactive services to support this;
2. Shift care into closer-to-home / better value care settings where appropriate;
3. Only provide services where there is the critical mass / volumes for the services to be delivering high outcomes and be economical; but also repatriate activity from out of area / private provision where this delivers better outcomes;
4. Optimise the use of fixed costs such as estates with locally required activity – including acute, community, private and non-healthcare;
5. Provide single points of access for patient, and integrated provision of services (which may require single management control); and
6. Using all of this to enable the system to cope with growing demand within expected resource constraints.

LSSR Background and Approach

LSSR Phase 1 Approach

In order to successfully carry out Phase 1 of the programme a four stage approach was created (see below). This approach helped guide the team right through from establishing a common vision for the programme and engaging with stakeholders to the development of the blueprint for the health economy and an associated roadmap.

1 Mobilisation & Visioning

July 15th – August 7th

This stage was used to:

- Mobilise the Lincolnshire and PwC delivery team.
- Put in place the Phase 1 governance, programme plan, and PMO.
- Engage specific stakeholder groups (e.g. CCG, Acute, Local Authority etc)
- Establish a common vision, strategic objectives and design principles
- Establish any constraints for the Lincolnshire health and social care economy

2 Current Position

August 10th - September 20th

This stage was used to:

- Establish a common baseline for the health and social care economy, including:
- The existing services delivered and providers of these services
- Qualitative and quantitative analysis on:
  I. The quality of services delivered
  II. The financial viability of services delivered
- Identification of programmes of work underway in the health and social care economy

3 Care Design

September 9th - October 11th

This stage was used to:

- Engage clinicians, care practitioners and patients in care design groups to design the clinical blueprint for future service delivery.
- Produce the Blueprint for the physical health system of the future
- Produce analysis to demonstrate what this means for acute and out of hospital services and the providers of those services

4 Blueprint Development

October 11th - November 4th

This stage will be used to:

- Summarise the proposed interventions to the health and social care economy in a case for change document, including indicative costs and benefits of the changes.
- Produce a roadmap defining how Lincolnshire will undertake this transformation

LSSR Background and Approach

LSSR Phase 1 Summary Delivery Plan

During 'Mobilisation & Visioning' the programme approach developed into a detailed programme plan, with three workstreams identified (as below):

1. **Programme Management** – Focused on supporting programme leadership of SRO and Programme Director, co-ordination of the Programme's Projects and management of their inter-dependencies including oversight of any risks and issues arising. Lincolnshire County Council provided some support on the logistics of the Care Design Groups, while GEM coordinated some of the external communication.
2. **Care Design –** Responsible for the organisation of meetings and the care design groups, development of material in advance of the workshop, presenting potential design options, a case for change, and an implementation roadmap for the Lincolnshire economy.
3. **Analytics –** Charged with gathering and modelling quantitative data to develop a current position report on the current services in Lincolnshire. The workstream was also responsible to develop a high-level modelling analysis on the impacts of the design options proposed by the care design groups

The detailed programme plan, identifying the main activities carried out by each workstream can be found on the next page of this report.

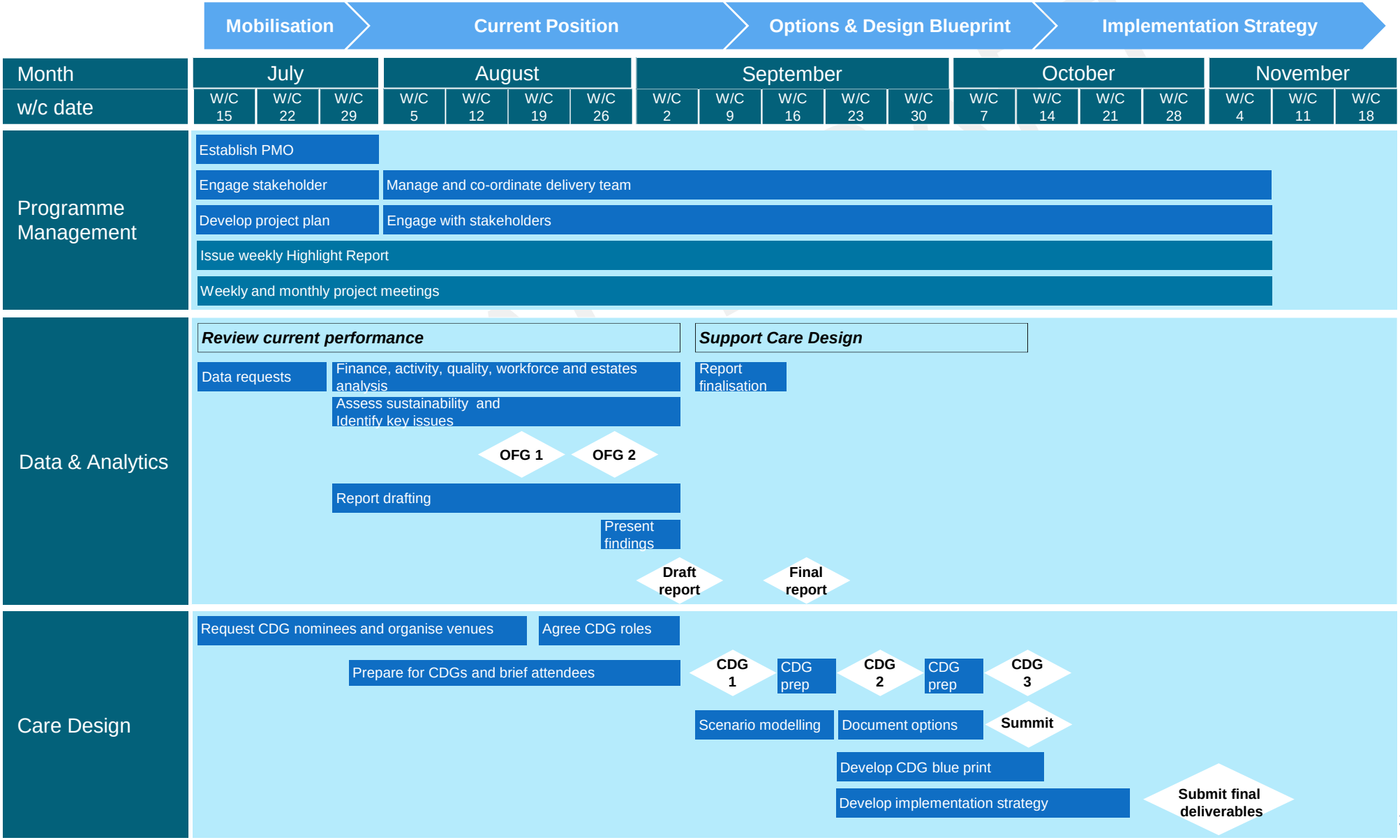
In order to deliver this programme, the organisations involved brought in support from PwC Consulting. Colleagues from PwC have been working alongside and under the direction of the Senior Responsible Owner (SRO), Dr Tony Hill, Director of Public Health for Lincolnshire and Mrs Annette Laban, Programme Director. The PwC team has led the work for each workstream, gaining approval of key decisions and receiving required information from the nominated organisation leads.

The PwC team, through the Programme Management workstream, has met on a weekly basis to discuss progress, resolve any issues and get approval of key decisions. The team has reported on a monthly basis to the Lincolnshire sustainable Services Review Programme Board (LSSR PB), comprised of representatives from each of the organisations. The board has been involved on a regular basis, asked to take key decisions, review progress updates and resolve any escalated issues. interest parties.

	Lincs Core Team		
	PwC Team		
Programme Governance	Health & Wellbeing Board		
	Lincolnshire Sustainable Services Review Board (LSSRPB)		
	Monthly LSSR PB meetings		
	LSSR Weekly Calls		
Programme Sponsorship	**Chair** Dr Tony Hill	**Programme Director** Mrs Annette Laban	**PwC Engagement Partner** Dr Tim Wilson
Programme Team	**Programme Lead** Rose Taylor	**PwC Clinical Lead** Dr Jonathan Steel	**PwC Engagement Director** Tom Hampshire
	PwC Data & Analytics Leads Oliver Senter Jason Calvert	**PwC Care Design Lead** May Mengyu Li	**PwC SMEs** Dr Linda Hutchinson, Dr Alexander Mayor
	PwC Team Members Dr Kuangyi Liu, Santiago Santandrea, Preithy Kumar		

LSSR Background and Approach

LSSR Phase 1 Summary Delivery Plan



LSSR Background and Approach

LSSR Phase 1 Stakeholder Engagement

The constituent organisations tasked users and professionals across Lincolnshire to work together to co-design how services will be delivered in the future. Responsibility for engagement was driven by the Programme Management and Care Design workstream.

As shown in the tables below, over eighty individuals have been involved in the co-design by taking part to three workshops, providing their inputs and sharing their expertise and insights on health and care services.

Attendees from each workshop included local clinicians, care professionals, voluntary sector representatives as well as designated patient representatives to design a blueprint for future service delivery.

Care Design Group (CDG) Care Category	CDG1 (11th-12th Sept)	CDG2 (25th-26th Sept)	CDG3 (10th Oct)	Care Summit (10th Oct)
Proactive	22	24	21	194
Urgent Care	23	17	16	
Elective Care	17	13	10	
Women's and Children's Care	22	21	21	

During the 'Mobilisation & Visioning' stage, it was agreed that the programme would consider health and care services by grouping them into four categories, as outlined below. This partition provided a useful framework to consider the sustainability of health and care services, facilitating the right level of depth and detail in the discussions.

The analysis of the current position of the health and care economy and the three workshops undertaken as part of the Care Design process all look at health and care services under these four categories.

- **Proactive ideas**
- **Urgent Care (Reactive)**
- **Elective Care**
- **Women's & Children's**

The Care Design phase involved a group of users and professionals for each care category. These four groups focused on the design of future service provision for those services falling within the definition of their own category.

As in many taxonomies, there is a certain degree of overlap across certain categories, since some services fall within more than one category of care. To address this, Care Design Groups were given insights at the beginning of each workshop on the progress the other groups were making in their areas. This communication across Care Design Groups made possible to reach the right depth of discussion at this stage for each care category, while maintaining a vision of the system as a whole.

For a description of the services falling within each care category please refer to Appendix 1.

SECTION 3
The Current Model of Care

This section provides an overview of the current position of the Lincolnshire health and social care economy. It also provides more specific detail on the current delivery of services for each of the four categories of care.

The Current Model of Care

Background

In order to design the services of the future in an informed way, it was important that a common and objective view of current services was agreed upon. So, a health and Social Care current position report was developed. This report was presented to and signed off by the LSSR Programme Board in September and has been used by the Care Design Group to inform decision making on future service design, assess the impact of changes, and to ensure that key measures of quality, safety and value are all improved.

The objectives of this Current Position Report were to:

- Create a common and collective high level view of how services are currently operating, their effectiveness and their efficiency
- Provide health and social care professionals, along with patients, managers and others, enough information to make evidence-based decisions on service configuration both now and in the future to support sustainable services for Lincolnshire
- Enable the impact of any changes to the way services are delivered to be assessed and understood
- The current configuration of health and social care services for Lincolnshire is already unaffordable (overspending by over £20 million) and not delivering the best outcomes with significant quality concerns in some areas

Key messages from the analysis

- The Keogh review identified some key areas of concern over the quality and safety of some services. In addition, there is evidence:
  - from patients and service users of services being fragmented (Pioneer Bid)
  - that service models do not reflect published clinical evidence that some elements of care can be better provided closer to home
  - that workforce structure, IM&T, incentive arrangements and other factors are not supporting transformational change
  - that workforce is not sufficient and does not appear to be likely to be sufficient with the current configuration of services with GP workforce being a good example
- All four Lincolnshire CCGs have above average disease prevalence for the majority of the disease categories investigated.
- The impact of growth in demand for services (growth in the elderly population and children) outstripping growth in funding means that if current services were continued, the health and social care system would have an annual overspend of just over £105 million in five years' time
- Within Lincolnshire there are some examples of ways of delivering services, which are more appropriate and successful than others
- A radical and innovative approach is needed to develop sustainable solutions given the scale of the challenge
- There are clearly particular patient outcome challenges in Reactive care. These were identified in the Keogh Review and also by the analysis of mortality indicators in this report

Lincolnshire Health and Social Care Overview

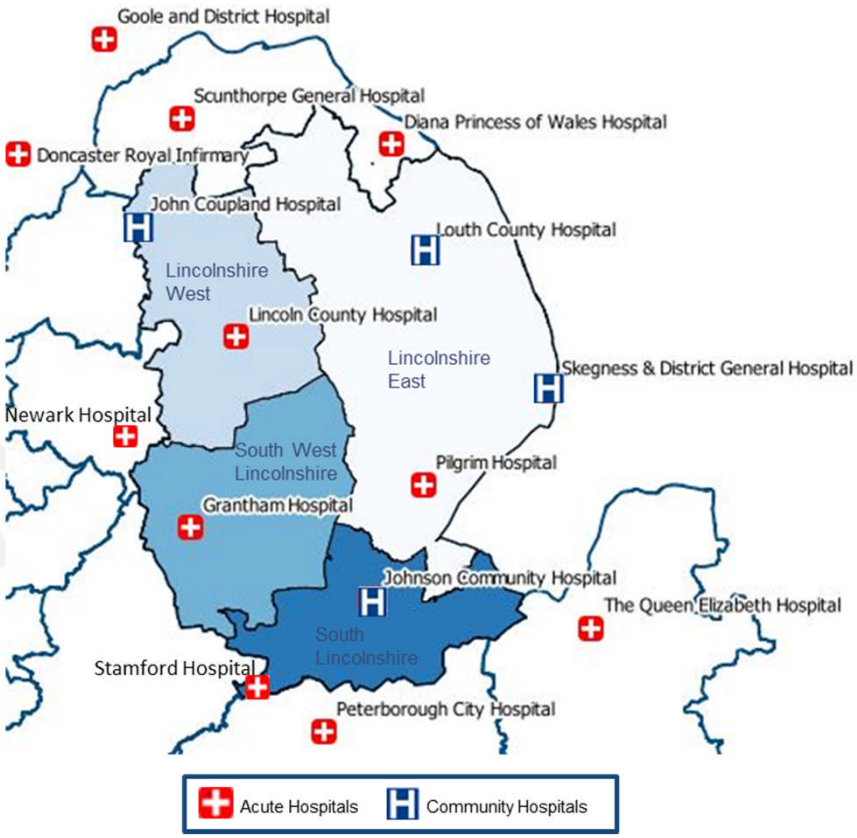
The map on the right shows the county of Lincolnshire and its main health and social care providers. The shaded areas are the CCGs of relevance for this report. There are over 715,000 people living in the four CCG areas, equating to almost half of the overall Lincolnshire county population of 1.4m inhabitants.

Primary Care Services Provision:

Lincolnshire has 5.7 GPs and 4.8 GP practice nurses per 10,000 people. There are 101 main GP practices across Lincolnshire with 30 in Lincolnshire East, 37 in Lincolnshire West, 19 in South West Lincolnshire and 15 in South Lincolnshire. The primary care budget in FY 2012-13 was equal to £111m.

Acute Services Provision:

The main acute provider in Lincolnshire is United Lincolnshire Hospitals NHS Trust, with sites in Lincoln, Boston and Grantham. The Trust's income for FY2012-13 was equal to £422.8m and it offers over 1,300 beds. Lincoln Hospital is the largest hospital, with over 88,000 inpatients and 65,000 emergency cases last year.



Community Care Services Provision:

The community provider, Lincolnshire Community Health Services NHS Trust, runs John Coupland Hospital in Gainsborough, Skegness and District General Hospital, Johnson Community Hospital in Spalding and County Hospital Louth. In FY 2012-13 the Trust's income totalled £107.7m and offered 155 beds.

Social Care Services Provision:

Adult Social Care Services are mainly provided by Lincolnshire County Council. In FY2012-13 £132.8m were spent on the provision of adult social care and the Council supported 3, 992 people in residential and nursing care.

Mental Care Services Provision:

Lincolnshire Partnership Foundation Trust provides mental care services, with 256 beds across hospitals and placements in the county. In FY2012-13 it recorded an income of £102m and registered 314,000 community contacts and 24,318 IAPT referrals.

The Current Model of Care

Lincolnshire Already Has High Disease Prevalence and an Older Population

We analysed the prevalence of long term conditions in Lincolnshire and profiled local demographics. All four Lincolnshire CCGs have above average disease prevalence for the majority of the disease categories investigated. In part this is due to the characteristics of the local population, which is significantly older than the England average. The high disease prevalence creates a burden on the health and social care economy.

Disease prevalence relative to all CCGs

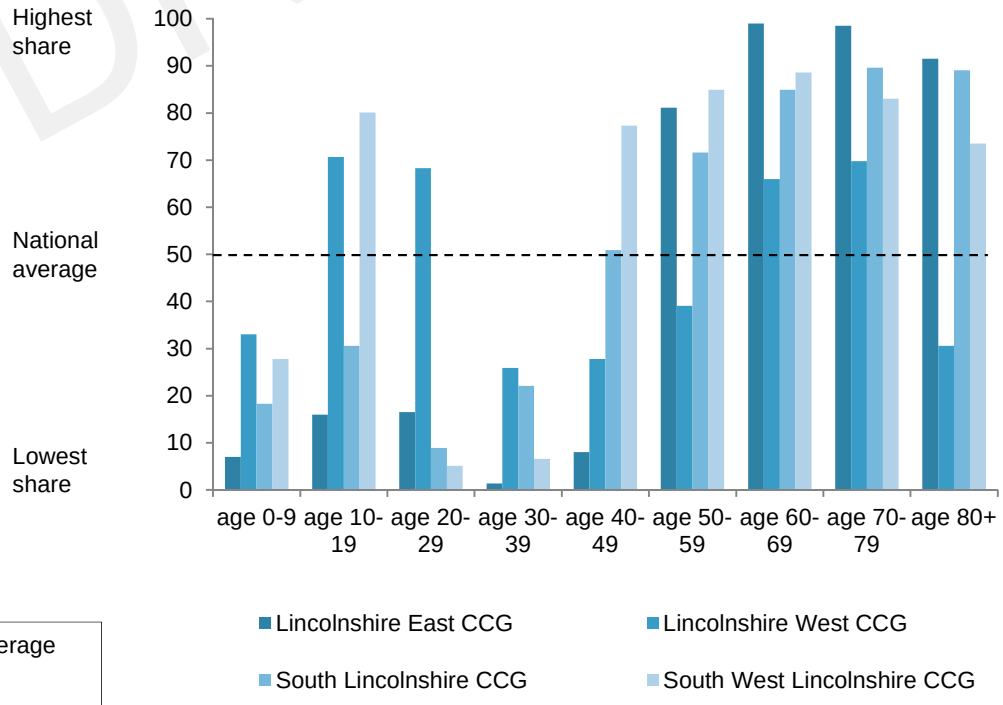
Disease	East CCG	South CCG	South West CCG	West CCG
Asthma	Average	Average	Average	Average
Atrial Fibrillation	Above average	Above average	Average	Average
Cancer	Above average	Above average	Above average	Average
Cardiovascular Disease Primary Prevention	Below average	Above average	Above average	Below average
Chronic Kidney Disease (ages 18+)	Above average	Above average	Above average	Above average
Chronic Obstructive Pulmonary Disease	Above average	Average	Average	Average
Coronary Heart Disease	Above average	Average	Above average	Average
Dementia	Average	Above average	Average	Above average
Depression (ages 18+)	Average	Above average	Average	Average
Diabetes Mellitus (Diabetes) (ages 17+)	Above average	Above average	Average	Average
Epilepsy (ages 18+)	Above average	Average	Average	Average
Heart Failure (2010)	Above average	Above average	Above average	Average
Heart Failure Due to LVD	Above average	Average	Above average	Average
Hypertension	Above average	Above average	Above average	Average
Hypothyroidism	Above average	Above average	Average	Average
Learning Disabilities (ages 18+)	Above average	Average	Average	Average
Mental Health	Below average	Below average	Below average	Average
Obesity (ages 16+)	Above average	Average	Above average	Above average
Palliative Care	Above average	Average	Average	Above average
Stroke or Transient Ischaemic Attacks (TIA)	Above average	Average	Average	Average

Below average
Average
Above average

Source: Quality and Outcomes Framework accessed via NHS England CCG Outcomes tool.

Share of population by age group, compared to national average

(percentiles related to all other CCGs)



Source: NHS England CCG Outcomes tool.

The Current Model of Care

The Keogh Review Highlighted Important Quality Concerns

In February 2013, a review into the quality of care and treatment provided by ULHT was requested due to its persistently high mortality rates. Mortality rates above the expected range were recorded in critical care medicine, general medicine and thoracic medicine. Of the nine "Key Lines of Enquiry" chosen for further investigation, two are particularly relevant to Reactive Care:

Urgent care

The focus on the urgent care pathway of ULHT was identified after a review of A&E operational effectiveness. Through observations, interviews, focus groups and documentation review, the processes and effectiveness of the urgent care pathway were assessed by a panel. Their findings were as follows:

Areas of good practice	Areas of concern
GP support within the Grantham A&E department	Patients seen, discharged or admitted in 4 hours is below 95%
The engagement and support of nursing staff	Good practice is not routinely shared between the three sites
The competency assessment process for staff	Urgent care staffing remains challenging
The handover of the night team at Lincoln County Hospital	Clarification is needed of consultant reviews
	Escalation is left too late

The overall view of the panel was that there was not a systemic problem with A&E operational effectiveness or the urgent care pathway, and no immediate actions were therefore required.

Critical care and surgery

Critical care and surgery were identified as key lines of enquiry after critical medicine was identified as a outlier in terms of mortality rates. The panel focussed on how ULHT is responding to contributing factors such as deteriorating Early Warning Score (EWS) rates and shock cardiac arrest triggers. Their findings were as follows:

Areas of good practice	Areas of concern
Clear articulation of the Trust's 'track and trigger' early warning process	The panel observed a number of issues with the completion of DNAR forms
Outreach team and 'hospital at night' team	Lack of understanding why the critical care pathway was identified as an outlier
Surgical Emergency Assessment Unit triage and score all patients to prioritise and escalate	The Trust often has insufficient capacity in its High Dependency Units and Critical Care Units
	Patients in inappropriate clinical areas due to capacity issues

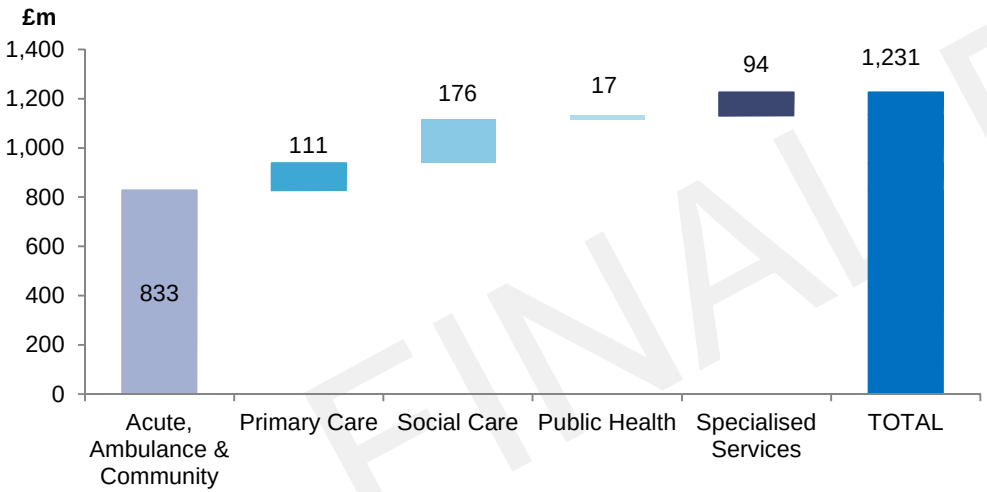
The panel also identified an urgent action for ULHT with regards to the completion of DNAR ('do not attempt resuscitation') forms, after concerns around the satisfactory completion of the forms were raised.

Lincolnshire Health and Social Care Overview

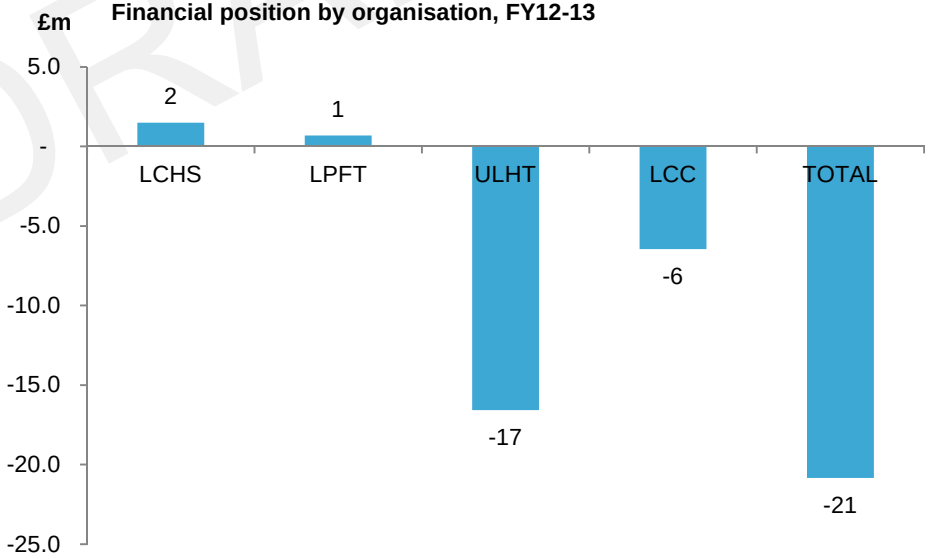
The Cost of Health and Social Care Services Provision was £1,230.9m in FY 12-13

The total cost of health and social care provision was £1,231m in FY12-13. Breaking down the deficit by organisation, ULHT had a net deficit of £16.6m (including net non-recurrent income of £16.85m). Lincolnshire County Council had a deficit of £6.4m in FY12-13, excluding the write-offs and non-recurrent funding for Adult Social Care.

Health and social care cost, FY12-13



Financial position by organisation, FY12-13



Notes:

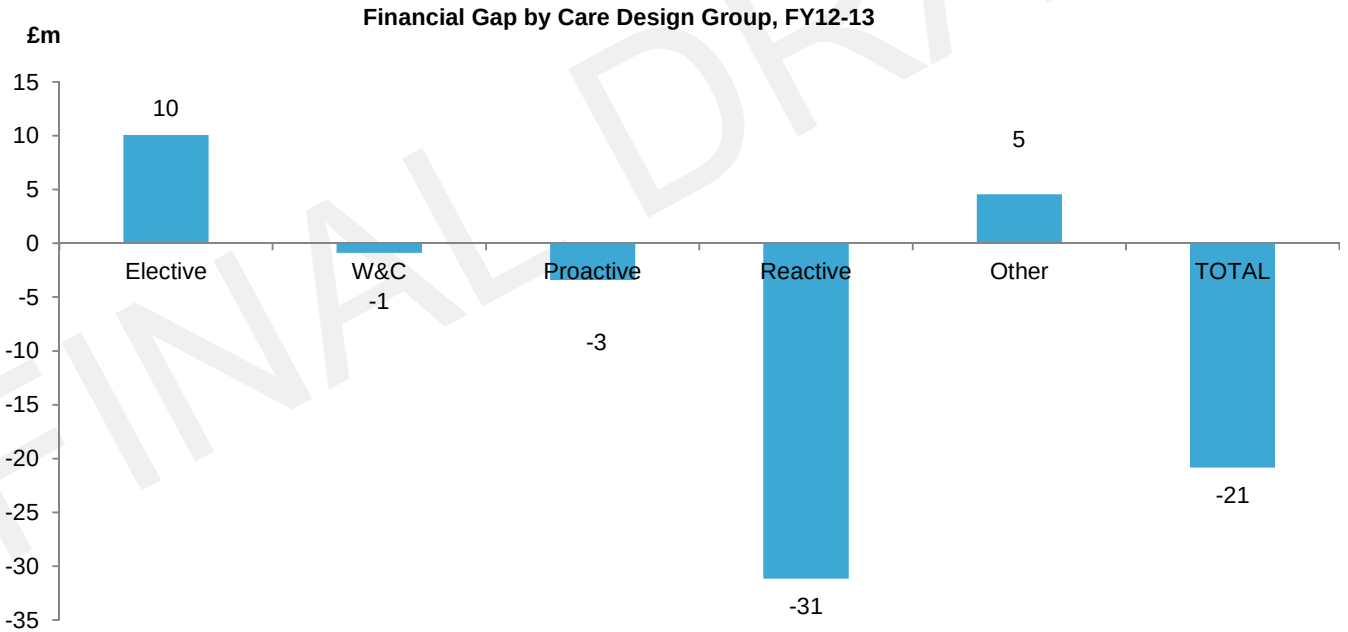
1. We have not adjusted for the provision of services to non-Lincolnshire patients.
2. We have taken ULHT's financial position to be as identified by KPMG in its 2013 Audit Highlights Memorandum
3. For LPFT, we have excluded non-recurrent income of £4.00m.
4. For primary care, we have assumed that the cost of provision is equal to the allocated funding because cost data is currently not available.
5. For non-Lincolnshire healthcare providers, the cost to the Lincolnshire health and care economy is the price paid for the services.
6. LCC is considered as a provider of social care in our financial analysis

Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

Lincolnshire Health and Social Care Overview

Demographic and Other Significant Pressures Contribute to the Financial Challenges in Lincolnshire

A financial analysis was carried out of service provision by Care Design Groups. In 2012-2013 Reactive care has the highest deficit of £31.2m, while Proactive is in deficit by £3.4m, and Women's & Children's is in deficit by £0.9m. Elective contributes a surplus of £10.1m. It is worth noting that the financial gap for Reactive care is a national issue as tariff funding may not reflect the true cost of provision. Finally, this analysis does not take into account the interdependencies between the Care Design Groups.



Notes:

1. The financial position for each trust is based on their Long Term Financial Model, FY12-13.
2. We further analysed Service Line Reports (SLR) FY12-13 to map income and expenditure to CDG.
3. The difference between the above two sources is grouped together with Dental and other services outside the CDGs as "Other Sources".

Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

Lincolnshire Health and Social Care Overview

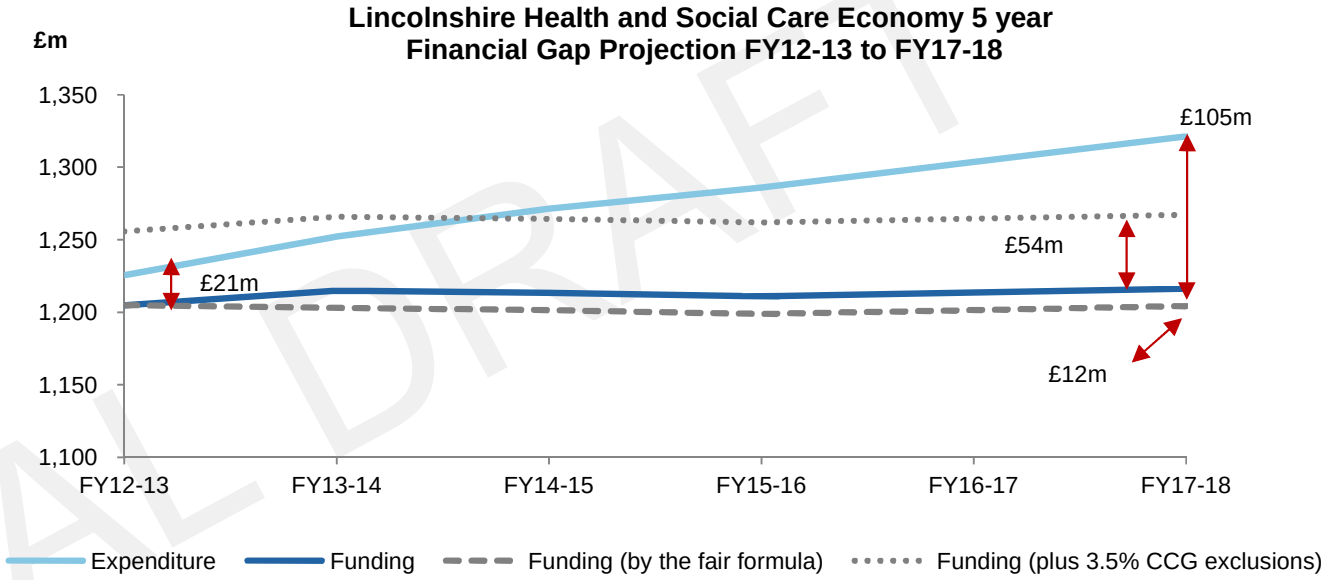
If Nothing is Done, The Financial Gap Could Grow To £105.1m by 2017-18

The recurrent funding gap of approximately £21m in FY2012-13 is projected to rise to over £100 million in FY17-18.

There is no rescue fund and only radical rearrangement of the way health and care are provided will achieve financial sustainability.

If NHS England pursues the "fair formula" for CCG allocations, the gap could widen by approximately a further £12m as 3 out of 4 Lincolnshire CCGs could receive lower allocations.

At present 3.5% of CCG funding is held back for non recurrent contingency (see notes point 9). If this was released in to recurrent funding streams for use within the care economy there would still be a financial gap of approximately £54m in FY17-18.



Notes:

1. The financial gap in FY12-13 was approximately £21m, which comprises of provider net surplus / deficit adjusted for net non-recurrent income, and the net deficit of LCC.
2. Healthcare funding is frozen in real terms for the next 5 years from FY13-14.
3. Healthcare expenditure increases in proportion to demographic change. 40% of cost is incurred from treating people aged 65 and older. The 65 and over population grows at 2.5% per year on average and the under 65 population grows at 0.7% per year on average (source: ONS forecasts).
4. CCGs share the PCT surplus from FY12-13 (little over £9m) in FY13-14. This is non-recurrent for FY13-14 and is hence excluded from our baseline.
5. Adult social care funding and expenditure is based on a 5 year forecast provided by LCC. Children's Social Care and Public Health funding and expenditure is assumed to be frozen and remain at breakeven,.
6. The long-term temporary population in Lincolnshire is usually excluded from population estimates used in the funding formula. If this population was included it has been estimated that an additional £22m funding may be provided.
7. In a different scenario (dotted line), the allocation to 3 out of 4 CCGs falls from FY13-14, based on the draft NHS England "fair formula".
8. Of the total CCG allocation, 96.5% of the allocation is available to spend on healthcare. 3.5% is required to be retained as headroom (2%), planned surplus (1%) and contingency plan (0.5%).
9. In our third scenario, this 3.5% is made available to the health and care economy. Even in this case, the financial gap would still be approximately £54m by FY17-18.

SECTION 3.1
Proactive Care – Current Position

This section provides a more detailed look at current services in Lincolnshire for Proactive Care, highlighting key challenges, programmes in-train and potential opportunities.

Proactive Care – Current Position

Key Findings

The Current Position Report presented the following findings that informed some of the discussion during the Care Design Group workshops:

Quality

- A well-functioning community care programme should enable older people to die at home when appropriate, with other common places of death being hospitals, care homes or hospices. Lincolnshire has above peer group deaths occurring at home. This might be a positive indicator of well functioning community provision, as the national average is 1% below Lincolnshire's. However, below peer group deaths are occurring in care homes and hospices, with more than expected deaths in hospital. This points to some further opportunity to review end of life care.
- There is significant variation in the number of emergency hip fractures, one indicator of effective proactive care, across Lincolnshire, with South Kesteven and South Holland outperforming the other districts. This does not appear to be correlated with demographics. Reducing hip fracture rates to the same rate as in South Kesteven could save £1.25m.
- Return to independence for older people through rehabilitation/intermediate care is above peer average, suggesting that some parts of proactive care are working well.

Provider landscape

- LCC is targeting significant efficiencies in adult social care. This may be challenging as our benchmarking analysis suggests that spend per adult on social care is already below peer average.
- LCHS, LPFT, GPs, Care Home and other social care provision are the main providers of Proactive Care.
- Lincolnshire GP practices are understaffed with doctors relative to peer average, although they have above peer average practice nurses. The analysis shows that Lincolnshire has 5.7 GPs per 10,000 people, the lowest out of the peer group analysed. On the other hand Lincolnshire does have 4.8 GP practice nurses per 10,000 people, which is above the England average and all but one of the peer group.
- Care homes represent a significant part of the provider base for Lincolnshire. Across the whole county of Lincolnshire in 2011-12 there were 421 care homes supplying 12,105 beds. Many of these are concentrated in the urban areas of Lincoln, Boston and Grantham.

Activity

- Disease prevalence across all CCGs is considerably higher than national average for nearly all LTCs. East Lincolnshire is in the top five percent of CCGs for disease prevalence for chronic kidney disease, coronary heart disease, diabetes mellitus, heart failure, hypertension and stroke.
- .This is expected to get worse as Lincolnshire ages rapidly. West and South West CCGs are ageing most rapidly in relative terms, while West and East CCGs are ageing most rapidly in absolute terms. POPPI forecasts have shown how these demographic changes may affect LTC prevalence, with some diseases increasing by more than 30% by 2020.

Proactive Care – Current Position

Demand for Health and Care is Expected to Increase as the Population Ages Rapidly Over the Years

Demographic analysis

We have analysed demographic trends in Lincolnshire which suggests that the West and South West of Lincolnshire are ageing most rapidly. We have highlighted the over 65 age band because this group is a significant user of health and social care.

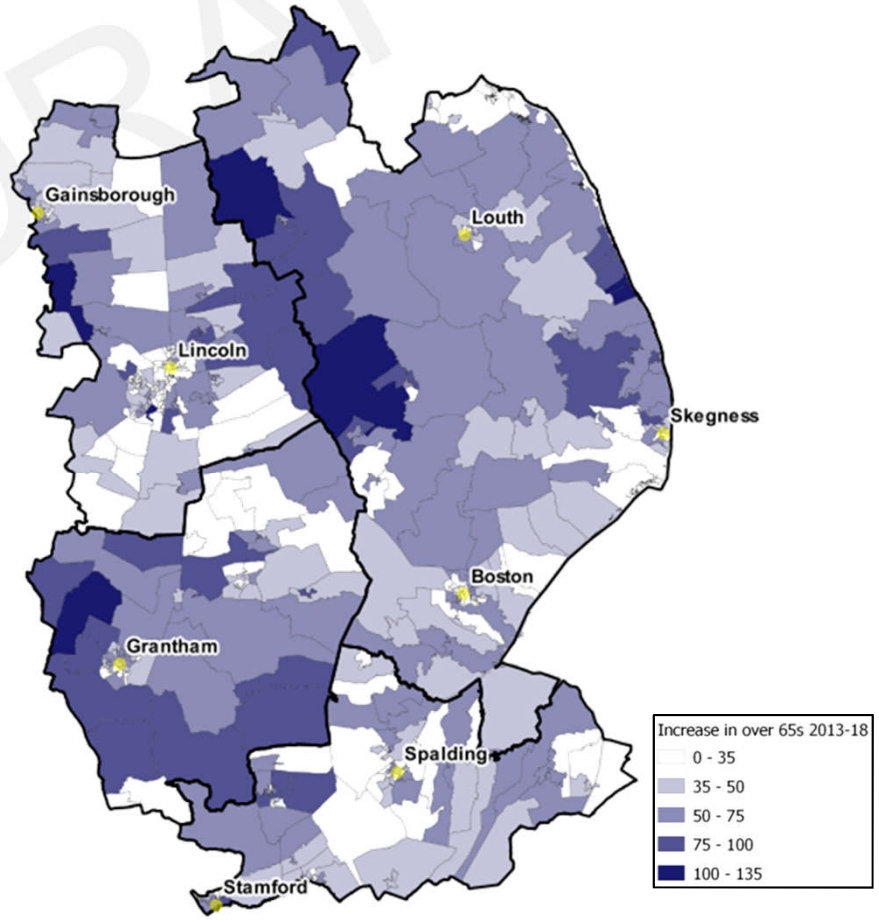
What this means for Lincolnshire

Although historically the population with the biggest health needs have been located in East Lincolnshire CCG, it appears that other CCGs are ageing more rapidly. East and West Lincolnshire are still expected to have the greatest number of over 65s in 2018.

Expected percentage increase in number of over 65s, 2013-2018

CCG	Projected increase in over 65s, 2013-18 (%)	Projected number of over 65s 2018
West Lincolnshire	12.59%	50,025
South West Lincolnshire	13.36%	29,391
South Lincolnshire	11.84%	35,611
East Lincolnshire	11.66%	65,909

Increase in over 65s, 2013-18



Source: ONS

Proactive Care – Current Position

Mental Health Patients Appear to be Proactively Managed with High Rates of Care Programme Approach Follow-Ups

Audiology

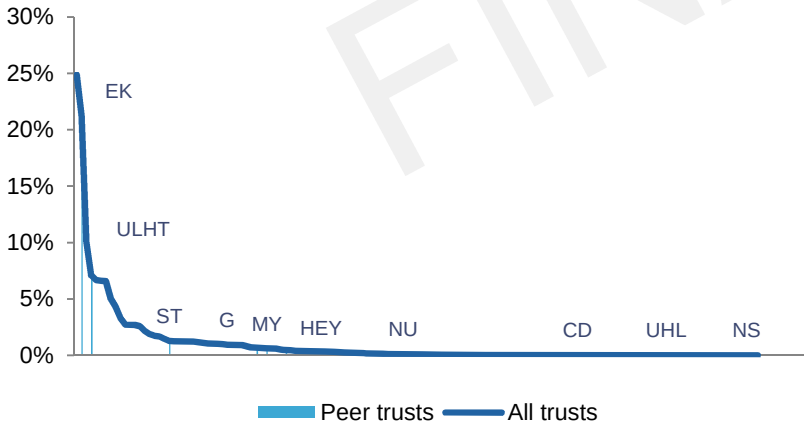
Direct Access audiology Referral to Treatment (RTT) times measure the elapsed time between an audiology patient being referred by a clinician, until the point in time a hearing aid is fitted or a clinical or patient decision is made to either refer or discontinue treatment.

At ULHT, 7% of audiology patients did not hit the national target of being treated within 18 weeks. This is a much greater proportion than the majority of its peers. ULHT has a median Referral to Treatment time of 12.8 weeks, compared to a national average of 4.6 weeks. Only four other NHS trusts had longer median RTT times.

Mental Health

Anyone experiencing mental health problems is entitled to an assessment of their needs with a mental healthcare professional, and to have a care plan that is regularly reviewed by that professional. It is best practice for patients on Care Programme Approach (CPA) to be followed up within 7 days after discharge from psychiatric inpatient care. The chart below shows the proportion of patients on CPA that were followed up within 7 days of discharge. 98% of Lincolnshire patients received a follow-up within 7 days.

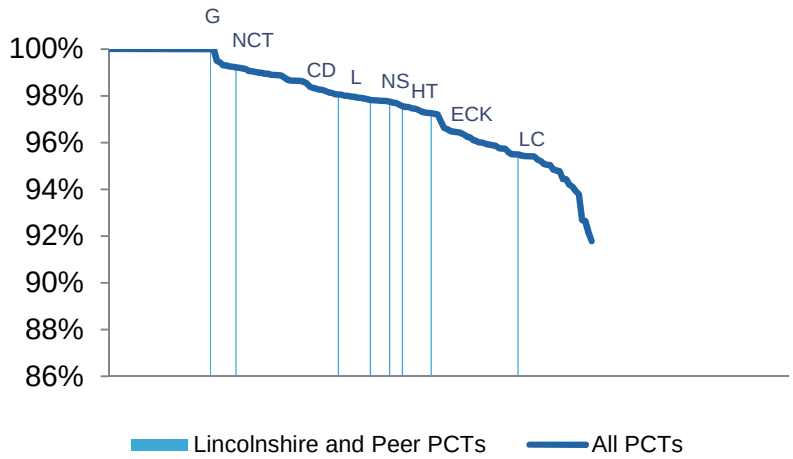
Percentage of audiology cases not treated within 18 weeks of being referred



Peers used (abbreviations in brackets):
Gloucestershire PCT (G)
Nottinghamshire County Teaching PCT (NCT)
County Durham PCT (CD)
Hull Teaching PCT (HT)
Lincolnshire Teaching PCT (L)
North Staffordshire PCT (NS)
Eastern and Coastal Kent PCT (ECK)
Leicestershire County and Rutland PCT (LC)

Source: NHS England Statistical Work, Direct Access Audiology, Jun 12-May 13

Proportion of patients on CPA that had a follow up within 7 days



Source: Health and Social Care Information Centre, Oct-Dec 2012

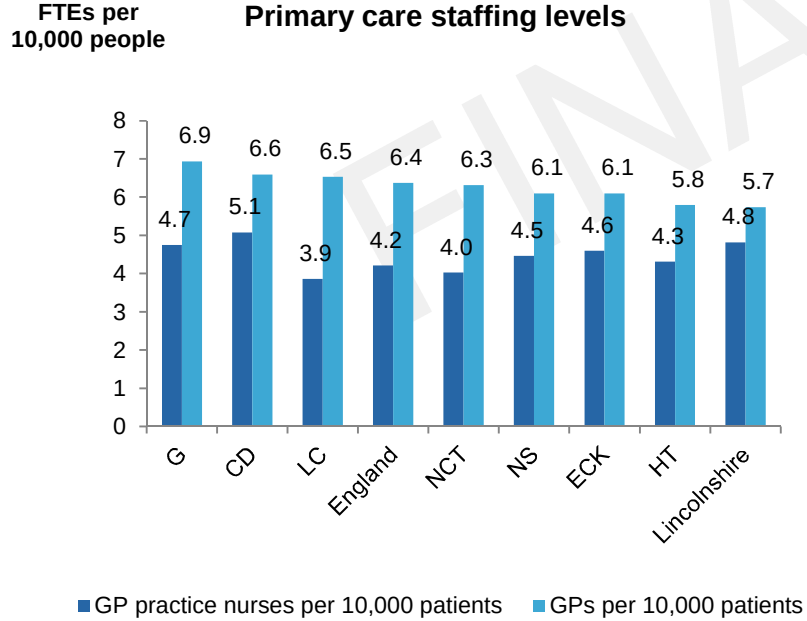
Proactive Care – Current Position

There Appears to be Below Peer Average GPs in Lincolnshire

We analysed primary care staff levels in terms of the number of GPs and GP practice nurses per 10,000 people. The analysis shows that Lincolnshire has 5.7 GPs per 10,000 people, the lowest out of the peer group analysed. On the other hand Lincolnshire does have 4.8 GP practice nurses per 10,000 people, which is above the England average and all but one of the peer group.

There are 101 main GP practices across Lincolnshire with 30 in Lincolnshire East, 37 in Lincolnshire West, 19 in South West Lincolnshire and 15 in South Lincolnshire. Lack of access to primary care is known to be a driver for high A&E attendances.

Primary care staffing levels



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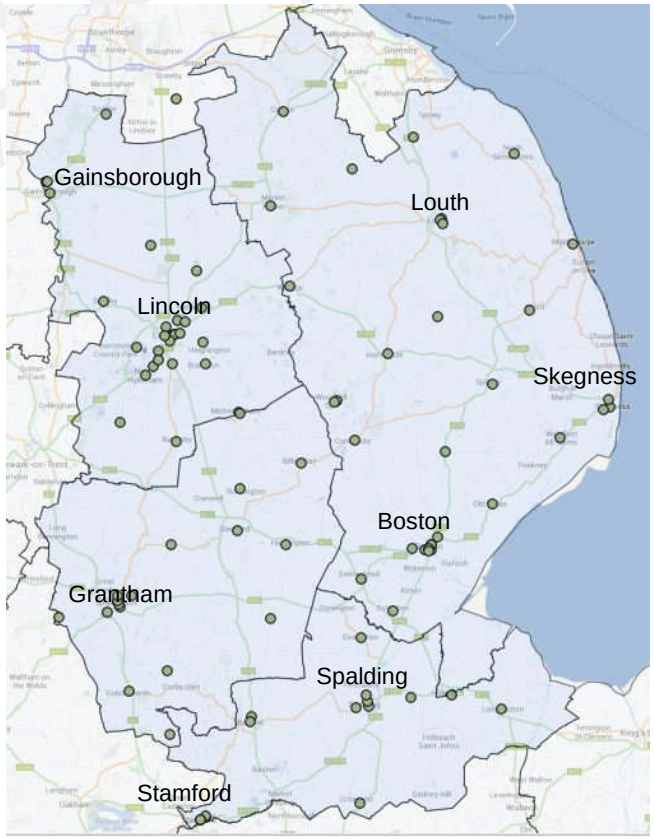
County Durham PCT (CD)
Hull Teaching PCT (HT)
Lincolnshire Teaching PCT (L)
North Staffordshire PCT (NS)
Eastern and Coastal Kent PCT (ECK)
Leicestershire County and Rutland PCT (LC)

Main GP practices in Lincolnshire

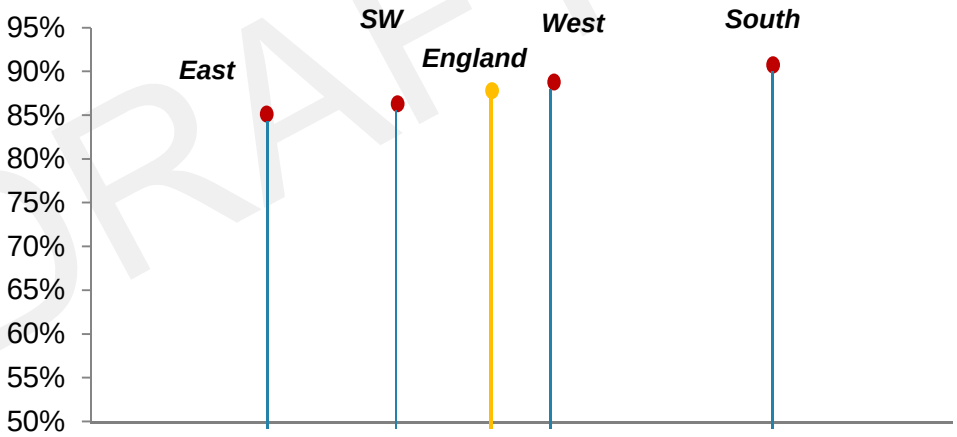


Source: Health & Social Care Information Centre, 2012

Proactive Care – Current Position

Primary Care Patient Experience is Above National Average on a Number of Metrics

Lincolnshire East performed below the national proportion in the ease of getting in touch with a GP surgery by phone, whereas South Lincs performed above it. South Lincolnshire scored above the national average for how long it took to receive out-of-hours service, as well as for confidence and trust in the clinician providing that service. Patient involvement in decision making was similar to national average for each CCG.



GP patient survey results, 2012-13

		Access to GP		Appointment	Waiting	Last visit	Out of Hours services			
	Response rates	Easy to phone GP surgery	Seeing preferred GP a lot of the time	Overall experience of making appointments	Waiting times were not too long	Patient involvement in decision making	Easy to phone GP in OOH	OOH service took right amount of time to receive	Confident and trusting in OHH clinician	Overall Experience of OOH services
England	35%	75%	63%	76%	59%	75%	79%	62%	81%	70%
Lincs East	48%	66%	55%	73%	63%	73%	74%	64%	80%	67%
Lincs West	41%	75%	68%	78%	66%	76%	82%	67%	85%	74%
Lincs SW	49%	75%	57%	76%	60%	74%	74%	67%	82%	66%
South Lincs	50%	79%	68%	81%	66%	75%	81%	71%	89%	76%

SECTION 3.2
Urgent Care – Current Position

This section provides a more detailed look at current services in Lincolnshire for Urgent care, highlighting key challenges, programmes in-train and potential opportunities.

Urgent Care – Current Position

Key Findings

The Current Position Report presented the following findings that informed some of the discussion during the Care Design Group workshops:

Quality

- EMAS are currently not delivering on national response and handover times. EMAS' response time for the Lincolnshire area is greater than the national target of 8 minutes, and so is the number of ambulance handover delays over 30 minutes (15% of ambulance handovers), significantly above national and peer average.
- As highlighted by the Keogh review, Urgent care provision in Lincolnshire presents an HSMR which indicates that mortality rates are much higher than expected given its case mix. Critical Care medicine, Thoracic medicine and General medicine have particularly high mortality statistics. Providers and commissioners are currently working together to address this issue.
- Across the ULHT sites, 20% of non-elective inpatients are discharged within 24 hours.

Provider Landscape

- A&E and critical care are currently provided on three sites. However, concerns about quality and staffing levels raised in the Keogh Review suggest that the current model is not optimal.
- There are also Urgent Care Centres (UCC) and Minor Injury Units (MIU) at six other sites in the County.
- There is a significant opportunity to review how urgent care management can be optimised within General Practice. There are a range of sites providing Reactive Care in Lincolnshire, which are located across the county. The distribution of attendances indicates that Lincolnshire patients predominantly rely on A&E departments for Reactive Care services.

Activity

- Activity benchmarking suggests that volumes are significantly above peer average, and reductions in activity levels could lead to commissioner efficiency improvements in cardiac surgery, respiratory system and digestive system volumes of up to £16.1m.

Potential options

- Reduce A&E provision to fewer sites.
- If Pilgrim A&E was closed, average patient travel times would increase by between 0 (MIU / UCC) and 23 minutes (A&E).
- If Grantham A&E was closed, average patient travel times would increase by between 25 (MIU / UCC) and 26 minutes (A&E).

Urgent Care – Current Position

Urgent Care Services Are Available Across the County, Including at a Number of Community Hospitals

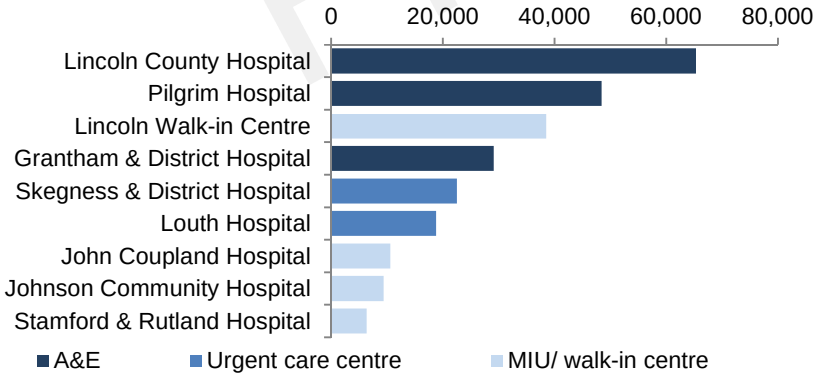
Reactive Care consists of urgent care, accident & emergency, non-elective inpatients (excluding maternity and children's), critical care and emergency transport, which are provided by either A&E departments, urgent care centres, walk-in centres, minor injuries units or ambulance trusts and General Practice.

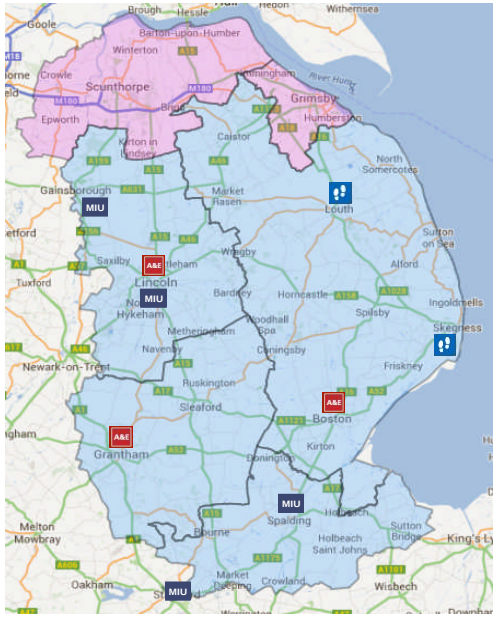
This report does not contain data to demonstrate the volume of urgent care consultation within general practice and this could be further reviewed during detailed design. For in hours General Practice clinical opinion would suggest that it is reasonable to assume that each GP sees approximately 10 of these patients per working day. Aggregated across Lincolnshire this points to approximately 900,000 urgent care consultations per year.

The two A&E departments in Lincolnshire are located in Boston and Lincoln. Grantham also provides A&E services, with the exception of emergency surgery and stroke services. The two urgent care centres are in Louth and Skegness, the latter of which was an A&E department before March 2012. John Coupland Hospital in Gainsborough, Johnson Community Hospital in Spalding and Stamford and Rutland Hospital have minor injuries units, and there is a Walk-in Centre in Lincoln.

There is a significant opportunity to review how urgent care management can be optimised within General Practice. There are a range of sites providing Reactive Care in Lincolnshire, which are located across the county. The distribution of attendances indicates that Lincolnshire patients predominantly rely on A&E departments for Reactive Care services.

Urgent care attendances 2012 / 13





A&E and critical care in Lincoln, Grantham & Boston

24hrs urgent care in Louth & Skegness

MIU in Gainsborough Spalding & Stamford and a walk-in centre in Lincoln

Source: Healthcare Evaluation Data, 2012-13

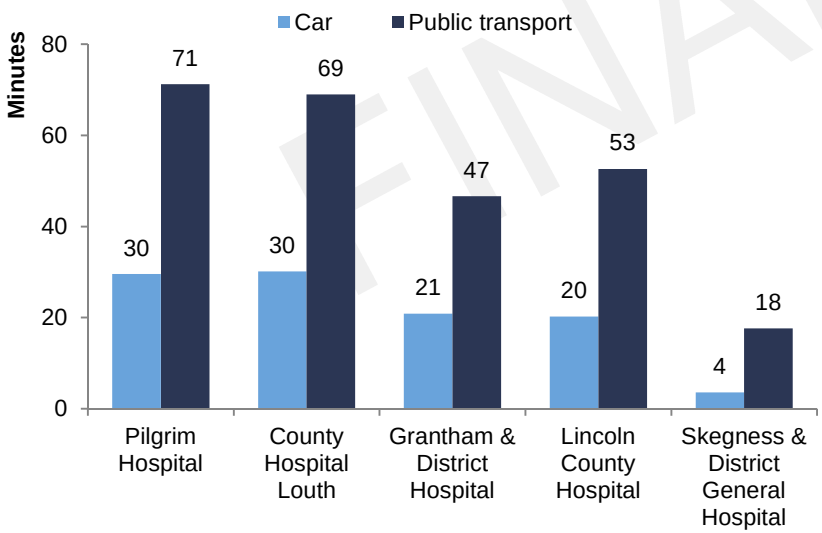
Urgent Care – Current Position

On Average, the Longest Travel Time for Reactive Care is to Pilgrim Hospital

The average Reactive Care travel time for Lincolnshire patients varies considerably depending on the destination hospital. The longest travel time is to Pilgrim Hospital, which takes approximately 30 minutes by car and 71 minutes by public transport on average. In contrast, Reactive Care patients at Skegness have an average journey time of only 4 minutes by car and 18 minutes by public transport.

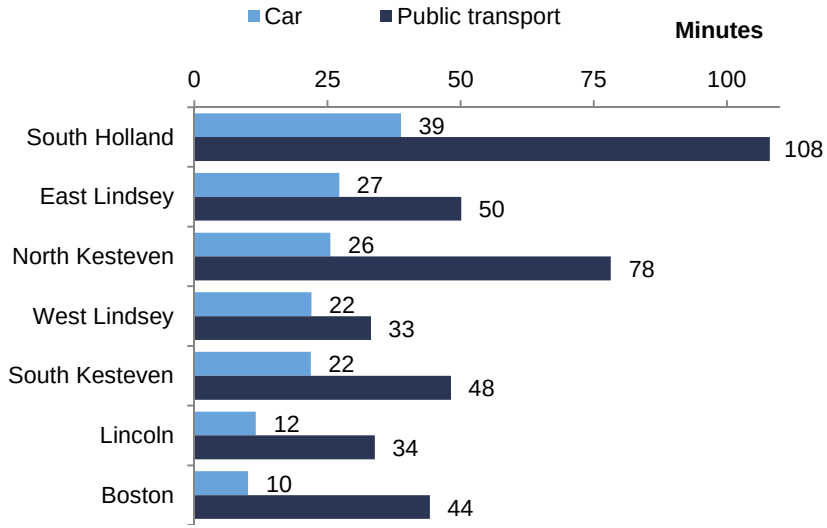
Travel time also varies depending on the area of Lincolnshire in which a patient lives. Residents of South Holland take an average of 39 minutes to arrive at their hospital by car, compared to only 10 minutes for residents of Boston. The difference between travel times by car and public transport reflect the difference in transport connections between particular areas and the nearest hospital, with North Kesteven residents facing lengthy journeys to Lincoln County and Grantham hospitals by public transport.

Average Lincolnshire patient travel time by hospital



Source: Hospital Episode Statistics, 2011-12 and Transport Direct

Average Lincolnshire patient travel time by patient location



Source: Hospital Episode Statistics, 2011-12 and Transport Direct

SECTION 3.3
Elective Care – Current Position

This section provides a more detailed look at current services in Lincolnshire for Elective care, highlighting key challenges, programmes in-train and potential opportunities.

Elective Care – Current Position

Key Findings

The Current Position Report presented the following findings that informed some of the discussion during the Care Design Group workshops:

Quality

- General medicine is the only treatment speciality within elective care with a higher than expected SHMI, having recorded a year-on-year 42% increase to 244 in 2012-13.
- Hospital Standardised Mortality Ratio and all other SHMI metrics are within expected range for Elective specialties.

Provider landscape

- Lincolnshire is particularly dependent on out-of-County providers for the following elective specialties: General Medicine, Trauma & Orthopaedics, General Surgery, Urology, Cardiology, Ophthalmology, Paediatrics and Obstetrics. 37% of elective inpatients, day cases and outpatients are provided by out-of-County providers
- Overall, ULHT is the leading provider of Elective Care across all CCGs. However, Northern Lincolnshire and Goole and Peterborough and Stamford present a significant share of Elective care in Lincolnshire East and South Lincolnshire respectively.
- Pilgrim's main, laminar flow and ophthalmology theatres appear under used.

Activity

- Volume benchmarking has identified that Grantham's Urology and Ophthalmology specialties are amongst the lowest volume sites in England.
- Benchmarking analysis suggests that up to £13.3m could be saved from activity reductions in Musculoskeletal and Digestive System, Trauma & Orthopaedics and Cardiology.
- Trauma & Orthopaedics, Urology, Pain Management, Breast Surgery and Clinical Oncology consistently perform poorly on operational metrics, such as Length of Stay, compared to a peer average.

Elective specialty benchmarking

Specialty	LoS	Day case conversion	New to follow-up ratio	DNA
1. Trauma & Orthopaedics	Average	Average	Worse than peers	Worse than peers
2. General Surgery	Worse than peers	Better than peers	Average	Average
3. Ophthalmology	Average	Better than peers	Average	Worse than peers
4. Urology	Average	Worse than peers	Average	Average
5. Gynaecology	Worse than peers	Worse than peers	Better than peers	Worse than peers
6. Cardiology	Average	Worse than peers	Better than peers	Average
7. Ear, Nose & Throat	Worse than peers	Average	Better than peers	Worse than peers
8. Gastroenterology	Better than peers	Better than peers	Average	Average
9. Clinical Haematology	Worse than peers	Better than peers	Worse than peers	Average
10. Dermatology	Average	Better than peers	Average	Average
11. Pain Management	Worse than peers	Average	Worse than peers	Average
12. Breast Surgery	Worse than peers	Worse than peers	Average	Worse than peers
13. Clinical Oncology	Average	Average	Average	Worse than peers
14. Respiratory Medicine	Average	Better than peers	Average	Average
15. Rheumatology	Better than peers	Better than peers	Average	Average

Worse than peers
Average
Better than peers

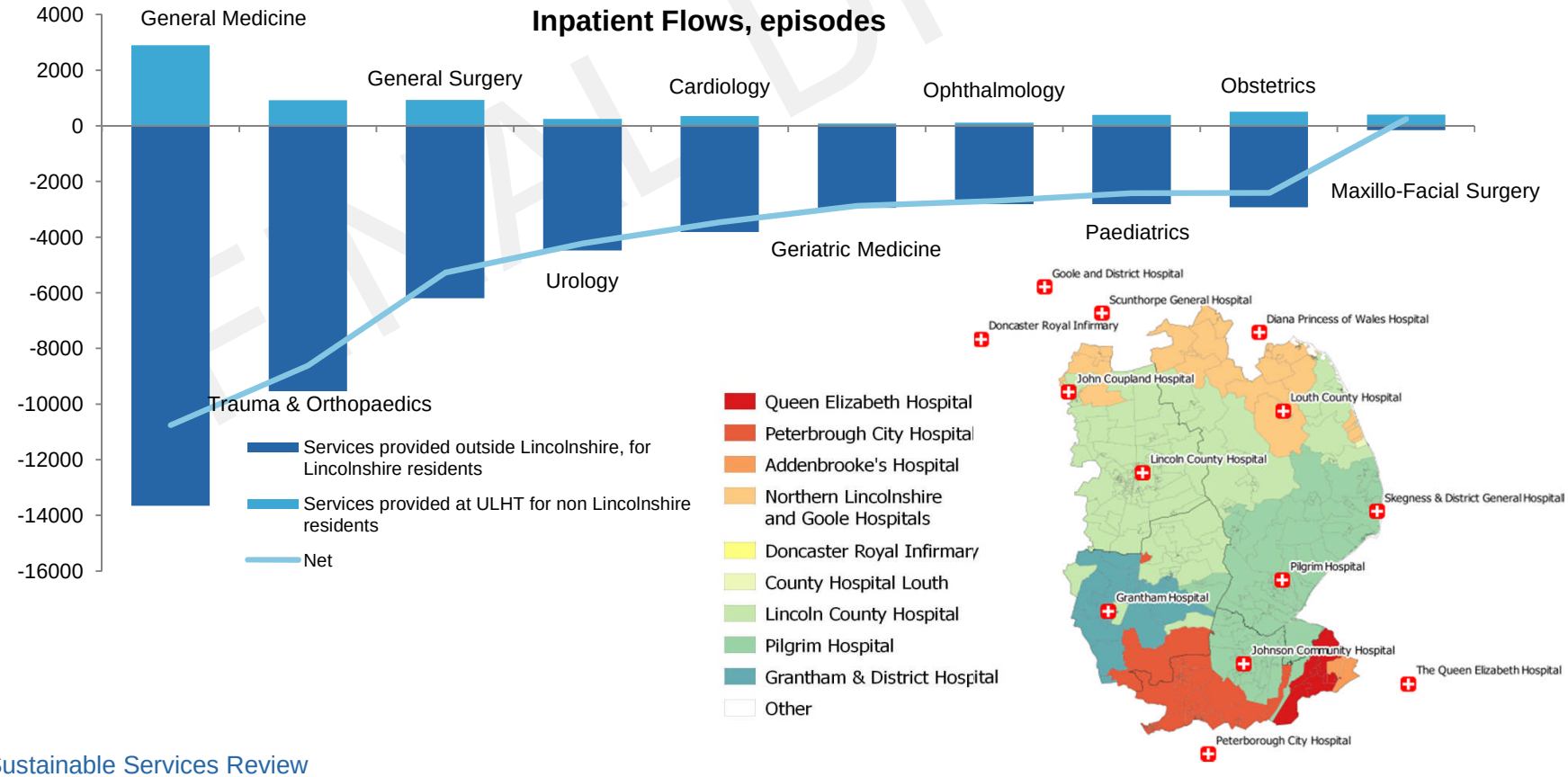
Source: HED, 2012-13

Elective Care – Current Position

There is a Significant Outflow of Patients from Lincolnshire for a Number of Specialties

We have analysed the volume of patients leaving Lincolnshire for treatment and that of patients entering Lincolnshire for treatment by inpatient elective specialty. The top net outflow specialties are General Medicine, Trauma & Orthopaedics, General Surgery, Urology and Cardiology. We could not identify a specialty where there was a significant net inflow of patients to Lincolnshire for treatment.

Lincolnshire is dependent on other providers, such as Peterborough, for many inpatient services. The number of patients leaving Lincolnshire for treatment is significantly higher than the patient inflows.



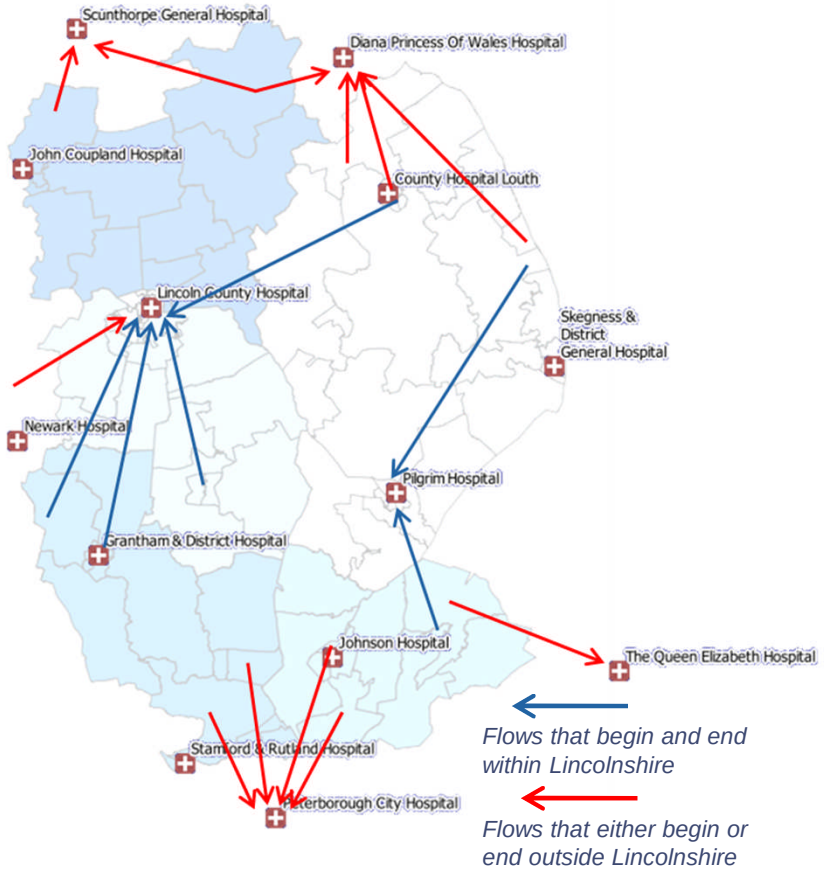
Elective Care – Current Position

We Analysed the Significant Patient Flows In and Out of Lincolnshire

There are several inpatient journeys in Lincolnshire where patients travel to a hospital which is significantly further than their closest site. In particular, Lincoln County Hospital and Peterborough City Hospital draw patients from far afield. For example, over 19,000 inpatient spells at Lincoln County Hospital involved patients travelling from Sleaford in North Kesteven.

Origin (town)	Destination (hospital)	Spells
Sleaford, North Kesteven	Lincoln County Hospital	19,236
Baston, South Kesteven	Peterborough City Hospital	9,326
Holbeach, South Holland	Pilgrim Hospital	6,758
Bourne, South Kesteven	Peterborough City Hospital	4,467
Holbeach St Marks, South Holland	Queen Elizabeth Hospital	3,966
North Thoresby, East Lindsey	Diana Princess of Wales	3,487
Alford, East Lindsey	Pilgrim Hospital	2,981
Sutton On Sea, East Lindsey	Diana Princess of Wales	2,445
Spalding, South Holland	Peterborough City Hospital	2,425
Crowland, South Holland	Peterborough City Hospital	2,324
Louth, East Lindsey	Lincoln County Hospital	2,133
Caistor, West Lindsey	Diana Princess of Wales	1,763
Louth, East Lindsey	Diana Princess of Wales	1,649
Blyton, West Lindsey	Scunthorpe General Hospital	1,460
Allington, South Kesteven	Lincoln County Hospital	1,403
Caistor, West Lindsey	Scunthorpe General Hospital	1,382
Newark and Sherwood	Lincoln County Hospital	1,336

Source: HED 2012-13



Elective Care – Current Position

South Lincolnshire Commissions More Than 50% of its Elective Activity From Non-Lincolnshire Providers

We have analysed CCG spending for elective inpatient, day cases and outpatient activity. The findings show that ULHT is the main provider of Elective care for three of the four CCGs. Indeed, ULHT's share ranges between 67% and 75% of total expenditure for Lincolnshire East, West and South West CCGs. The only exception is South Lincolnshire, where the main provider is Peterborough and Stamford, holding 52% of the £45.5m expenditure. In Lincolnshire East and West CCGs the second largest provider by expenditure is Northern Lincolnshire and Goole Hospitals Trust.

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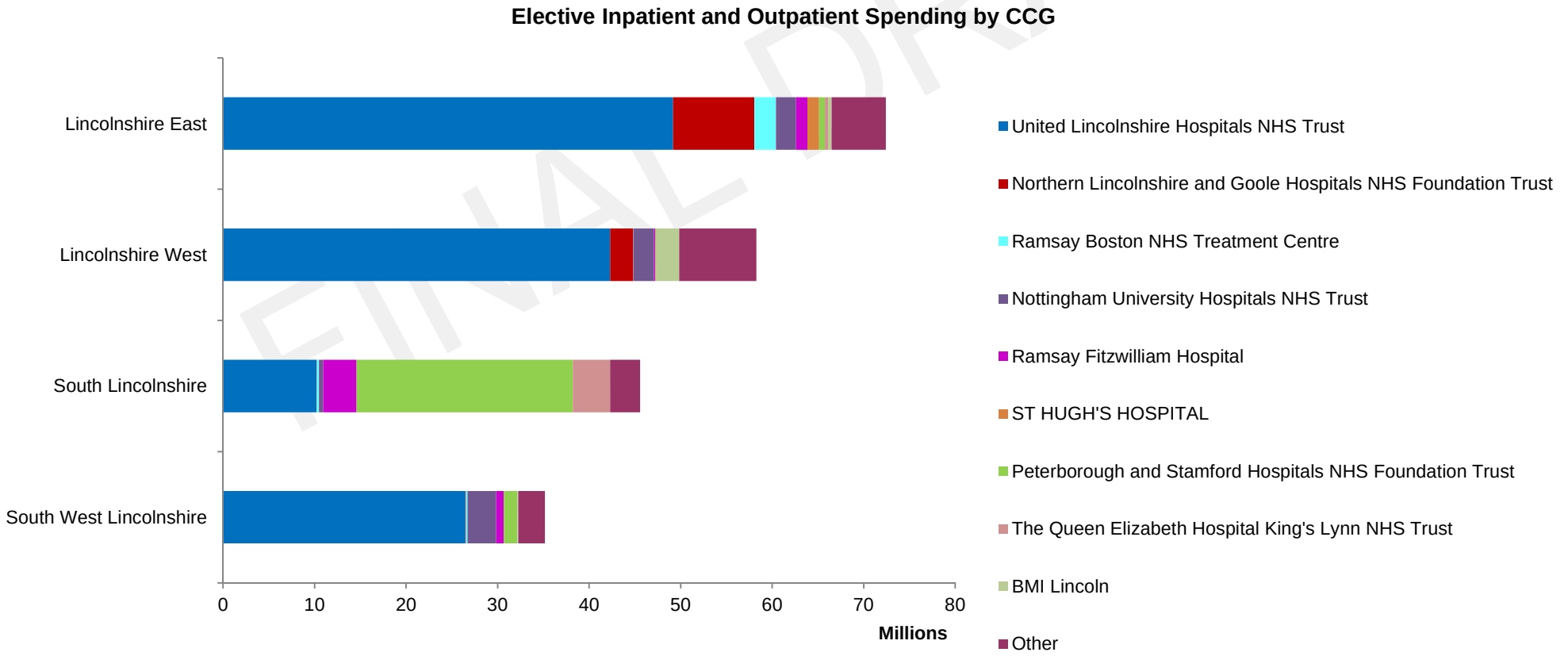


SECTION 3.4

Women's and Children's Care – Current Position

This section provides a more detailed look at current services in Lincolnshire for Women's and Children's Care, highlighting key challenges, programmes in-train and potential opportunities.

Women's and Children's Care – Current Position

Key Findings

The Current Position Report presented the following findings that informed some of the discussion during the Care Design Group workshops:

Quality

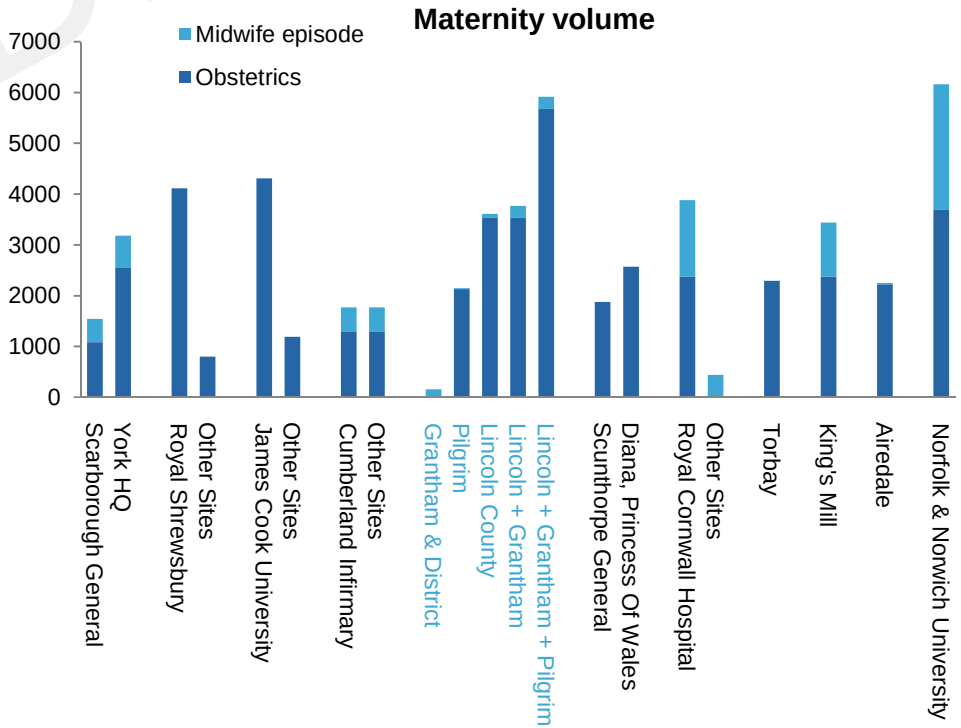
- The cost of Lincolnshire's "Children Looked After" programme is low compared to the national average, yet outcome measures are above the national average.
- Lincolnshire has a low vaccination rate for Whooping Cough (86%) and MMR (92%).

Provider landscape

- Both in the North and South of Lincolnshire other providers play a significant role in the provision of services for Women's and Children's.
- Lincoln and Boston hospitals are the lead providers for large parts of Lincolnshire. There are few regions which are overly dependent on the Women & Children services provided by Grantham. The Midwifery Led Birthing Unit at Grantham is to be relocated. All three sites currently provide paediatric services.
- Neonatal Care is provided at Lincoln and Boston. Both units show low occupancy rates of 48% and 42% respectively.

Activity

- Midwife-led appears underused for maternity in Lincolnshire relative to comparator trusts. There could be potential benefits from moving to a model such as that used by Norfolk & Norwich, where a higher proportion of maternity activity is midwife-led.
- Our analysis of relocating Grantham's Midwifery Led Birthing Unit to either Lincoln or Pilgrim suggests that in order to minimise the impact of increased travel times, over two thirds of current Grantham patients would have shorter journeys to Lincoln than Boston.
- For paediatric inpatient activity at site-level, ULHT's hospitals have low volumes compared to the national site-level median. As a result, there might be scope for consolidation of some paediatric services to realise the quality benefits associated with higher volumes of activity.



Women's and Children's Care – Current Position

It is Forecast That the Number of Children in Lincolnshire Will Grow by 10% Over the Next 5 Years

Children

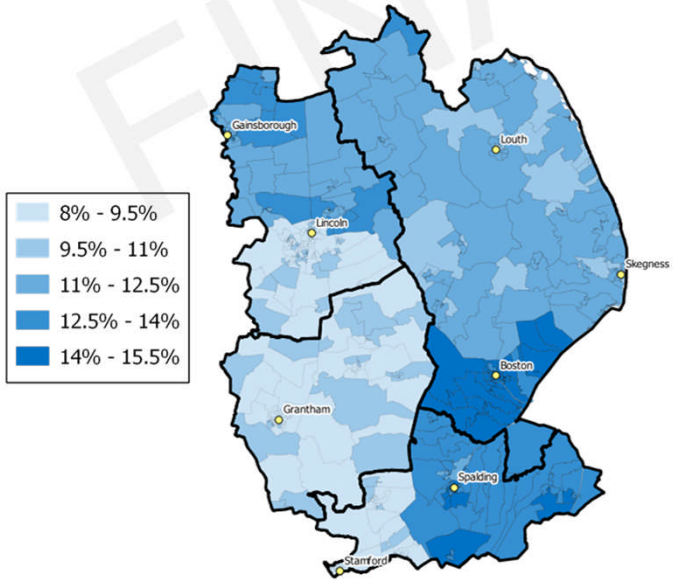
The number of children in Lincolnshire is projected to grow by 10% to 128,025. At the same time the number of births is projected to fall by 0.39% to 8,279 per year mainly driven by a reduction of births in Lincolnshire West CCG. The number of children in Lincolnshire will grow the most in Lincolnshire East CCG. South West Lincolnshire CCG, which is projected the lowest growth rate, might want to take future potential demand into account when implementing any changes to children services in Grantham as part of Shaping Health for Mid-Kesteven.

Births

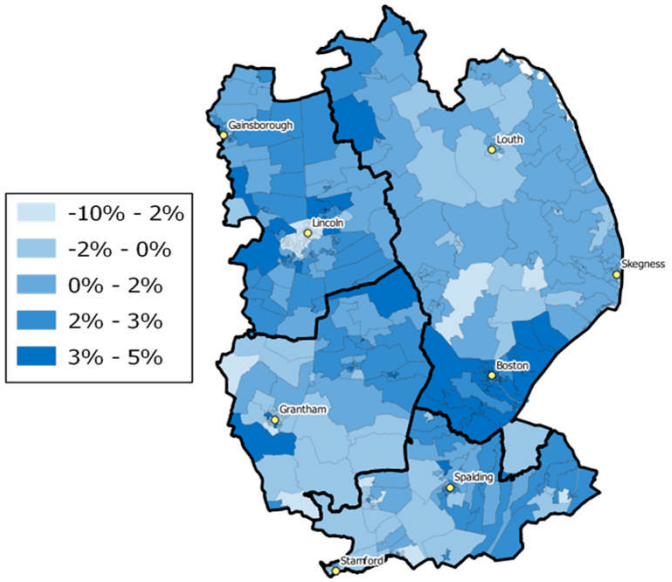
West Lincolnshire CCG is projected to have the largest change in the number of births with 79 births per year fewer in 2018 compared to 2013.

CCG	Growth rate of no. of births per year 2013-18	Change in no. of births per year 2013-18	Growth rate of no. of children 2013-18	Change in no. of children 2013-18
East	1.28%	31	11.38%	3,991
West	-2.65%	-79	9.19%	3,399
South West	0.30%	4	8.42%	1,771
South	0.67%	11	10.66%	2,482

Growth in numbers of children 2012-13



Growth in number of births per year 2013-18



Source: Office for National Statistics 2013, PwC population projections

Women's and Children's Care – Current Position

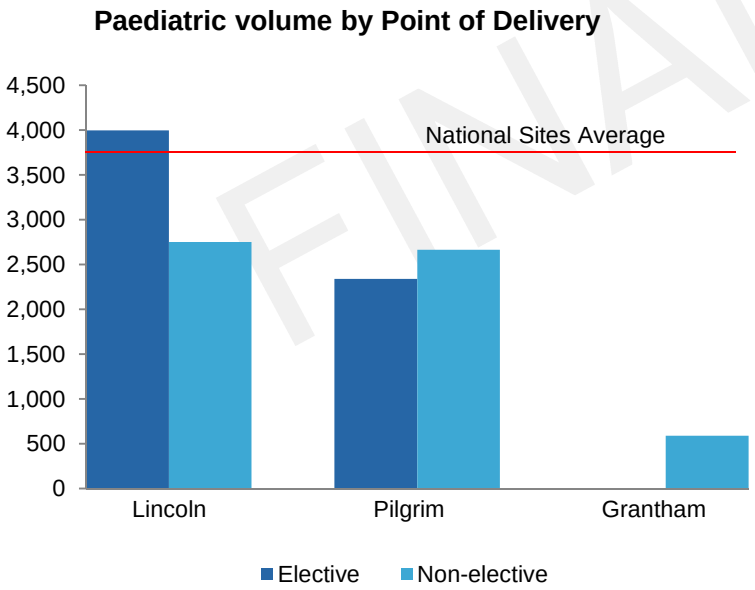
Paediatric Volumes at Grantham and Pilgrim are Below National Site-Level Average

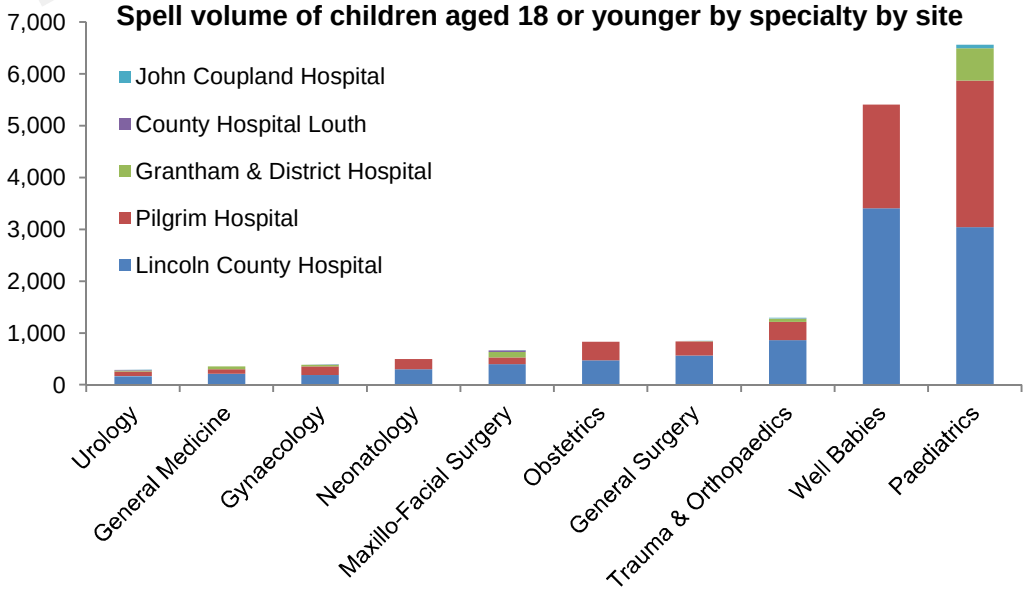
Paediatrics

A site level analysis of ULHT's paediatric volume shows that Lincoln County is in the 56th percentile for elective and in the 43rd percentile for non-elective paediatric activity compared to all hospital sites nationally with more than 500 paediatric spells per year. Pilgrim is in the 30th and 42nd percentile respectively. Grantham currently only provides non-elective paediatric services at a low volume, positioning itself in the 20th percentile.

Children activity

Looking at all inpatient activity of children aged 18 or younger, it becomes apparent that the main providers are Lincoln (10509 spells) and Pilgrim (7169). Grantham (1052), John Coupland (92) and Louth (69) play only a minor role in providing inpatient services to children. Paediatrics and well babies constitute the largest number of spells, followed by Trauma & Orthopaedics.





Source: Hospital Episode Statistics Nov 2011 – Oct 2012

SECTION 4

Blueprint for a Future Model of Care

This section draws all of the design options established at the care design groups into a future model of care for the Lincolnshire health and social care economy. It also provides details on all of the design options established and the benefits that could result from the implementation of these options.

SECTION 4.1
Summary Future Model of Care

This section draws all of the design options established at the care design groups into a future model of care for the Lincolnshire health and social care economy.

Summary Future Model of Care

Future model of care

The overall objective of this phase of work has been to design a future model of care that will allow the Lincolnshire health and social care system to deliver high quality services within a sustainable financial model. In order to develop this future model of care, the programme created four Care Design Groups. Divided into the core delivery areas, these groups were then tasked with agreeing an overall vision and then developing a series of interventions that, if implemented, they believed would make this vision achievable. The four Care Design Groups (CDGs) were:

Proactive ideas	**Urgent Care (Reactive)**
Elective Care	**Women's & Children's**

To provide a structure for understanding the future model of care developed by the CDGs, the programme team have considered the future model of care in terms of:

1. The overall goal – sustainability in Lincolnshire's health and care economy
2. The principles of how the overall goal will be delivered
3. The assets needed to achieve these outcomes
4. The brave ideas required to achieve the future blueprint

1. The overall benefit

A sustainable and safe health and social care economy for Lincolnshire.

2. The principles

1. People are engaged and informed
2. From fragmentation to integration
3. Prevention is better than cure
4. Shared decision-making

3. The assets

The Future Model of Care will include ten assets designed to drive our four principles and overall benefits:

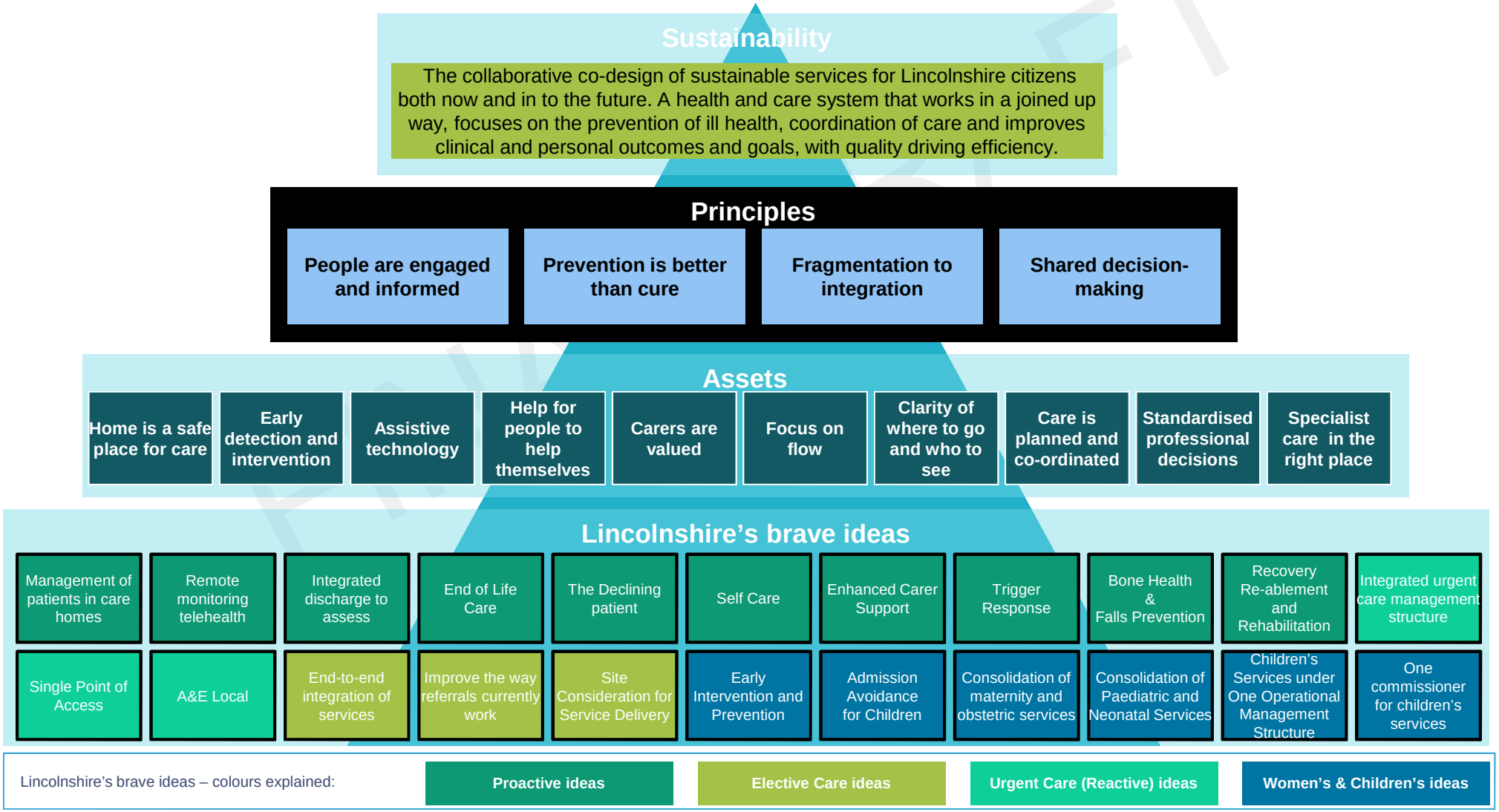
1. Home is a safe place for care
2. Early detection & intervention
3. Assistive technology
4. Help for people to help themselves
5. Carers are valued
6. Focus on flow
7. Clarity of where to go and who to see
8. Care is planned and co-ordinated
9. Standardised professional decisions
10. Specialist care in the right place

4. The interventions

In order to achieve the future model of care and the proposed capabilities, twenty-two interventions (as proposed by the Care Design Groups) have been proposed (see next page). These will be supported by some key enablers, such as: estates, IM&T, contracting and workforce planning.

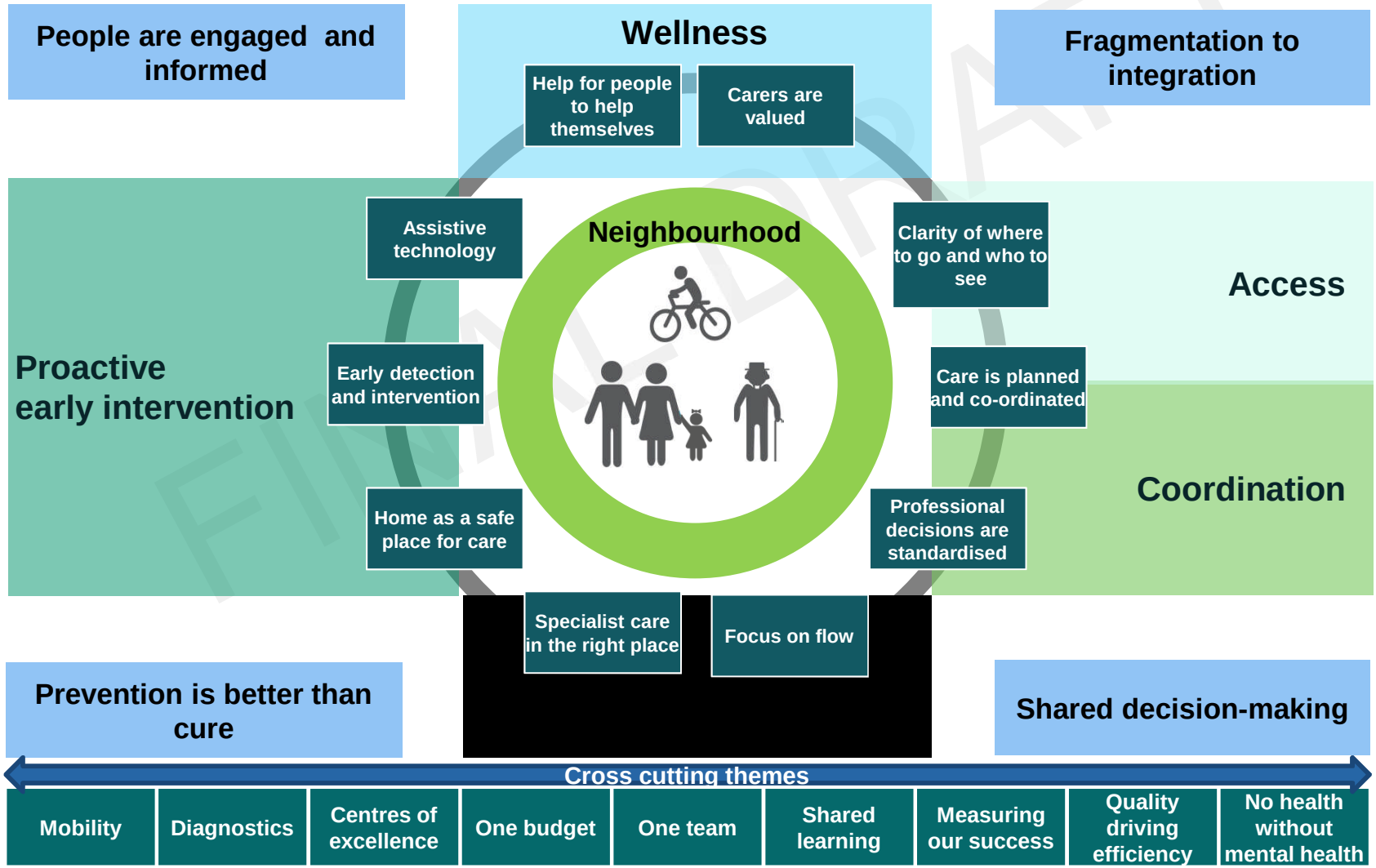
Summary Future Model of Care

The diagram below provides on one page the golden thread between Lincolnshire's goal of the design of sustainable services in the future model through key principles, use of assets and brave ideas:



Summary Future Model of Care

The diagram below details, on one page, the elements which have been described across all four care design groups and reviewed by the Programme Board to form the proposed future model of care. This model is intended to encompass the full spectrum of physical, mental health and social care services across Lincolnshire.



Summary Future Model of Care

The Future Model of Care

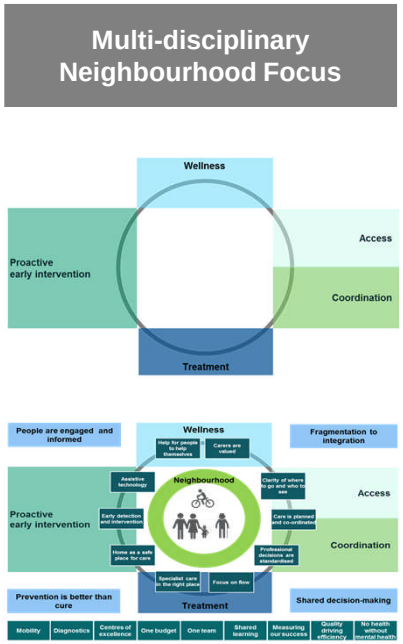
The model on the previous page is intended to provide a vision for the delivery of sustainable integrated care services in Lincolnshire. Detailed within the model are a number of key elements:

1. **Building the assets–** the core delivery method of the future model of care will be through the assets identified. In the majority of circumstances these already exist within the whole system but will require detailed discussion regarding optimal design and configuration for improved safety, quality and efficiency. The development of seamless patient / citizen journeys through connections into other parts of the system to ensure an integrated operational model.

2. **Optimising a cyclical process**– it is acknowledged that the health and social care process should not be seen as linear but as cyclical; with patients going through a pathway from proactive care settings to access and coordination stages, treatment, discharge and returning to proactive care settings once more. Whilst it is accepted that not every patient / citizen journey will experience every point in this process, it provides a useful lens through which to view the operation of the system as a whole.

3. **Driving integration** – the future model of care has at its heart a commitment to support a more integrated health and social service in the coming years. Throughout the blueprint design process, the Care Design Groups have kept in mind the linkages between the different care settings, with the interventions proposed and the consequent model of care aimed at improving these links.

4. **Focus on delivering the outcomes** – the delivery model being proposed is closely linked to the key principles pulling the programme together. Each part of the model, and the interventions proposed in order to meet it, is therefore focused on delivering one of the four principles proposed opposite.



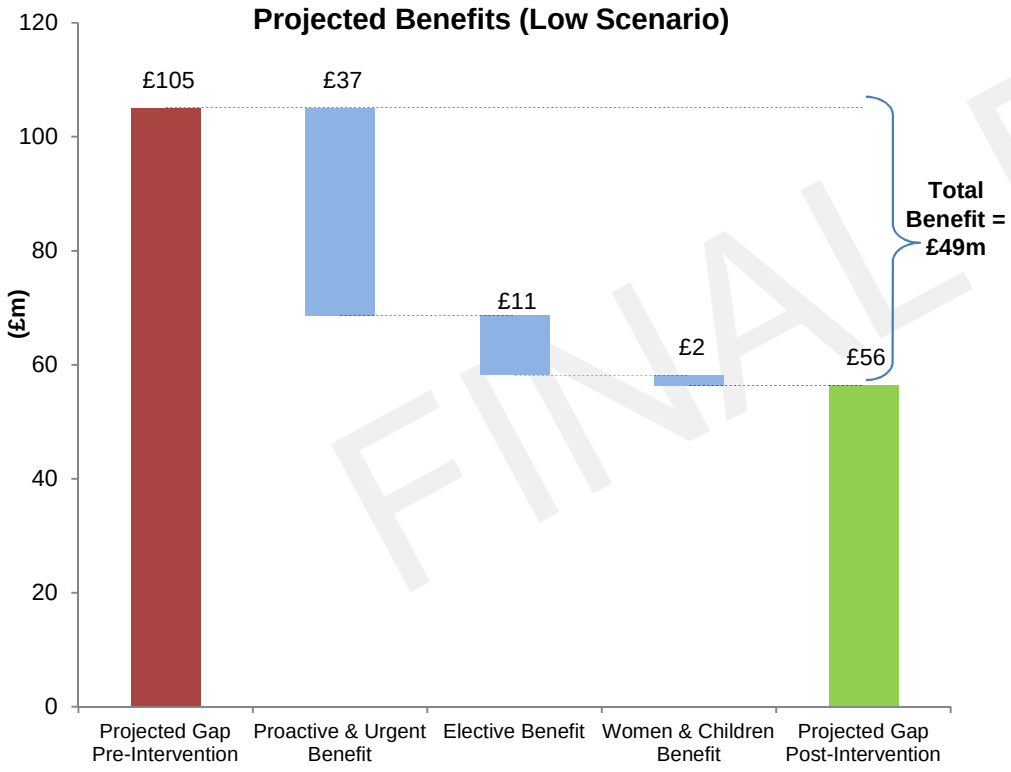
People are engaged and informed	Fragmentation to integration
Prevention is better than cure	Shared decision-making

SECTION 4.2
Intervention Summary

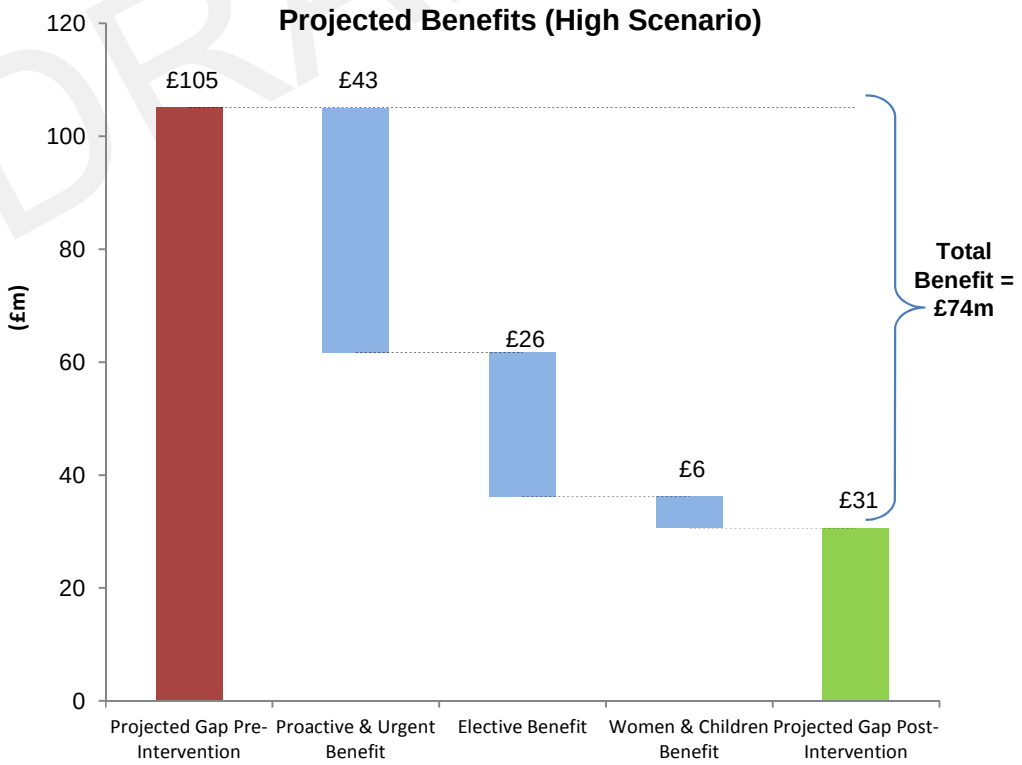
This section provides an summary of the projected benefits from all interventions (aggregated up into the four care categories) mapped against the financial gap. It also includes a dashboard highlighting at a high level the recommendations of each care design group.

Modelling Results

A high-level modelling was conducted on the likely impact of interventions on Lincolnshire's economy. As the impact depends upon how these and to what extent interventions would be implemented, two scenarios were modelled. It is worth noting that both scenarios are achievable. The combined modelled initiatives could potentially provide between £49m and £74m in annual benefits by 2017/18, with proactive and urgent care initiatives providing the largest share of projected benefits. Although the gap would not be closed, in the high scenario it would be reduced by 71%. Additional measures would be needed in order to completely close the gap. These are analysed in slide 22. Each Care Design's impact is explored further in Section 4.3.5.



'Low' Intervention Scenario Gap: cautious modelling assumptions



'High' Intervention Scenario Gap: achievable but ambitious modelling assumptions

Sources: HES 11-12; 2011-12 Reference Costs; ULHT, LPFT LHCS SLR 2011-12, Local Authority Personal Social Services Statistics, LCC

Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

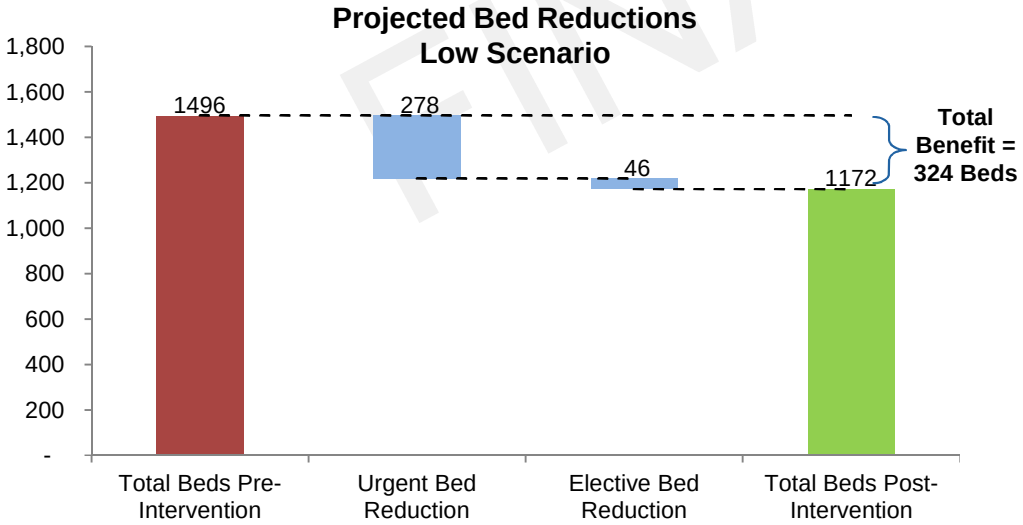
Acute Bed Impacts Through the Proposed 'Big Brave Ideas'

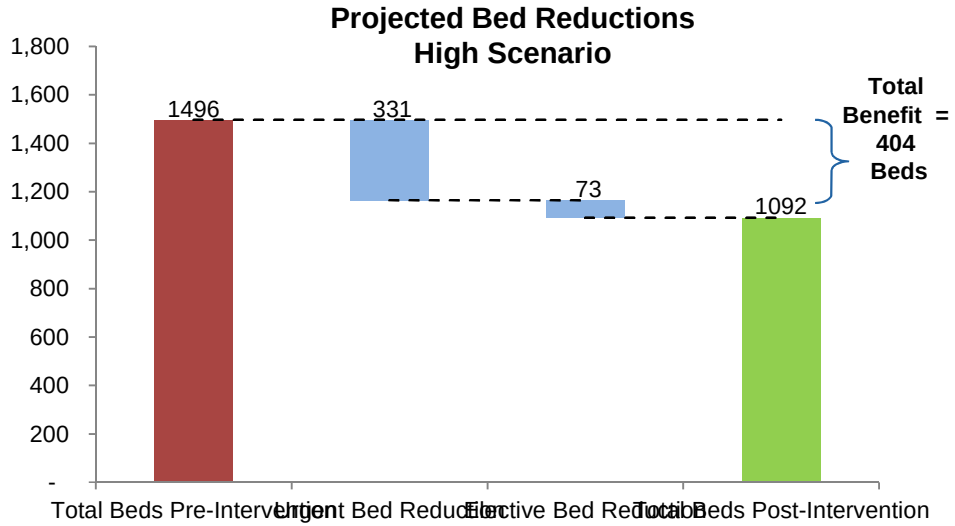
Aspects of the proposed initiatives impact upon acute activity, and their impact can therefore be expressed in terms of bed reductions. The analysis is long-term in nature given the practicalities of reducing beds, however it provides an illustrative reference point to interpret the high-level modelling. The modelling projects a reduction of between 324 and 404 beds.

The Urgent bed reductions shown below are driven by investment in Proactive interventions. Note that Women's & Children's bed reductions are not shown as the current assumption proposed through care design is that activity levels may remain the same for this group. The consolidation modelled is focussed on quality and safety, with efficiency benefits potentially eventuating in the longer-term.

The modelling was undertaken through converting the modelled benefits into bed days using the average cost per bed day and then converting to number of physical beds assuming that a bed is fully occupied for a whole year. These bed reductions correlate with the financial benefits presented previously. Urgent includes all non-elective beds, but does not include non-admitted A&E presentations

As an illustrative comparison, we can note that the focus of Proactive interventions is to shift care away from hospitals and acute settings where possible. 2011 Census data shows the population of Lincolnshire (usual residents) as being over 700k. Broadly, this represents the number of home 'beds' available in Lincolnshire that could also be utilised more efficiently in situations where care can safely be shifted to the home environment

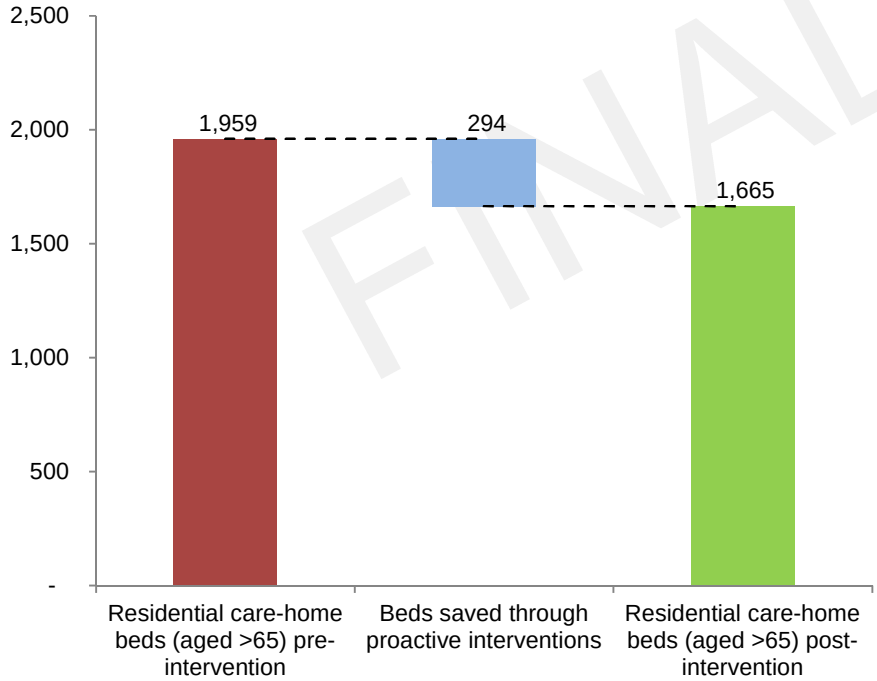




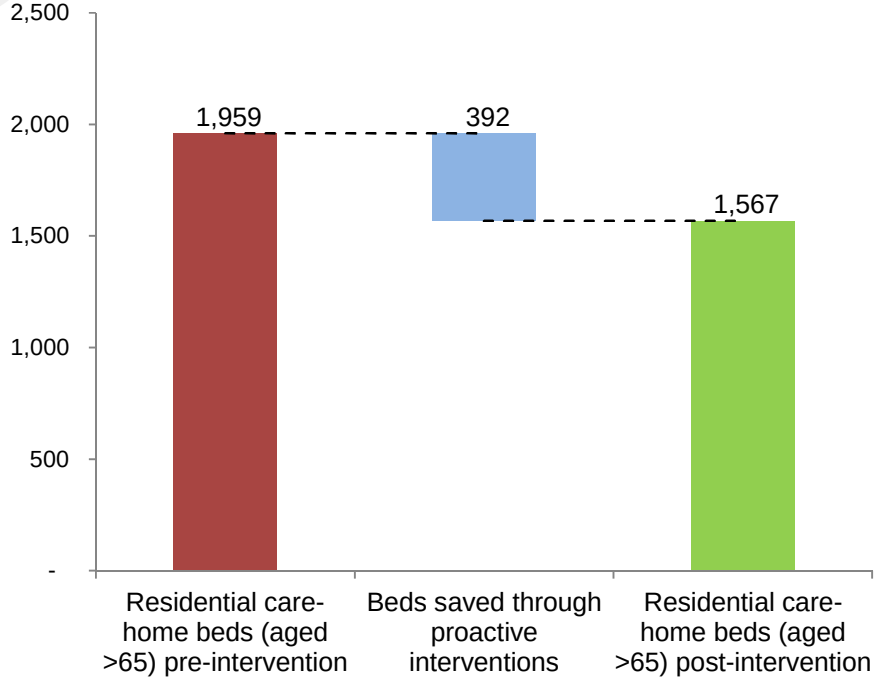
Residential Bed Impacts Through the Proposed ‘Big Brave Ideas’

The spectrum of proactive interventions described is expected to provide reductions in residential care home beds in the longer term. Our modelling projects that the reductions in residential care home usage by those aged over 65 would equate to a reduction of between 294 and 392 residential care home beds. These bed reductions represent between £8m and £10m of benefit in FY17-18, and are included in the Proactive & Urgent financial benefits presented previously. Note that the baseline beds of 1,959 represents only residential care home beds for those aged over 65 as opposed to all care home beds, as this is the area where proactive interventions are likely to have the largest impact.

Projected Residential Care Home Bed Reductions (>65)
Low Scenario



Projected Residential Care Home Bed Reductions (>65)
High Scenario



Thinking behind Lincolnshire's "Big Brave Ideas"

Underpinning the future model of care are the interventions put forward by the Care Design Groups. The table below outlines a high level summary (by care category) of the thinking behind Lincolnshire's "Big Brave Ideas" identified by the Care Design Groups and presented to the LSSR Programme Board. These changes are transformational in nature, though considered to be both realistic and achievable. The integration of previously separate services to meet local needs (including primary, community and mental health care and social care supported by the voluntary sector) will be defined by local population needs.

Proactive	• Clinical evidence is increasingly demonstrating that **proactively managing people** – and particularly those with long terms conditions and the frail elderly – delivers better health and social outcomes, and through **avoiding unnecessary hospitalisation** – can be more affordable • Lincolnshire will establish a **properly resourced proactive care** service – drawing on the best of primary care, community and mental healthcare, social care and with support from hospital expertise and delivering them in a way that does not perpetuate these categories of care.
Urgent	• When people experience a crisis, they should expect a **clear, simple response** appropriate to the needs they have. • Rather than lots of services run by different organisations without single co-ordination – from out of hours primary care to A&Es – Lincolnshire will **align all of the urgent care response services under a single operational management** – with simplified ways to access these services. • By drawing together all urgent care services under one umbrella, Lincolnshire **will** be able to **have a safe service**, and **afford to preserve the geographical access points** to urgent care services and make best use of the workforce available.
Elective	• Access to urgent care will be made **more consistent** and based on evenly applied criteria – **protecting the specialist services** for those whom clinical evidence shows are most likely to benefit. • In hospital services **will no longer be set up in competition with community services** – and decisions about how people can best be supported will be made by the care professionals across these settings working together based on value to patients. • Work with others to recruit high quality staff e.g. joint posts with other acutes, specialist and tertiary centres
Women's & Children's	• **Safety and quality** have been the **main focus** of the care design group, with consolidation options considered for different Women's and children's services • **A careful balance** to be considered **between improved quality through centralisation and increased volumes of care / efficiency** through rationalisation of services across sites and patient safety including access and travel times and should include detailed risk benefit and equality impact analysis.

Lincolnshire's "Big Brave Ideas"

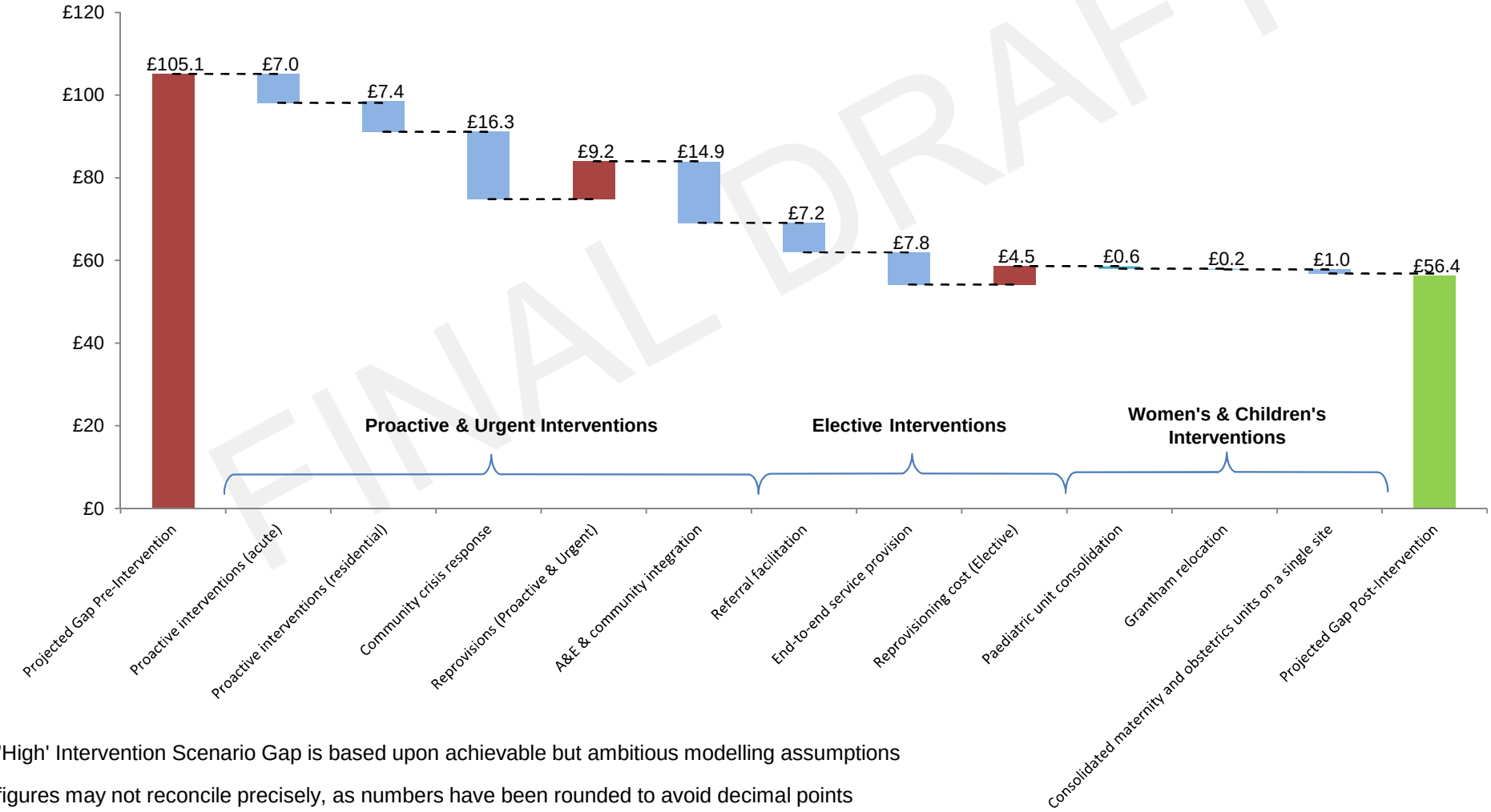
Care Category Dashboards

Underpinning the future model of care are the interventions put forward by the Care Design Groups. The table below outlines a high level summary (by care category) of the interventions identified along with the associated cost avoidance estimated in 2017-18. These changes are transformational in nature, though considered to be both realistic and achievable. In addition to these opportunities, it is envisaged all organisations in the system will continue to make traditional cost improvements over the next few years.

Proactive (see Urgent)	• Ten different ideas were considered: Self Management, Trigger response, Telehealth & remote monitoring, Supported carers, Single point of access, Right person right time right place, Care coordination, Care planning, Neighbourhood teams, Integrated crisis response, Supported early discharge • The financial impact of Proactive ideas has been combined with that of Reactive ideas, as Proactive will have a financial impact on Urgent activity through, for instance, the reduction in acute beds, lowering A&E presentations and shorter length of stay
Urgent £36-43m	• Eight initiatives were considered and grouped into three design options by the Urgent care design group. These are: • A Single Integrated Urgent Care Service under a Single Management Structure • A Single Point of Access that has access to Directory of Services which includes community, social care and other intermediate care options and coordinates direct patients with urgent care need to the right services. • An A&E Local (branding to be discussed) is an integrated multi-disciplinary service comprising traditionally separated acute, primary and other care professionals of an A&E (primary care currently approximately 40-50% but could increase in the future model). 7 day service.
Elective £11-26m	• The elective care design group identified the need for a single end-to-end service commissioned for a particular patient group, service or specialty, including all of the acute and community aspects of the service. The group specifically considered how such initiative would apply to fifteen specialties. • An overall referral structure was identified as needed to support referring clinicians to decide the appropriateness of referrals, together with simple guidelines developed community-wide to aid GPs and feedback loops between GPs and specialists • High-level site considerations on the principles that need be considered when analysing where services should be provided • These initiatives are estimated to lead to benefits in the region of £10-26m.
Women's & Children's £2-6m	• The design options within this CDG were primarily focused on the provision of safe, quality services around 7 key interventions promoting proactive early intervention, coordinated multi-disciplinary teams working in neighbourhoods and drawing in specialist support where required, admissions avoidance and models of commissioning and provision to reduce fragmentation of services. • The group considered options around the consolidation of consultant led and midwifery led units on the same site (24/7 consultant available at all times) or consultant led and midwifery led unit on separate sites (24/7 Consultant cover at one site). Consolidation was also discussed around paediatrics and neonatal services, including acute care, ambulatory care / paediatric assessment services, surgical units and neonatal support. The interventions discussed are estimated to create benefits of between £2-6m

Interventions – Summary of Benefits (High Scenario)

The following chart shows the projected benefits (low scenario) of the modelled interventions across all Care Design Groups in a single chart. In the low scenario the combined interventions modelled reduce the gap from £105m to £56m in 2017/18. More detail is provided in Section 4.3.

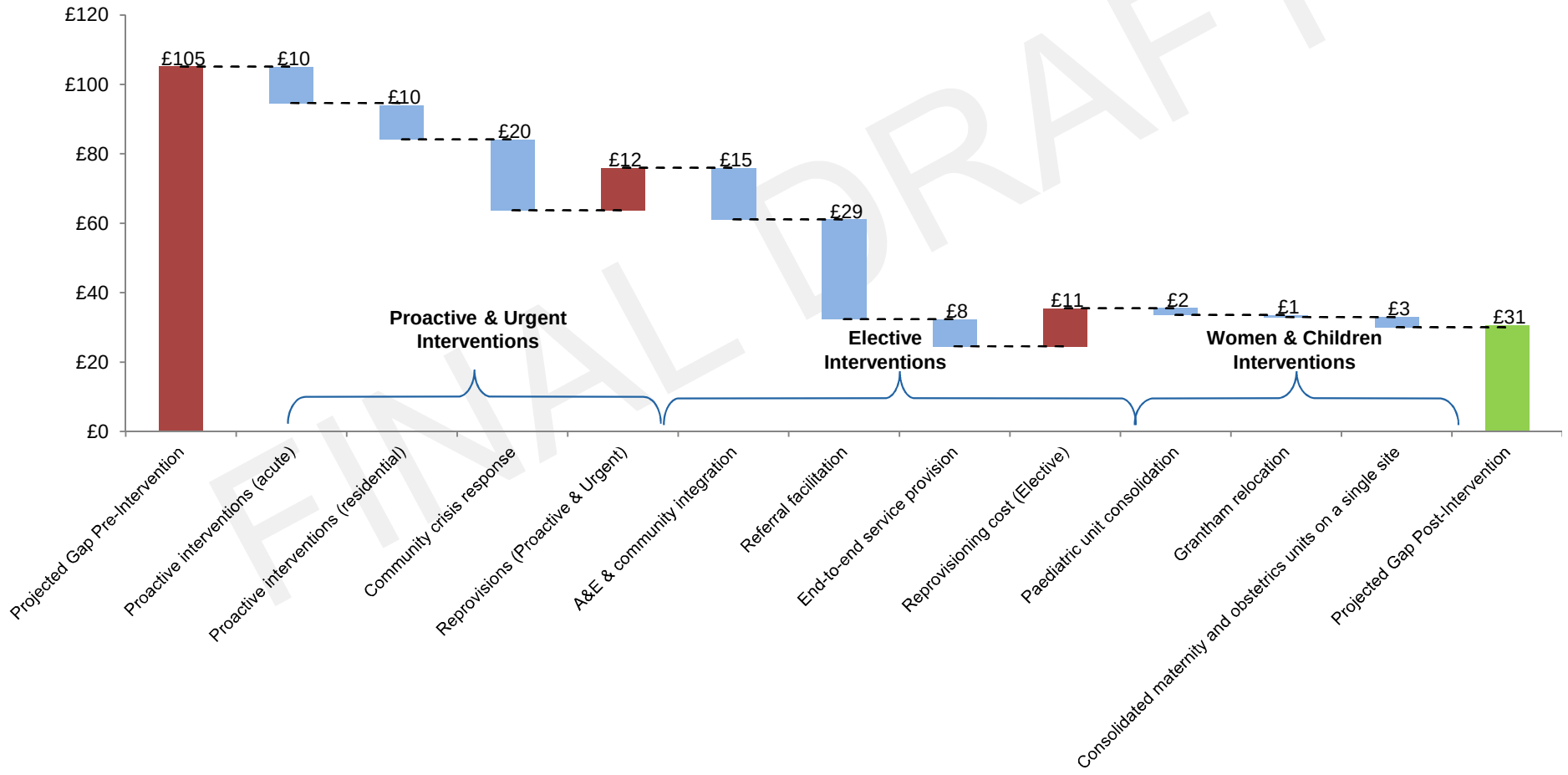


Note: 'High' Intervention Scenario Gap is based upon achievable but ambitious modelling assumptions

Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

Interventions – Summary of Benefits (Low Scenario)

The following chart shows the projected benefits (low scenario) of the modelled interventions across all Care Design Groups in a single chart. In the high scenario the combined interventions modelled reduce the gap from £105m to £31m in 2017/18. More detail is provided in Section 4.3.



Note: 'Low' Intervention Scenario Gap is based upon cautious modelling assumptions

Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

The ‘Big Decisions’ – Possible Options for Urgent Care Services?

Urgent Care

Urgent care in Lincolnshire is currently served by three A&E departments, two 24-hour urgent care centres, two MIUs and a walk-in centre. Two potential options have been proposed based upon discussions during the care design process and Programme Board review:

Option #	Description:
Option 1	No change in current configuration, although it has been shown in this document that this option is not sustainable Realisation of benefits through workforce and other productivity and efficiency improvements
Option 2	A single main A&E department* supported by a number of 24 hour ‘A&E Locals’ / A&E Care Centres (consolidating and coordinating urgent care services provided by Primary Care (in and out of hours) centres, Urgent Care Centres and MIUs)

*The location of a single main A&E department would require further discussion and analysis, however focus should be on co-location with available specialist facilities such as trauma and ICU. Analysis of these options would need to factor in impacts on travel times, however noting that A&E Locals / 24hr A&E Care Centres would be able to provide an extended scope of services compared to current community-based urgent care services.

Within the modelling of the future state scenario’s for Urgent Care services, we assumed a level of consolidation to reflect discussions during the care design process. This is also reflected in the benefit assumptions. We understand that there are a range of potential options for these services that could be explored. For each option three key domains need to be considered; Quality; Cost and; Acceptability

In most cases, consolidation has better cost implications, but lower public acceptability. Quality is a more complex domain that could have both positive and negative implications through consolidation. Public acceptability could be established through consultation, public surveys or a similar research-based approach. Alternatively it could be gauged by key stakeholders within the county.

Another consideration is the estate implications of consolidation. This has not been a primary focus for Phase 1, but as a key enabler for the delivery of a future model would be part of the detailed design required in Phase 2 of the LSSR. Consideration will need to be given to the ability for existing estate to accommodate consolidation options, and for the identification of additional capital investment required. Also worth noting is that the Proactive and Elective interventions are expected to free up additional capacity that could be re-deployed within existing estate. For any consolidation, the proposed locations for services would need to be examined and agreed in light of these domains.

With any consolidation of sites, there is a careful balance to be considered between improved quality through centralisation / increased volumes, and efficiency through rationalisation of services across sites. Key considerations that need to be taken account in a more detailed analysis of impacts, risks, benefits and equity would need to consider these trade-offs and their implications for – amongst other things – patient safety, travel times and workforce distribution.

The ‘Big Decisions’ – Possible Options for Women’s & Children’s Services?

Maternity Services

Lincolnshire currently has two obstetric units with the Midwifery Managed Unit at Grantham closed following the Shaping Health in Mid Kesteven Consultation.

For maternity services, within the current blueprint we have assumed efficiencies from the relocation of the Grantham service, already underway for the 17 / 18 financial year. It is acknowledged that this relocation of services is not currently improving the system wide deficit and this reconfiguration has been driven by quality, safety and workforce improvements.

It is important to note that since women giving birth are generally healthy, their acceptability for travel and preference for choice is higher. Reconfiguration could therefore see some women travelling to other counties to give birth (as they already do). It is therefore imperative that any consolidation is combined with a strong focus on the quality of care provided within Lincolnshire, and potentially coupled with a clinical services review. A key point to note is that where maternity-led or obstetric-led units are consolidated, there is still the ability for other sites across Lincolnshire to provide pre- and post-natal services to maintain access, quality and acceptability for routine service provision, whilst still achieving efficiency benefits.

Home delivery is also proactively promoted as a birth place choice by maternity service and primary care providers.

A careful risk benefit analysis related to increasing travel times between units and consideration of birth trauma for mother or baby would need to be undertaken. Public acceptability would be a key consideration – and could potentially be measured through consultation, public surveys or a similar research-based approach.

Current neonatal provision

- Level I Neonatal Unit at Pilgrim Hospital in Boston – providing special care but not aiming to provide any continuing high dependency or intensive care
- Level 2 Neonatal Unit at Lincoln County Hospital – providing high dependency care and some short-term intensive care in line with agreed protocol
- Also supported by the Transitional Homecare Team who are a team of specialised neonatal nurses based at Lincoln County Hospital and Pilgrim Hospital, Boston providing support to parents taking their baby home from Special Care Baby Units (SCBU).

It is important to consider any changes to maternity and paediatrics provision due to clinical adjacency issues with neonatal services.

Option #	Description:
Option 1	No change in current configuration Realisation of benefits through workforce and other productivity and efficiency improvements
Option 2	Midwifery-led and obstetric-led clinics on two sites
Option 3	Consolidation and co-location of midwifery-led and obstetric-led clinics to a single site

The ‘Big Decisions’ – Possible Options for Women’s & Children’s Services?

Paediatric Services

ULHT currently offers paediatric services for children ranging from 0 to 16 years of age, including:

- An emergency service with links to inpatient beds
- An elective and day case service
- A Day Assessment Unit
- A broad range of outpatient service with visiting specialist consultants
- Intermittent respite care for specific diseases

The service is available seven days a week and offers 24 hour cover at Lincoln County Hospital and Pilgrim Hospital, Boston. Acute paediatric services are located across the sites including day case services at Boston, Grantham and Lincoln, outpatients at Boston, Grantham, Lincoln, Louth Gainsborough, Skegness and Spalding and Holbeach and inpatient services at Boston and Lincoln. At Grantham and District Hospital, the Kingfisher Unit is open between 10am and 5pm Monday to Friday and provides an urgent care response (note: the sickest children are taken to specialist units further afield in keeping with county wide pathways) and outpatient service with Consultant cover from either Lincoln County Hospital or Pilgrim Hospital, Boston.

Option #	Description:
Option 1	No change in current configuration (emergency and 24hr in patient care on two sites) Realisation of benefits through workforce and other productivity and efficiency improvements
Option 2	Consolidation to a single site supported by multi-disciplinary, coordinated neighbourhood based (size and number of neighbourhood sites / virtual networks to be determined in Phase 2) children’s services provision
Option 3	Build a purpose built paediatric unit in a central location e.g. Sleaford to service the whole county (costs not modelled in Phase 1)

During the care design process it has been proposed that there is a general acceptance to travel further for specialist care, but less acceptance to travel for generalist care. Public acceptability would be a key consideration – and could potentially be measured through consultation, public surveys or a similar research-based approach.

The ‘Big Decisions’ – Possible Options for Women’s & Children’s Services?

Within the modelling of the future state scenario’s for Women’s & Children’s services, we assumed a level of consolidation to reflect discussions during the care design process. This is also reflected in the benefit assumptions. We understand that there are a range of potential options for these services that could be explored. For each option three key domains need to be considered; Quality; Cost and; Acceptability

In most cases, consolidation has better cost implications, but lower public acceptability. Quality is a more complex domain that could have both positive and negative implications through consolidation. Public acceptability could be established through consultation, public surveys or a similar research-based approach. Alternatively it could be gauged by key stakeholders within the county.

Another consideration is the estate implications of consolidation. This has not been a primary focus for Phase 1, but as a key enabler for the delivery of a future model would be part of the detailed design required in Phase 2 of the LSSR. Consideration will need to be given to the ability for existing estate to accommodate consolidation options, and for the identification of additional capital investment required. Also worth noting is that the Proactive and Elective interventions are expected to free up additional capacity that could be re-deployed within existing estate. For any consolidation, the proposed locations for services would need to be examined and agreed in light of these domains.

With any consolidation of sites, there is a careful balance to be considered between improved quality through centralisation and increased volumes of care / efficiency through rationalisation of services across sites and patient safety including access and travel times and should include detailed risk benefit and equality impact analysis.

SECTION 4.3
Intervention Detail

This section provides a one page summary for each intervention (split by care category). These summaries include detail on clinical outcomes, financial outcomes, timeframes and assigned Care Design group owners. This section also provides a summary of the financial benefits of each care category, and the benefits of all interventions for all care categories mapped against the overall financial gap.

Mapping Quality Against Outcomes Frameworks

Adult Social Care Outcomes Framework

In later slides, we detail the expected quality outcomes from the proposed interventions in the future model of care. Given that Lincolnshire's Health and Social Care Economy work to national outcomes frameworks, for consistency we have mapped some of the main expected quality outcomes to these national frameworks. Below we show mapping to the Adult Social Care Outcomes Framework, and the subsequent slides show mapping to the Public Health Outcomes Framework and the NHS Outcomes Framework.

Adult Social Care Domains (The Adult Social Care Outcomes Framework 2013 / 14)	**Expected quality outcomes**
1) Enhancing quality of life for people with care and support needs	• Earlier return to independence • Reduced isolation • Improved quality of life
2) Delaying and reducing the need for care and support	• Promotion of independence • Reduction in unnecessary referrals • Possible reduced chance of requiring a care home • Decrease patient usage of services
3) Ensuring that people have a positive experience of care	• Improved continuity of care and decreased fragmentation • Improved patient experience and satisfaction • Improved patient choice • Patients set their own goals • Direct access to services from home • Greater coordination of care • Reduction in patients 'bouncing' between services
4) Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.	• Inclusion of all safeguarding requirements for vulnerable adults in the specifications alongside more simplified performance management regimens due to proposed unified operating models for future models of care • Improved support to carers • Improved medication compliance • Decreased falls / infections / mortality / adverse events, etc.

Mapping Quality Against NHS Outcomes Frameworks

Public Health Outcomes Framework

Public Health Domains (The Public Health Outcomes Framework 2013 / 14)	**Expected quality outcomes**
1) Improving the wider determinants of health	• Enhanced self-management • Community empowerment • Provision of consistent services across the county • Greater emphasis on patient education and awareness • Decreased culture of dependence • Enhanced carer support
2) Health improvement	• Improved medication compliance • Improved wellbeing • Patients set their own goals • Higher volumes, correlated with higher safety and quality outcomes • Improvements in paediatric public health indicators (breastfeeding rates, immunisation rates, school readiness, etc.)
3) Health protection	• Improved screening / disease detection • Greater coordination between services, leading to greater patient inclusion
4) Healthcare, public health and preventing premature mortality	• Safer standards through more skilled and efficient workforce • Improved position at United Lincolnshire Hospital for mortality ratios in line with Keogh action plan • Possible reduced chance of requiring a care home through greater care coordination and proactive models of care preventing deterioration and providing care in the right setting at the right time • Decreased falls / infections / mortality / adverse events, etc. • Reductions in unnecessary referrals

Mapping Quality Against NHS Outcomes Frameworks

NHS Outcomes Framework

NHS Outcome Domains (The NHS Outcomes Framework 2013 / 14)	**Expected quality outcomes**
1) Preventing people from dying prematurely	• Decreased falls / infections / mortality / adverse events, etc. • Higher volumes, correlated with higher safety and quality outcomes • Improved screening / disease detection
2) Enhancing quality of life for people with long-term conditions	• Improved quality of life / wellbeing • Greater emphasis on patient education and awareness • Reduction in deterioration of functioning • Improved carer support and decreased ill health of carers • Preferred place of care and death accommodated • Reduction in unnecessary referrals
3) Helping people to recover from episodes of ill health or following injury	• Flexible provision of services between primary and secondary care • Direct access to services from home or within local neighbourhood MDT • Earlier returns to independence • Improved medication compliance
4) Ensuring that people have a positive experience of care	• Improved continuity of care • Improved patient satisfaction • Improved patient choice • Decreased fragmentation • Patients set their own goals • Reduction in patients 'bouncing' between services
5) Treating and caring for people in a safe environment; and protecting them from avoidable harm	• Provision of consistent joined up services across the county • Reduced change of requiring a care home • Reduced isolation • See outcomes for 2) which overlap with this domain

SECTION 4.3.1
Proactive Care

Proactive (see Urgent)	• Ten different ideas were considered : Self Management, Trigger response, Telehealth & remote monitoring, Supported carers, Single point of access, Right person right time right place, Care coordination, Care planning, Neighbourhood teams, Integrated crisis response, Supported early discharge • The financial impact of Proactive ideas has been combined with that of Reactive ideas, as Proactive will have a financial impact on Urgent activity through, for instance, the reduction in acute beds, lowering A&E presentations and shorter length of stay.

Intervention Detail

Proactive Care Design Options

The following design options were identified as part of the Proactive care design group:

1. Management of patients in care homes
2. Remote monitoring, telehealth
3. Integrated discharge to assess
4. The declining patient
5. End of Life Care
6. Self Care
7. Enhanced carer support
8. Trigger Response
9. Bones Health / falls prevention
10. Recovery , Re-ablement and Rehabilitation

The financial impact of Proactive ideas has been combined with that of Reactive ideas, as Proactive will have a financial impact on Urgent activity through, for instance, the reduction in acute beds, lowering A&E presentations and shorter length of stay.

A future model of Proactive Care

Given the demographic pressures, and the relative difficulty in recruiting staff consideration should be given to the development of an Institute of Elderly Medicine, with key partners including Lincoln University.

Across Lincolnshire there will be nurses, therapists, care workers, Primary Health Care Teams and community mental health teams working together within neighbourhoods. These teams will be responsible for ensuring that frail, often elderly people are proactively managed so they can enjoy a good quality of life, maintain their independence and only use hospital services when absolutely necessary. Specialist services will then be available locally to support these teams for those who need them.

They will do this by co-ordinating all of our community assets, supporting carers, acting when a relatively minor event signifies a potential decline, encouraging people to be responsible for their own care through a comprehensive self care toolkit.

Falls resulting in hip fractures are a particular concern as the elderly often do not recover from this and yet some hip fractures can be prevented. We will be ambitious and have a countywide comprehensive bone health and falls programme.

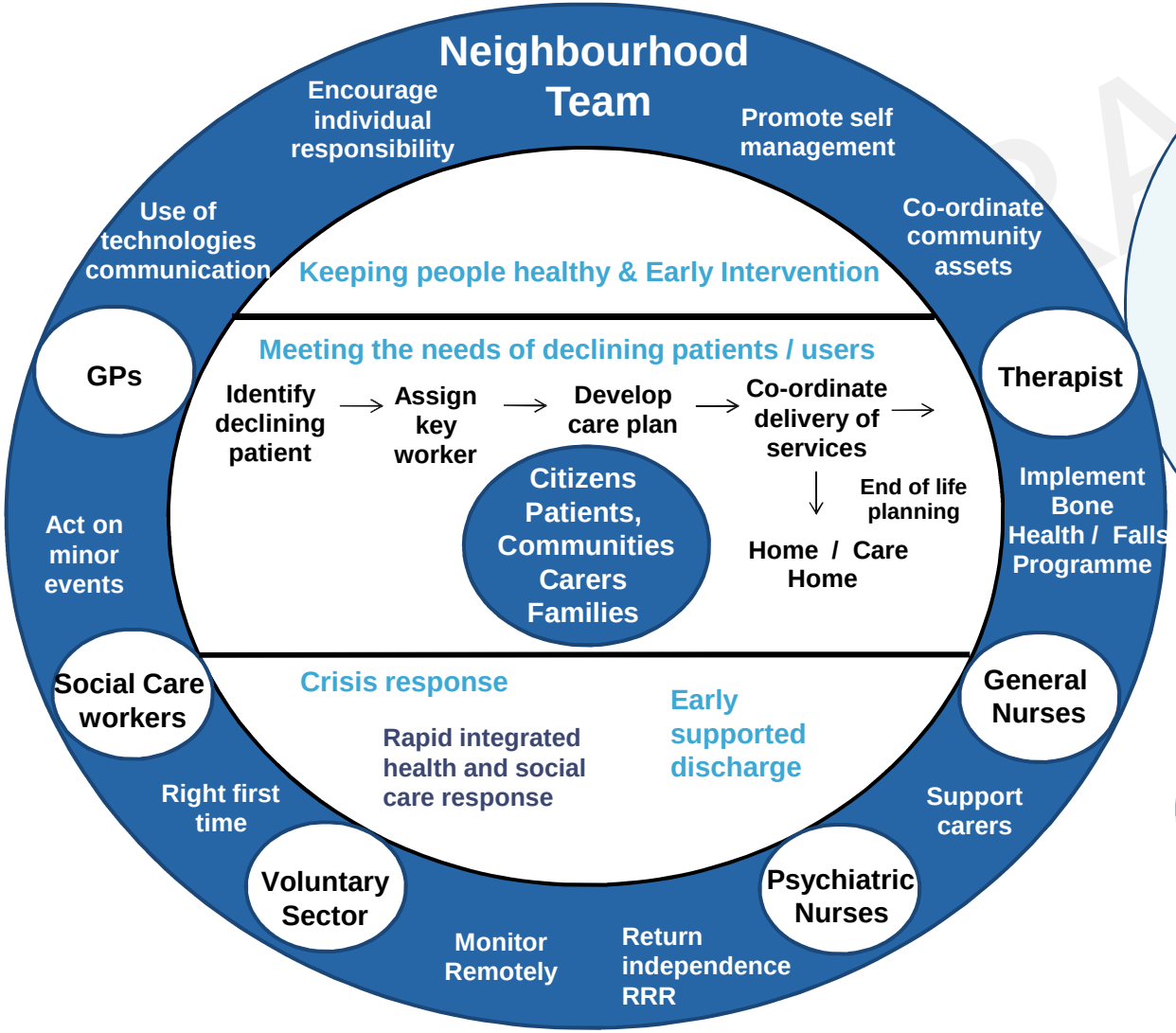
Resources will be targeted to those declining patients who have the most intensive needs. We will identify these people, assign a key worker to work with them on a care plan and co-ordinate the delivery of the services that are needed. For those that are at the end of life we will be sensitive of their specific needs and circumstances and keep them at home if this is their wish. Some patients will move into care homes, we will make sure they continue to receive the best possible care.

If there is a crisis the team will respond quickly to avoid the need for a hospital admission. Where patients do have to go to hospital the team will know they are there and will work closely with the ward to allow them home even if they have not yet fully recovered.

It takes time to recover from illness, especially for the elderly and therapists within our teams will encourage people to stay independent at home. This independence will be supported by remote monitoring and communication technologies so patients feel confident to remain at home.

Through this approach we will ensure that people can access services in an easy way and that we use our resources wisely so that those with care needs enjoy a good quality of life. We have represented this in a pictorial way in the following slide.

Future Proactive Care Model



Specialist advice

Shared between a number of Neighbourhood Teams:

- Community geriatrician
- Mental Health for all ages
- Specialist nurses
- Dietetics
- SALT
- Palliative care specialists

- Specialist rehab
- Neurology
- Cardiology
- Respiratory medicine
- Rheumatology
- Other medical specialties

Design detail – Proactive

Proactive Care 1: Management of patients in care homes

What is the idea / option?	A comprehensive care programme for residents of care homes (residential and nursing) to include end of life planning, medicines optimisation, and proactive intervention when conditions deteriorate. • This will enable care home patients to stay in their familiar environment with the use of hospital services being exceptional. • Patients will be provided consistent and pro-active care to minimise the instances in which the patient requires hospitalisation. This will require long-term planning by trained staff across medical, pharmacy, mental health, district nursing and a dedicated consultant. • Commissioning of care home services should be completely integrated • The idea requires incentives to encourage patients to be kept in care home unless it is absolutely necessary to take them to hospital.
What service issues does this idea address?	• Improve the perception and stigma of care homes • Improve quantity and skill set of care home staff • 'Unnecessary admission of care home residents
What are the outcomes / quality outcomes of this idea?	• Improved continuity of care • Improved quality of life • Possible reduced chance of requiring a care home

What are the financial / activity outcomes of this idea?	• Reduced travel costs associated with patient transportation
	• Earlier, pre-emptive interventions to prevent hospital admissions
	• Prevention of A&E admissions
	  − Approximately 50% of sub-acute admissions from care homes could be avoided
	  − Reduced variable costs associated with these admissions
	  − Study presented: one area of Lincolnshire with 1,700 care beds was associated with 1,000 A&E admissions

What are the challenges?	• Significant work needs to be undertaken to improve the perception and stigma associated with care homes. In particular this relates to the view that care homes provide sub-standard of care and the status and perception of staff that work in care homes – impacting upon attraction and retention in the sector • The quantity and skill set of the staff in care homes needs to be increased. They are currently under-resourced, and the current skill level of staff means that that are not equipped to deal with many issues that could be treated in the care home as opposed to a hospital setting. The resource improvements (skill and quantity) will contribute towards greater workforce stability, translating into improved continuity of care for patients. Staff pay in care homes also to be addressed to contribute towards the stigma and perception of working in the sector • As the elderly population increases, only those patients who have to be in care homes should be there.
What else do we need to know?	• Clear guidelines will be required and protocols will need to be in place to assist staff in determining the optimal course of action. • More immediate access to Geriatrician input to supplement GP response • How do we control admission to a care home? • Should the cost of care home residents (that falls on the state) be from a joint health and social care budget that is also used for other services? • As an extreme resort, could LCC consider restrict funding to cap the number of beds in care homes in Lincolnshire?
How does this idea fit in with existing initiatives?	• Care Home Project – Skegness and Coast • Educator Programme – Lincolnshire South CCG • Dementia Project – Boston Locality
How can this idea be delivered?	• Risk assessment tools; equip staff; relatives shared plan • More GP visits to care homes will be needed • Greater support from community geriatrician, GP, nurses, palliative care teams • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 2: Remote monitoring telehealth

What is the idea / option?	Supporting patients at home through tele-monitoring and using technology such that patients/professional can access advice and support remotely, especially in rural areas.
	• The following concepts to be distinguished:
	  • Provision of remote consultations to patients
	  • Connectivity between clinicians to facilitate knowledge sharing
	  • Remote monitoring of patients utilising devices
	• Connectivity to be facilitated through appropriate infrastructure

What service issues does this idea address?	• Patients are often currently unsupported to stay at home. • Improved access to self-help and psychological therapies (eg. IAPT and CBT) • Enhances self-management and allows better coping and greater adherence to medication, better disease detection and stop exacerbation
What are the outcomes / quality outcomes of this idea?	• Benefits to patients in terms of direct access from home and greater coordination of care • Improved medication compliance through more regular consultation and checking-up on patients
What are the financial /activity outcomes of this idea?	• Most significant benefit is the travel costs – particularly for those in rural areas of the county • Benefits to clinician productivity – particularly regarding the time taken if doctors are travelling to see patients in rural areas. Opportunity cost of clinician time • Potential decreased hospital admissions for those with long-term conditions through improved self-management

What are the challenges?	• Need to acknowledge that remote monitoring and telehealth services may not be appropriate for all patients:
	  • Need to define clear parameters regarding who can receive the greatest benefit
	  • Not suitable for initial consultations – perhaps follow-ups after a series of in-person consultations
	• Telehealth facilities (particularly video conferencing) needs to be available across all organisations. This will not be useful if only select services can provide services remotely
	• Telehealth services should not remove the 'human' aspects of care delivery. For example, remote monitoring cannot be done without a video or personal interaction with a care provider on a regular basis. Telehealth is more than simply about devices and equipment.

What else do we need to know?	• What is the equipment and infrastructure that we need? • How much will this cost? • For which patients / cohorts can the most benefit be derived?
What are the interdependencies with other Care Design Groups?	• Not identified during Care Design Phase 1
How does this idea fit in with existing initiatives?	• Not identified during Care Design Phase 1
How can this idea be delivered?	• IT system in place across organisations (in some cases Skype could be a simple and appropriate technology) • Training for staff & patient needs to be provided • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 3: Integrated discharge to assess

What is the idea / option?	• Single, co-ordinated community-based discharge support programme that pulls patients out of hospital , including:
	  – voluntary sector discharge support (e.g. support for return to home)
	  – 24/7 availability of primary care, community nursing and social care
	• For discharge management, the team looking after the needs of patients should be similar if not the same as teams who generally manage proactive care / preventive health. This is to improve the continuity of care and patient familiarity with the relevant workforce.
	• Strong linkages are needed with Recovery, Re-ablement and Rehabilitation services
	• This cannot be about purely saving money – it should be focussed on in the context of improving quality of care and patient satisfaction

What service issues does this idea address?	• Relatively high length of stay • High numbers of patients in care homes
What are the outcomes / quality outcomes of this idea?	• Improved patient satisfaction • Earlier return to independence • Enhanced rehabilitation • Reduced infection rates, malnutrition, etc. • Improved quality and continuity of care
What are the financial / activity outcomes of this idea?	• Reduction in long-term care costs • Decreased readmission rate • Average LoS decreases by up to 50% for admissions that early discharge could apply to

What are the challenges?	• Clear distinction is needed between early discharge programs and discharge management service:
	  – Early discharge is referring to specific interventions that enable the discharge of a patient faster than usual – generally through the provision of additional supports to enable the patient to recover in a home setting (e.g. after surgery). Effectively implies the entire ‘episode’ does not need to be in an acute setting
	  – Discharge management is referring to patients for whom an early discharge program may not be in place (i.e. length of stay remains average and they are not discharged earlier than usual) however work could be done in the community/primary setting to prevent a readmission or a new admission occurring.
	• These two approaches require different skills and services. Early discharge requires more hospital-in-the-home type support, whereas discharge management is about following up with patients and the provision of preventive services and social care where appropriate. The focus should be on patients at a higher-risk of readmission (e.g. long-term conditions)
	• Incentives need to be aligned to ensure that core care teams still have a responsibility for patients once they leave the acute setting to prevent patients being “pushed” out
	• Intermediate care facilities

What else do we need to know?	• What are the extra skills we require in the neighbourhood teams to support this? • What are the times that they would be available?
How does this idea fit in with existing initiatives?	• The idea is already being put into practice, but with mixed effectiveness
How can this idea be delivered? (Time, stakeholders, dependencies)	• On arrival admission: discharge plan on admission; predicted date of discharge on admission; contract with person + family /carer in bed • Need to draw in local communities / 3rd sector to improve the scope and reach of the neighbourhood teams • IT system security levels have to converge • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 4: The declining patient

What is the idea / option?	This idea looks at various care planning, co-ordination and delivery improvements to care for the declining patient
	• Identify tools and local knowledge
	• For points of access, there should be a:
	  − Single point of access for all with appropriate staffing
	  − A unified team for care planning
	• The community should retain responsibility for patients if they go into hospital
	• There needs to be a strong understanding of payment mechanisms
	• The Locality team should consist of: a) Group of practices; b) Community nursing; c) Mental health; d) Social care; e) Therapists; f) Palliative care; g) Voluntary sector
	• The wider team must have a community geriatrician
	• Day therapy is needed in primary care

What service issues does this idea address?	• No current focus on these patients who have significant needs • Good evidence that better care planning co-ordination and integrated delivery is cost effective
What are the outcomes / quality outcomes of this idea?	• Improved patient experience
What are the financial /activity outcomes of this idea?	• Decreased admissions • Decreased acute hospital beds (take a ward out – 30 beds) • Decreased length of stay in all beds • Reduced readmissions • Better and more appropriate use of community hospital facilities • Decreased crisis calls up or down • Decreased hospital to nursing home conversion (may be number not %)
What are the challenges?	• Need to enhance overnight support at home to reduce reliance on community beds. Within 48hrs individuals start to loose independence
What else do we need to know?	• Cultural shift to support anticipatory care planning: collaborative learning programme
What are the interdependencies with other Care Design Groups?	• Urgent care system should have access to these patients records so that they can be managed appropriately
How does this idea fit in with existing initiatives?	• Frail elderly pathway currently includes this thinking
How can this idea be delivered? (Time, stakeholders, dependencies)	• GP IT systems need to be able to extract problems, link them to "care pathways", "technical plan" which can then be treated with/ for patient /client (at moment can do this in certain cases) • Practice nurse role development • Support neighbourhood teams – free up resources so anyone can commission resources to support people • Need to draw in local communities / 3rd sector to improve the scope and reach of the neighbourhood teams • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 5: End of Life Care

What is the idea / option?	• Proactive identification of patients approaching the end of their life • Advanced Care Planning including nomination of preferred place of care and place of death • Palliative Care buddy-this will be a professional who accompanies the patient throughout their journey regardless of care setting. This should be non-organisational/ non professional specific and reflect patient need. • Individual palliative care plan to promote and enable self management and incorporate plans to support deterioration / crisis / change • Responsive needs tool that enables service to respond promptly and refreshed to cover all care settings • Dedicated 'pull' of palliative to provide access to holistic assessment by palliative professionals able to address patient needs first time • Multi-disciplinary teams both neighbourhood and extended • Effective co-ordination of information that can be accessed easily in all settings throughout 24/7 • Standardised approach to underpin quality of life e.g. GSF • Acute services to have access to information • Carer as a partner in care, and dedicated support for carers
What service issues does this idea address?	• Poor identification of patients approaching the end of their life and late access to palliative professionals leading to crisis and hospital admissions
What are the outcomes / quality outcomes of this idea?	• Holistic assessor and support • Decreased ill health of carers • Managed end of life care • Preferred place of care • Preferred place of death • Single quality support tools e.g. one pain score used by all professionals enabling review of whether pain or other symptoms are being effectively managed • Access for patients with dementia • Effective symptom management for patients in care homes
What are the financial / activity outcomes of this idea?	• Decreased number of admissions
What are the challenges?	• People need to be encouraged to make advanced care directive • In some cases, there needs to be acceptance that patients might require support that is avoidable, e.g. patients with non cancer diagnosis, so resources need to be avoidable to step-up, step-down
What else do we need to know?	• What extra resources do we need to deliver this? • Is this a specialised service or could it be delivered by generalist neighbourhood teams? • Need responsive palliative resource to provide intensive support and link with specialist palliative medicine • True decision regarding how to commission to ensure consistency of approach • Refresh of responsive needs tool to cross all settings • Responsive palliative resource to provide intensive support • Links with specialist palliative medicine
What are the interdependencies with other Care Design Groups?	• Link with Urgent care group • Patient records should be available across the system so appropriate care can be given.
How can this idea be delivered? (Time, stakeholders, dependencies)	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 6: Self Care

What is the idea / option?	This idea focuses on helping to look after yourself. It involves: • Focusing on positive assets that the individual has • Empowering confidence to ask and explore • Encouraging patients to take responsibility – supporting behavioural change • Access – referrals from care professionals to self care • Training of patients, and facilitating patients to help other patients • Improving knowledge of condition and self-monitoring • A befriending service • A directory of community assets – peer support, 3rd sector services, etc (we looked at NHS Kirklees Self care toolkit)
What service issues does this idea address?	• Patient interviews for the pioneer bid suggest that patients feel “done to” and not encouraged to take responsibility for themselves. • Comprehensive self care programmes are proven to be cost effective
What are the outcomes / quality outcomes of this idea?	• Improved Quality of life • Improved wellbeing • Closer to home • Multidisciplinary group sessions looking at bio psycho social aspects of the condition + providing social work support work very well can be very cost effective saving medical time • Change in responsibility • Empowered community and maximised user contact
What are the financial / activity outcomes of this idea?	• Decreased cost • Decreased hospital admissions (recent evidence suggest c 4% of NHS funding would be saved by comprehensive self care) • Decreased service usage • Increased service timeliness / capacity
What are the challenges?	• A behavioural change is needed from both the patient and care professionals
What else do we need to know?	• What do we need to do now to make this happen? • If we invested in this what should we spend the money on? • What is welcome? IT training, IT access, hard & software, easy & guided access, patient champions, telehealth support; podcasts, apps iPads
What are the interdependencies with other Care Design Groups?	• Need to consider preventative activity e.g. health & social benefits of health walks programme, vitality

Design detail – Proactive

Proactive Care 7: Enhanced Carer Support

What is the idea / option?	• Language: 'carer self-care' • Identify capacity of carer to provide care. • Council has a statutory duty to offer carer assessments. 5,000 of these are undertaken per year, yet according to census data there are 80,000 carers • Needs: provided and signposted • Practical things: power of attorney, transport, befriending, social network • Emotional / spiritual support • Health prevention programmes (wellness, rest, respite, etc) for carers to stay well • Life after caring?
What service issues does this idea address?	• There are plenty of informal carer support networks but these are not co-ordinated and patients / professionals are often not aware of them
What are the outcomes/quality outcomes of this idea?	• No escalation to experience care empowerment-more expensive care setting • Better quality of life for patients and carers • Reduced isolation • Carer's health and wellbeing maintained • Decreased patient usage of services • Impacts to carer's physical and mental health
What are the financial / activity outcomes of this idea?	• DH estimated that carers 'save' the NHS and social care £119bn per year • Admissions to care homes reduced • Hospitals reduced • Length of stay reduced
What are the challenges?	• Reducing dependency on a small group of 'heroic leaders' equipping our teams to provide diffuse leadership throughout the system
What else do we need to know?	• What do we need to do now to make this happen? • If we invested in this what should we spend the money on? • Do we have enough volunteers? If not, how can more be recruited?
How can this idea be delivered? (Time, stakeholders, dependencies)	• Educate neighbours and families • Excellent workforce planning and coordination of existing devices and organisations is essential • Need to involve Lincolnshire workforce team HEEM • Transitional leadership management • A system to assess the capacity of careres to provide care and help enhance them where possible, would be useful • Identify careres should be made easier, either via social media, peer support, formal referral, agencies, support mechanisms • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 8: Trigger Response

What is the idea / option?	• Curiosity: spotting precipitating events: pet dies, carer away, boiler breaks, etc. • Medicine / intervention self management • Support network replacement • Spot practical events and intervene (e.g. shopping) • Telecare / phone support • Alarm schemes • Wellbeing service • Non-emergency response
What service issues does this idea address?	• Prevention of escalation of care needs not currently systematic
What are the outcomes / quality outcomes of this idea?	• Decreased falls • Decreased suicide rate • Decreased infection • Decreased illness • Decreased mortality • Closer to home • Supports carers • Decreased fragmentation • Good neighbourhood
What are the financial / activity outcomes of this idea?	• 13,000 in supported homes • Possible range of dampening effect 0 – 15 % at each care level of social care (data available from wellbeing services modelling) • Least intrusive
What are the challenges?	• EMAS support: following the guidelines needs to be easier
What else do we need to know?	• Who should the trigger event be reported to? • What do we need to do now to make this happen? • If we invested in this what should we spend the money on?
What are the interdependencies with other Care Design Groups?	• Multi-agency integration: cross over of checklists e.g. Fire & falls
How does this idea fit in with existing initiatives?	• The neighbourhood team would be instrumental towards the achievement of this initiative • Educating family and people who are in contact with frail and elderly people about precipitating events and
How can this idea be delivered? (Time, stakeholders, dependencies)	• Circulate and make information available to family, carers and wider community • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 9: Bones Health / falls prevention

What is the idea / option?	Commission a pathway/service that is integrated and seamless
	• First need to identify patients at risk of osteoporosis/falls based on family history and a patient list
	• Identify family and carer of patients
	• Manage risk/those who have fallen
	  − Review is needed of patients environment, medical risks, footwear, lifestyle issues etc.
	  − Self Care/Health Promotion
	  − Bone health medication
	• A key worker is needed to be responsible for each person who is the most appropriate depending on patient needs.
	• This will allow the patient to knows who to contact
	  − Self-management is also needed to empower patients to contact the key worker and use telemedicine/care
	• Medication/polypharmacy is a key issue.
	  − Currently it is unclear what medication patient have been prescribed one worker who can take ownership of each patient can track this
	  − Communication between different agencies/services needs to be improved. They are currently working in silos.
	• Recognition of falls as a critical event
	• Tailored fall care, high alert patient, carer + patient work together

What service issues does this idea address?	• High hip fracture rate and variation across the county • Good evidence to support interventions to reduce the fracture rates
What are the outcomes / quality outcomes of this idea?	• Seamless service • Patient set goals
What are the financial / activity outcomes of this idea?	• Decreased number of falls results in decreased acute care costs • MDT model can prevent falls • 1 pathway, 1 contract rather than lots
What are the challenges?	• Up to 50% of >65 attend the ED with a fall. Guidelines are available but perception that these are not followed, EMAS support is needed • More GPs, FOPs + GP reviews help, OT's + physios needed, research
What else do we need to know?	• What do we need to do now to make this happen? • If we invested in this what should we spend the money on?
How can this idea be delivered? (Time, stakeholders, dependencies)	• Capture non injury fall from low level 'services' of carers • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design detail – Proactive

Proactive Care 10: Recovery, Re-ablement and Rehabilitation

What is the idea / option?	This intervention focuses on multi-disciplinary teams and the creation of an integrated pathway.
	• The pathway needs to be full, whole and continuous
	• A commissioned pathway needs to be generated. Currently some pathways are successful but there are gaps in others.
	  − The pathway needs to be team focused so that if one individual fails the team fails.
	  − A comprehensive, pan organisational county wide directory of services, including voluntary and voluntary sector needs to be produced.
	  − Single point of access should be used to co-ordinate services working together
	  − For patient's a data source needs to be available providing patient history and medication and who has previously seen the patient
	  − A key worker / practitioner is needed to be responsible for each patient. They need to manage the patient care, have the right skills, and ensure an integrated pathway is followed.
	• Implement a practitioner led hub and spoke model which is equitable across the county. One centre of acute services followed by community centres managing rehabilitation, therapy etc..
	• Integrate hospital care budget and social care budget to integrate the pathway and ensure social care can be commissioned easier.
	• Create a personalised budget for rehabilitation patients.

What service issues does this idea address?	• Following recovery from illness, re-ablement / rehab to previous functional level doesn't receive enough attention
What are the outcomes / quality outcomes of this idea?	• Better patient experience which is not organisation or service dependent • Outcomes related to goals • Promote independence • Prevent carer breakdown • No "patient bouncing"
What are the financial / activity outcomes of this idea?	• Reduced unnecessary hospital admission –quantification requested-contact LC • Trusted assessors / assessment to reduce duplication • Attractive for workforce, as it avoids duplication, creates opportunities, a proper pay structure / incentives, sense of valued and leadership, skill mixing, Right person, right place, right time
What are the challenges?	• For the hub and spoke model assessment beds are needed for patients who have no rehabilitation potential, not acute / medically unwell and do not need to be at hospital but need more support from being at home. Rehab beds and respite beds to avoid crisis are also needed along with step up / step down provisions. • Protection of budgets and work loads • Needs teams of OT's / SS / Physios
What else do we need to know?	• Do we currently have the staff capacity to deliver this? • What therapy staff should there be in a neighbourhood team and what specialist skills need to be provided at a wider level? • Complex case managers were successful
What are the interdependencies with other Care Design Groups?	• Community involvement is vital in the neighbourhood team. Hired into community services offers support – befriending / home from hospital / all • Housing: housing adoption & DFG • Current IT availability

SECTION 4.3.2
Urgent Care

Urgent £36-43m	• Eight initiatives were considered and grouped into three design options by the Urgent care design group. These are: • A Single Integrated Urgent Care Service under a Single Management Structure • A Single Point of Access that has access to Directory of Services which includes community, social care and other intermediate care options and coordinates direct patients with urgent care need to the right services. • An A&E Local (branding to be discussed) is an integrated multi-disciplinary service comprising traditionally separated acute, primary and other care professionals of an A&E (primary care currently approximately 40-50% but could increase in the future model). 7 day service. • Together with Proactive interventions, the cost avoidance range identified equals approximately £36-43m.

Intervention Detail

Urgent Care Design Options

The following design options were identified as part of the Proactive care design group:

1. Integrated urgent care management structure
2. Coordination Centre / Single Point of Access
3. A&E Local

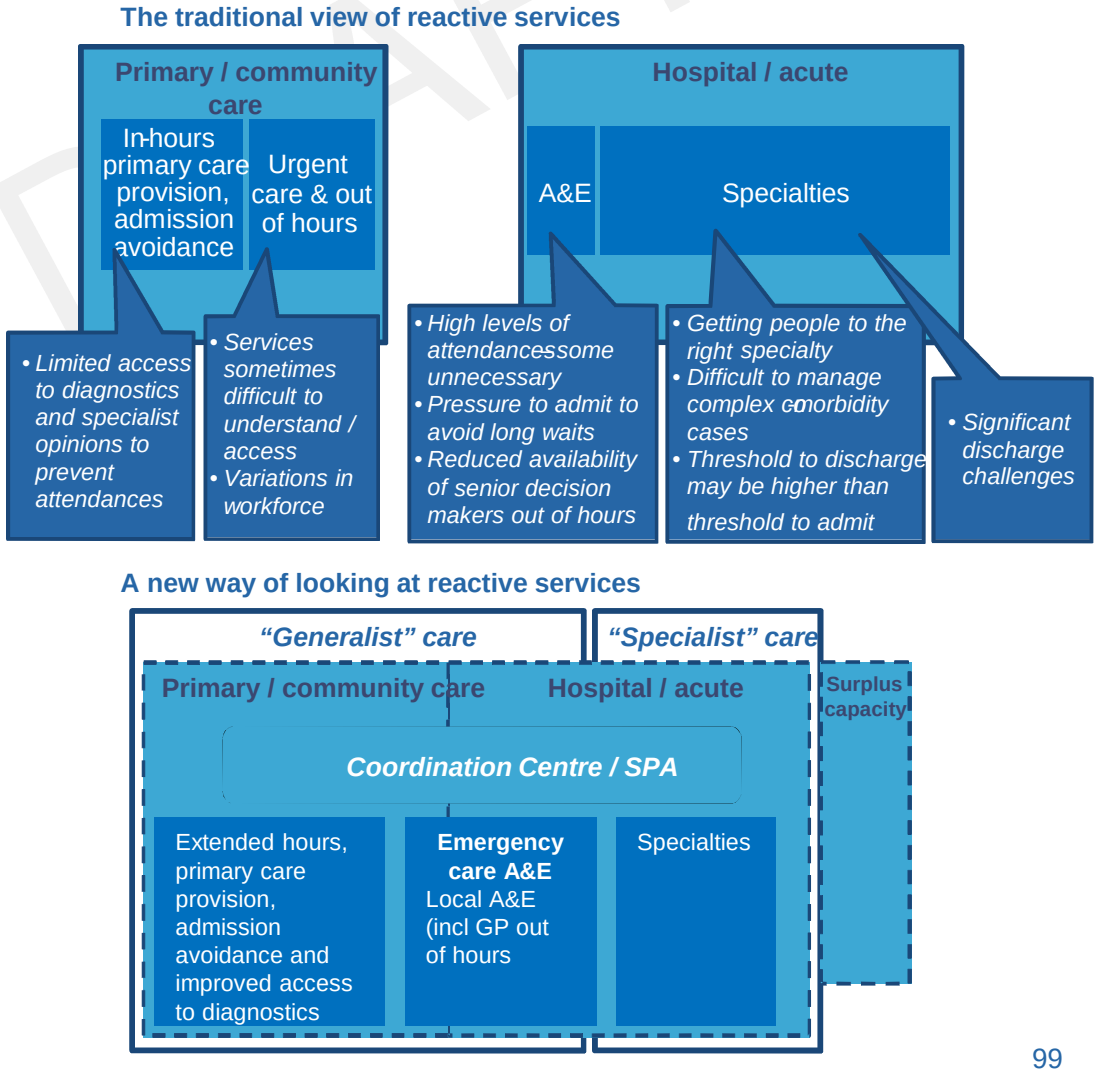
The intent of these interventions is to offer the appropriate way for patients to access urgent care, providing the right experience irrespective of the point of entry. This recognises that the right access during the first spell is likely to determine the patient's behaviour in the future.

The creation of A&E locals is instrumental to this as it would result in a range of options designed around what can best suit the patient and an optimal utilisation of resources in acute hospital settings and other type of settings.

An integrated urgent care management structure would result in a more integrated provision of urgent care services across Lincolnshire under one umbrella with an adequate utilisation of resources across acute hospital and other type of settings driven by the patient's needs and greater visibility of the patient journey from the point of entry to the end of the spell.

Finally, the Single Point of Access is also instrumental toward the achievement of this, as it coordinates the access the right services for patients.

Urgent (Reactive) Care: changing the way we look at reactive services



Design Detail – Urgent

Urgent Care 1: Integrated Urgent Care Management Structure

What is the idea / option?	A Single Integrated Urgent Care Service under a Single Management Structure. A central / macro management team would pull together budget and resources from urgent primary care, social care, community healthcare and A&E / A&E Local / MIU and MAU in hospitals. The macro management team would support on a local level, micro units, which can commission and provide urgent care services for the local people. The service will require senior clinical decision makers involved early in the process and will also require collaboration between organisations (e.g. a commissioner federation).
What service issues does this idea address?	• Reduces duplication in service • Removes confusion for staff / patients on pathway of care • Effectively manages increasing demand
What are the clinical outcomes of this idea?	• Allows more flexible deployment of resource to higher utilised areas (consultants deployed to "virtual wards" rather than being aligned to organisations) • Improves quality as patients will access the appropriate service, rather than the first they get to • Provides access according to need • Provides consistent services across the county • Allows flexible provision of services across primary and secondary care according to patient needs
What are the financial outcomes of this idea?	• Realises economy of scale by centralising budget and budget management • Centralises demand management • Reduces admissions due to better managed demand and referrals • Reduces length of stay, equivalent to reduction in bed days by X (e.g. reduce to the level at Devon)
What are the challenges?	• This approach requires breaking the dominance of acute provider • Need to create the right incentive for providers – issue of selecting the "right" provider in the market • GPs' role can be fundamentally challenged • Political challenge
What else do we need to know?	• What's the benefit of having a micro commissioning / managing unit? • How can we quantify financial outcomes? (What efficiency / productivity improvement through economy of scale?) • How does women's & children's fit into this? • What are the enablers we need to consider to make this possible?
What are the interdependencies with other Care Design Groups?	• Provision of Women's and Children's services would likely have an impact on this initiative, particularly which Women's and Children's services would be provided where and Children initiative 6: Children's Services under One Operational Management Structure
How does this idea fit in with existing initiatives?	• The initiative fits well in the broader integrated future model of care and is also related to Women's and Children's initiative 6: Children's Services under One Operational Management Structure
How can this idea be delivered?	• Cross-organisation collaboration and between health and social care providers • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design Detail – Urgent

Urgent Care 2: Single Point of Access

What is the idea / option?	A Single Point of Access that has access to Directory of Services which includes community, social care and other intermediate care options and coordinates direct patients with urgent care need to the right services. The SPA is in charge of 24/7 call handling & crisis coordination and also linked in with community led 'discharge-to-assess'.
What service issues does this idea address?	• Currently there are multiple points of access for patients with urgent care need, resulting in fragmented pathway, inconsistency of services provided • Data is not shared across function
What are the clinical outcomes of this idea?	• Allows better coordination between acute and primary care • Directs patients to services best suited to their care need • Improves quality as patients will access the appropriate service, rather than the first they get to • Allows resources to be better utilised as the hub will have access to all urgent care services available
What are the financial outcomes of this idea?	• Reduces costs of running different call coordination / crisis response services • Achieves economy of scale
What are the challenges?	• Can potentially cause delay in responses • Resistance from GPs to incorporate GP 111 into this service
What else do we need to know?	• Who is this for? Patients or professionals or all of these? • For what? Urgent care or routine? Social care or health care? • What's the construct at a high level? • Is it information provision or deploying? • What access points currently exist? • Should GP 111 be included in this configuration? i.e. rather than having patients directly book appointments with GP out of hour services, all calls/ contacts from patients will be centrally managed. If so, GPs will have strong resistance to this • Who should be operating this service? • What IT infrastructure needs to be put in place? • What are the workforce requirements?
What are the interdependencies with other Care Design Groups?	• Proactive CDG – crisis response delivered in the neighbourhood team and Proactive Care Intervention 3: Integrated discharge to assess
How does this idea fit in with existing initiatives?	• Single Point of Access LCHS, LPFT
How can this idea be delivered? (Time, stakeholders, dependencies)	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design Detail – Urgent

Urgent Care 3: “A&E Local”

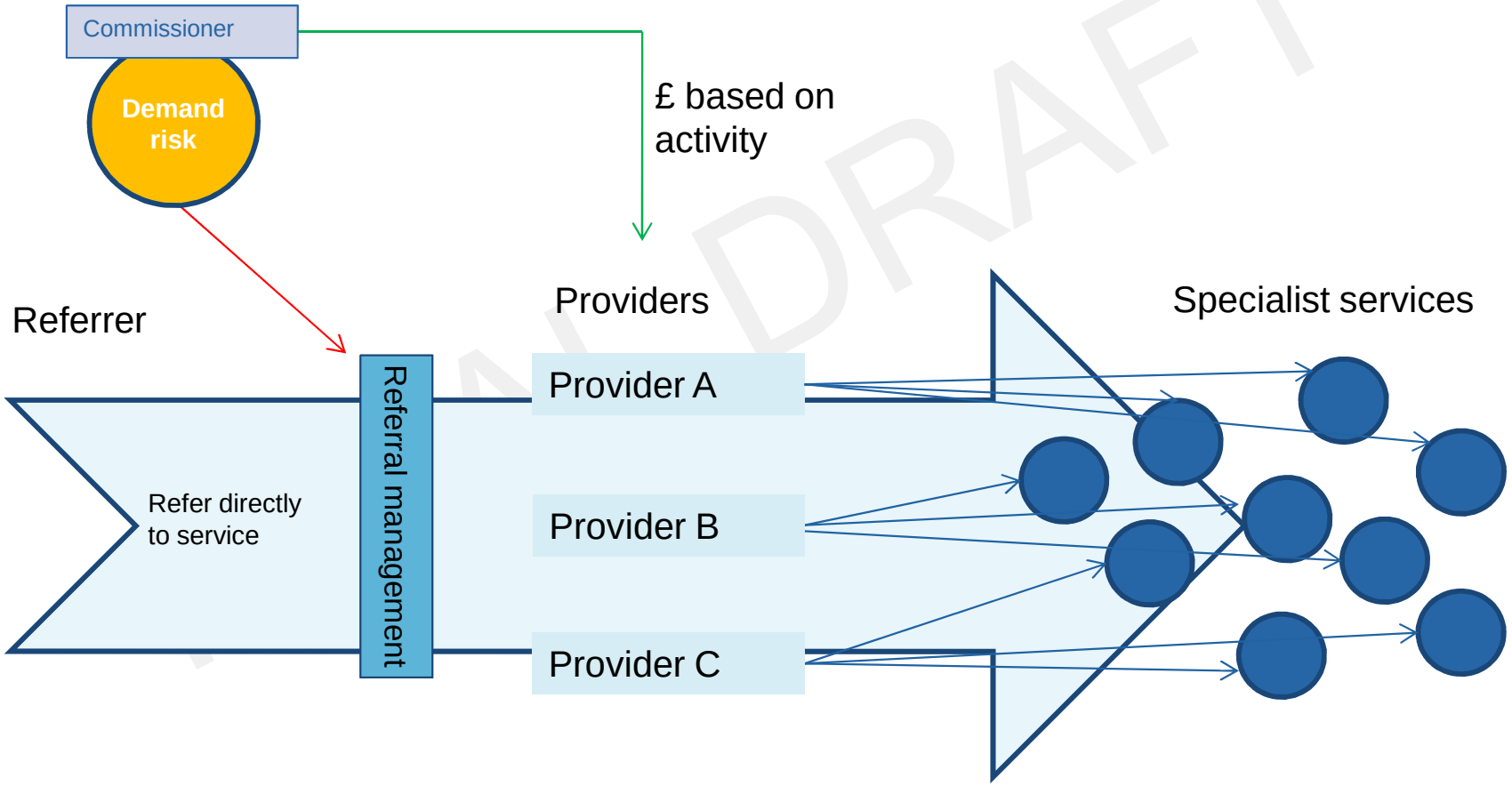
What is the idea / option?	An “A&E Local“ is an integrated multi-disciplinary service comprising traditionally separated acute, primary and other care professionals of an A&E (primary care currently approximately 40-50%). The integration of previously separate services that respond to urgent care (including primary, community and mental health care and social care) has the potential to create sufficient scale and critical mass to support delivery from more locations than would be possible for traditional A&Es. The configuration of these services will be defined by local population needs. This is a 7 day service (still to define whether it is in hours or out of hours). An A&E Local does not have beds. Minor injuries could be provided in a mobile setting and have near patient testing for some activities and for patients with low mobility. Senior clinical staff opinions to be provided early in the process (this is potentially a GP at an A&E Local).
What service issues does this idea address?	• Current model of multi-site delivery is not financially or clinically sustainable • A&E locals to meet the demand to shift activities from current A&E • To absorb growing demand
What are the clinical outcomes of this idea?	• Allows better coordination between acute and primary care • Allows flexible provision of services across primary and secondary care according to patient needs(A&E local staff will consist of GPs, A&E consultants, consultant nurses etc., all working as urgent care clinicians) • Provides alternatives to A&E to absorb demand growth • Improves quality as patients will access the appropriate service, rather than the first they get to • Provides consistent services – all A&E locals will provide consistent range of services
What are the financial outcomes of this idea?	• Replaces MIU, out of hours primary care • Reduces A&E admissions and bed days • Possibly reduces demand for primary care
What are the challenges?	• There may be the risk of developing a “Walk-in syndrome” that effectively resulted in the creation of a new demand • It would be hard to get GPs on board, as they are not employed by NHS England or the CCGs • The affordability of this model needs to be tested • The “A&E local” brand would have to be clear so as to avoid any confusion to the community • There is a dependency on EMAS mobile services SPA
What else do we need to know?	• What is the scope of services of an A&E Local? • How does an A&E Local fit with GP surgeries, GP out of hour services, visiting services? • Is it 24 hours? • How many A&E Locals? Where should they be situated? • What’s the impact of seasonal variations in flow of patients ? (some services need to be provided over a certain period of the year not all year long.) • How does A&E Locals fit with MIU services (e.g. are services provided during bank holiday and weekends) • How can we make this happen?
What are the interdependencies with other Care Design Groups?	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board
How does this idea fit in with existing initiatives?	• Urgent Network Board • Current thinking around SPA
How can this idea be delivered? (Time, stakeholders, dependencies)	• Need also to have good gatekeepers to the hospital, so that they are efficiently sorting between those who need to be admitted to the hospital and those who don’t need A&E • Long term (10 year) train EMAs workforce on where to take patients • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

SECTION 4.3.3
Elective Care

Elective	• The elective care design group identified the need for a single end-to-end service commissioned for a particular patient group, service or specialty, including all of the acute and community aspects of the service. The group specifically considered how such initiative would apply to fifteen specialties. • An overall referral structure was identified as needed to support referring clinicians to decide the appropriateness of referrals, together with simple guidelines developed community-wide to aid GPs and feedback loops between GPs and specialists • High-level site considerations on the principles that need be considered when analysing where services should be provided • These initiatives are estimated to lead to benefits in the region of £11-26m.
£10-25m	

Design detail –Elective Care

Current Service Provision

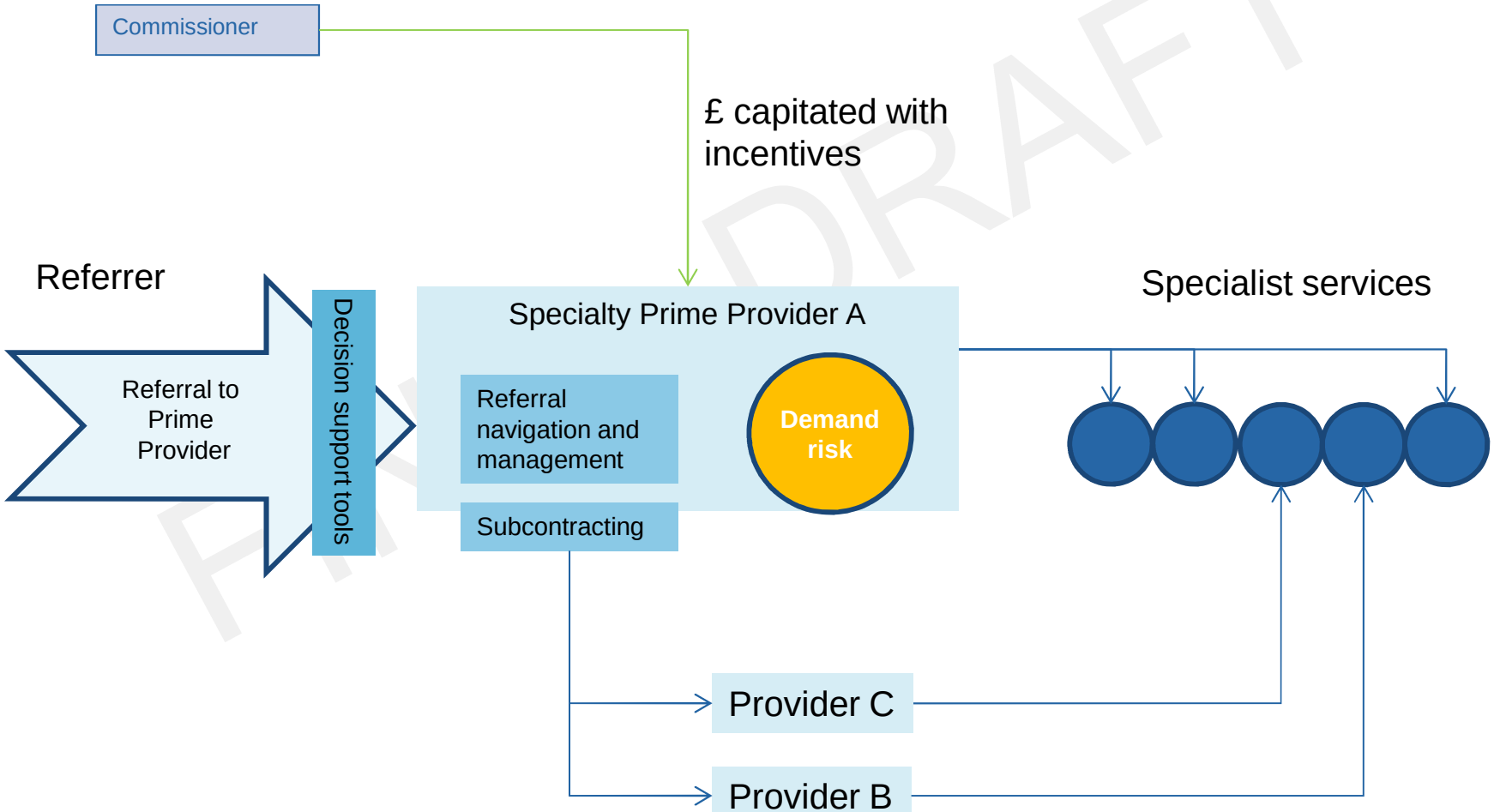


Results in:

- Hand offs
- Fragmented patient journey
- Difficult financial control

Design detail –Elective Care

Proposed Future Service Provision



Results in:

- Integrated patient journey
- Robust financial control

Design Detail – Elective

Elective Care 1 : End-to-End Integration of Services

What is the idea / option?	• A single end-to-end service commissioned for a particular patient group / service / specialty – including all of the acute and community aspects of the service. Once the established threshold is passed, the patient goes to a single provider who coordinates the patient journey and delivers their care by bringing other expertise when required. • The single service provider will manage referrals throughout the patient pathway. They will also decide what follow on activities are needed for patients. • Many of the activities currently delivered in an acute setting can be delivered by other care professionals in different settings. • Complex surgery to be centralised to create critical mass to deliver safe services • Less complex surgery can be delivered in other acute hospitals, community hospitals, primary care and mobile. Specialist clinicians' time, over and above clinical delivery, could be used more effectively to provide remote advice and guidance and training opportunities to the wider healthcare team.
What service issues does this idea address?	• Currently, commissioners separately commission services from broad service line providers (e.g. orthopaedics from a hospital trust, MSK from a community provider, physiotherapy as a primary care LES, etc.) • Traditionally, referrers are expected to diagnose and refer to the right service and availability of services is constrained by budget (e.g. referral to a specialist may be faster than availability of a community service) • Giving one sum of money to providers to manage a single service contract across acute and community would increase visibility of all processes patients go through and would likely result in greater efficiency throughout the process • An integrated model has many advantages but is no simple decision, as there are risks as well as potential benefits
What are the clinical outcomes of this idea?	• Better coordination between acute and primary care – pathway more joined up • Centralising services can lead to higher volume which is correlated with higher quality outcomes
What are the financial outcomes of this idea?	• Reducing duplicated services (currently provided in both acute and community) • Better referral facilitation – due to centralised responsibility within a single provider • Economy of scale – centralised services with a leaner management structure • Many services currently delivered in acute can be moved to community, achieving financial savings

Design Detail – Elective

Elective Care 1 : End-to-End Integration of Services (cont.)

What are the challenges?	• Currently primary care is not equipped to carry out many of the elective activities • Carrying out procedures in non-acute settings or community will result in the need for lots of units to meet regulatory requirements • IT support needed to deliver this integrated service model • Behavioural change and cultural change are needed to encourage this new way of working for clinicians • Incentives are not in place currently to motivate more activities to be delivered in community and shift clinicians' preference to undertake more simple procedures and fewer complex ones • Incentives for capitated budget need to be linked outcomes • Dependency on GP contract negotiation – GPs need to be given the right incentive to upskill • Lack of detailed data on specialties (e.g. how much is currently delivered in acute vs. community, capacity to repatriate services) to inform decision on delivery model for each specialty
What else do we need to know?	• Should each specialty have an independent contract for elective care? • What do we need to do to make this happen? • What are the requirements for workforce, infrastructure, and any other investment? • Need to understand dependencies across specialties. Otherwise, a contract for each specialty might complicate things when more than one specialty is involved • Would an incentives system that rewards consultants who carry out fewer simple procedures in acute hospital setting / greater complex procedures or carrying simple procedures in on-acute hospital setting work? • Need to define specialty at the right level – or else will result in an increase in bureaucracy
How can this idea be delivered? (Time, stakeholders, dependencies)	• Volume is key for an independent contract for elective care at specialty level and clinical input is needed to define the pathway (2nd independent) • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design Detail – Elective

Elective Care 1 : End-to-End Integration of Services (cont.)

	End-to-end integration	Delivery model
Trauma & Orthopaedics	• Orthopaedics interdependent with trauma (desirable to separate) • Simple procedures can be delivered in Grantham, possibly in Louth, in patient services can be delivered in Lincoln • Multiple sub-specialties	• Hands can be delivered in community • Ortho Surgical in acute • Medical can be in community
General Surgery	• Majority not complex and a small percentage is complex surgery (10-15% in HDU) • Need a bigger HDU / ITU set up to deal with complex parts of general surgery • Lincoln has all the facility but no capacity. Most facilities are in Boston but not a proper HDU.	• 1/3 needs to be dealt with in acute setting • 1/3 delivered by mobile services • 1/3 in community
Ophthalmology	• The vast majority is low acuity elective (80% may be cataract), so could move 80% in the community and have what is very complex / more acute delivered out of area • The alternative is repatriation with a branded treatment centre with good transport • A majority of follow-ups could easily be done in the community	• 80% in community • 20% in acute
Urology	• 90% of urology falls under day care, and 10% is inpatient • For highly complex procedures (e.g. cancer): low volume, high mobility • For less complex activities: high volume, less willing to travel	• 1/3 needs to be dealt with in acute setting, 1/3 can be done in mobile setting (mobile cystoscopy) • 1/3 in community
Gynaecology	• 1/3 of activities currently delivered in acute can be delivered in e.g. ultrasound • Upskilling / on-going education needed. Outcome needs to be assessed • A small amount needs to be delivered in acute, such as cancer, implant, urogyanecology • 1 hospital (possibly Lincoln) should deliver all gynaecology surgery	• 1/3 without upskilling • 50-75% of activities currently delivered in acute can be delivered in community with upskilling
Cardiology	• The greater % of less acute are more willing to travel • Most follow-ups could be treated in the community	• 50% in acute • 50% in community
Ear, Nose & Throat	• Follow-ups, diagnosis and audiology can be done in the community or mobile. • CT scanning should be done in the hospital or in a centre. • CoE for surgery with good transport can be put in place	• 80% in community or mobile • 20% in acute

Design Detail – Elective

Elective Care 1 : End-to-End Integration of Services (cont.)

	End-to-end integration	Delivery model
Gastroenterology	• Hub – spoke model • Endoscopy can be delivered at multiple sites • Use remote monitoring	• 80% can be delivered in community
Clinical Haematology	• Multiple variations of diagnosis + treatment • Centre of Excellence can be put in place • Importance of continuity – Long term (Should see specialist first -> management plan) • Delivery can use a mix of CoE + mobile + remote	• 80% can be delivered in community
Dermatology	• Vast majority (80%) could be done in the community via primary care (GP) and self-care • For follow-up in the community (community hospitals & suitable primary care estate) • Currently 80% is delivered in acute and 20% in acute	• 80% in community • 20% in acute
Pain Management	• One service • Hub-spoke model • Spend on high cost interventions and not high volume low cost	• 80% or more can be delivered in community
Breast Surgery	• Asymptomatic: need good relationship between diagnosis and surgery • Centralise plastic surgery (currently low volume – can be out of area or in Lincoln) • 1 stop shop for diagnosis, imaging, biopsy & simple surgery (histology on the day)	• 80% in one-stop diagnosis centre (incl. simple surgery) • 10-20% in acute (out of area or Lincoln)
Clinical Oncology	• End-to-end integration does NOT apply • Although some elements of treatment could be provided in the community in the future (first chemio should be in hospital, next treatments could be in the community) • Low volumes and requires high expertise, so it needs to be provided in a central location	• Some activities can be in the community in the future
Respiratory Medicine	• Appx. 50% of respiratory medical doctors' time deals with acute general medicine (unplanned emergency admission) • A small percentage of it needs to be in acute: complex diagnosis on lung cancer, bronchoscopy, complex imaging	• 1/3 in acute • 2/3 in community (Need to improve communication between acute and community)
Rheumatology	• Hub – spoke model • Electronically linked • Mobility depends on transport services • Psychological therapies	• 80% can be delivered in community

Design Detail – Elective

Elective Care 2: Improve the Way Referrals Currently Work

What is the idea / option?	• An overall referral structure is needed to support referring clinicians to decide the appropriateness of referrals. • Following referral, the single service provider is responsible for navigating and managing the patient throughout the pathway.
What service issues does this idea address?	• Perception that there is a high number of unnecessary referrals • Some evidence shows that referral management centres can lower the number of unnecessary referrals, direct referrals to the most appropriate route and fast-track urgent cases in a more centralised way, however it might increase overall costs, demoralise GPs and might misdirect certain referrals when information is incomplete • A referral management strategy built around peer review can enhance GP's capabilities to refer when it is needed, empower GP by helping them making referrals to the right setting and improve quality of referrals; however, it requires behavioural change from the GPs and high commitment • It has been shown that GPs at times unnecessarily refer a patient and this might be due to the GP's relative inexperience with certain symptoms or illnesses and the desire to mitigate risk or reducing patient's fears • Some evidence points to GPs not making as much usage of certain services as they could and predominantly referring patients to hospital-settings, even if alternative options might be more appropriate for the patient
What are the clinical outcomes of this idea?	• Referrals managed by a single service provider can help to provide a clear, integrated pathway • GP decision aid would empower GPs, allowing them to make more informed decisions on where to send their patients
What are the financial outcomes of this idea?	• Reduces unnecessary referrals • Better utilisation of different services, reducing pressure from hospitals
What are the challenges?	• GPs need to be incentivised to use decision tools • Balance between appropriate referral and GP's management of patient expectations and patient choice • Currently the IT system only allows for a referral to be YES / NO, there is no comment box or possibility for immediate feedback loop aside from ad hoc phone call or email
What else do we need to know?	• What does the clinical decision tool look like? • How does the referral facilitation within a single service provider look like? • What do we need to do to make this happen? e.g. IT infrastructure, training, monitoring
How can this idea be delivered? (Time, stakeholders, dependencies)	• Better IT systems: possibility to book a 10min slot to speak with a consultant over the phone over a shared IT programme • Integrated system patient management plan • Post-discharge patient plan • Set-up an advise line with a consultant advisor – incentivise secondary care • A more formalised way to communicate between GPs and clinicians, and not merely ad-hoc phone calls • Need to have a route for key for don't knows • Easy, consistent use of guidelines, such as map of medicines • Health-community wide-developed simple guidelines around each specialty and pathway • Stronger reviews/ vetting: in some cases secretaries can be well-placed to vet forms • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design Detail – Elective

Elective Care 3 : Site Consideration for Service Delivery

What is the idea / option?	• Complex procedures centralised to create the critical mass to deliver safe services. • Less complex procedures to be delivered in other acute sites, community hospitals, primary care and mobile. • Low volume specialties would need further consideration to decide whether they should be carried out
What service issues does this idea address?	• Evidence shows that high volume is associated with better outcomes across a wide range of procedures and conditions • The CDG's view is that patients prefer a calm environment where elective activity is separated from non elective activity • It is generally agreed at the CDG that many of the services currently delivered in acute can be delivered by other care professionals in a non-acute setting
What are the clinical outcomes of this idea?	• There will be critical mass to provide specialist services at one site • Less complex procedures can be delivered at other sites with appropriate training and knowledge transfer • Better outcomes due to patients receiving services most suited to their needs
What are the financial outcomes of this idea?	• Reduces duplication in service delivery • Some low volume activities can be delivered out of area, leading to potential savings • A hub or centre of excellence would have a positive effect on recruitment
What are the challenges?	• In a hub and spoke it is important to keep the links between the two • When volume is too low, cost outweighs the benefits • Separation of "hot" and "cold" on different sites
What else do we need to know?	• What is the thought process we need to go through to decide what activities to deliver for low volume specialities? • Where should services be delivered for complex and less complex services?
What are the interdependencies with other Care Design Groups?	• EL1 integrated services
How does this idea fit in with existing initiatives?	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board
How can this idea be delivered? (Time, stakeholders, dependencies)	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design Detail – Elective

Elective Care 3: Site Consideration for Service Delivery

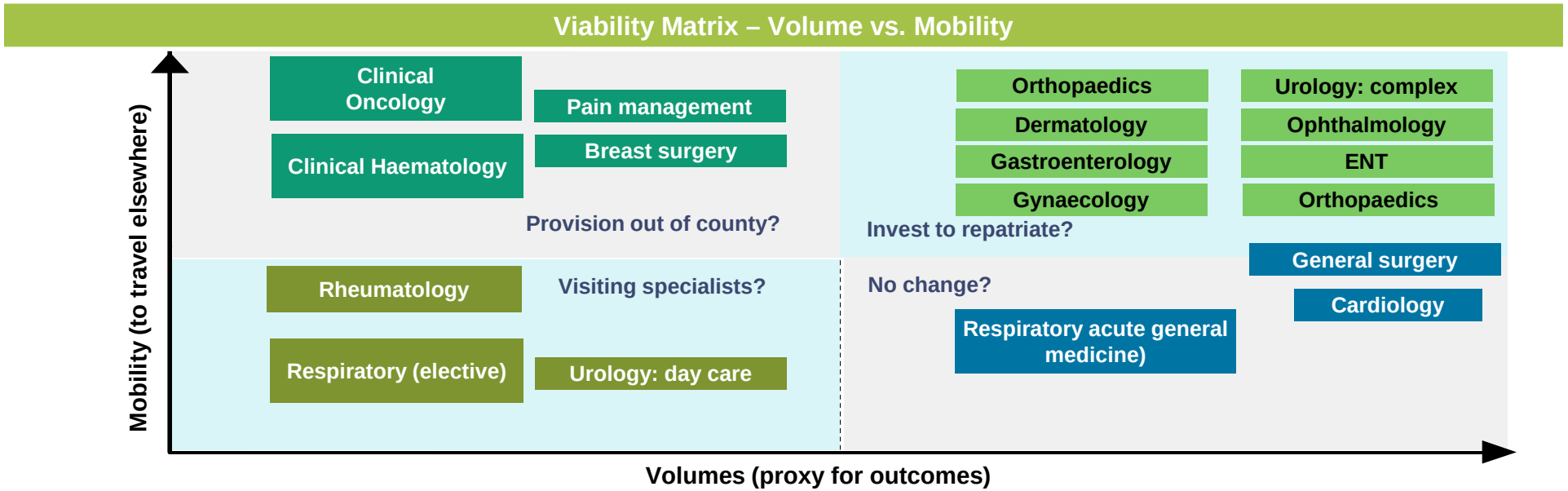
Care Design Group 2 looked at the top 15 specialities by income (proxy to volume). Each specialty was analysed in terms of whether it is suitable for end-to-end integration, whether it should be provided in acute or community settings taking into consideration patient mobility.

End-to-end integration is considered appropriate for the majority of the 15 specialties analysed. There was a general agreement that many of the activates currently delivered in acute can be shifted toward community provision.

The matrix below looks at:

1. The volume of activity the service provided (this was used as a proxy for outcomes)
2. The ease of patients obtaining the given service from another provider

During the Care Design Group sessions, it was agreed that, whilst work would be undertaken to understand the cases for repatriating, retaining or moving / delivering differently the service areas discussed, this was by no means a decisive conclusion. Instead, it was stated that, given the individual nuances of each specialism, work should be undertaken during the detailed design stage on a specialism-level basis to understand in more detail the potential for changing the current service provision. It was also noted that, whilst the Care Design Group contained a number of clinicians, the detailed design stage should involve the key individuals from each specialism when discussing their area



SECTION 4.3.4
Women's and Children's Care

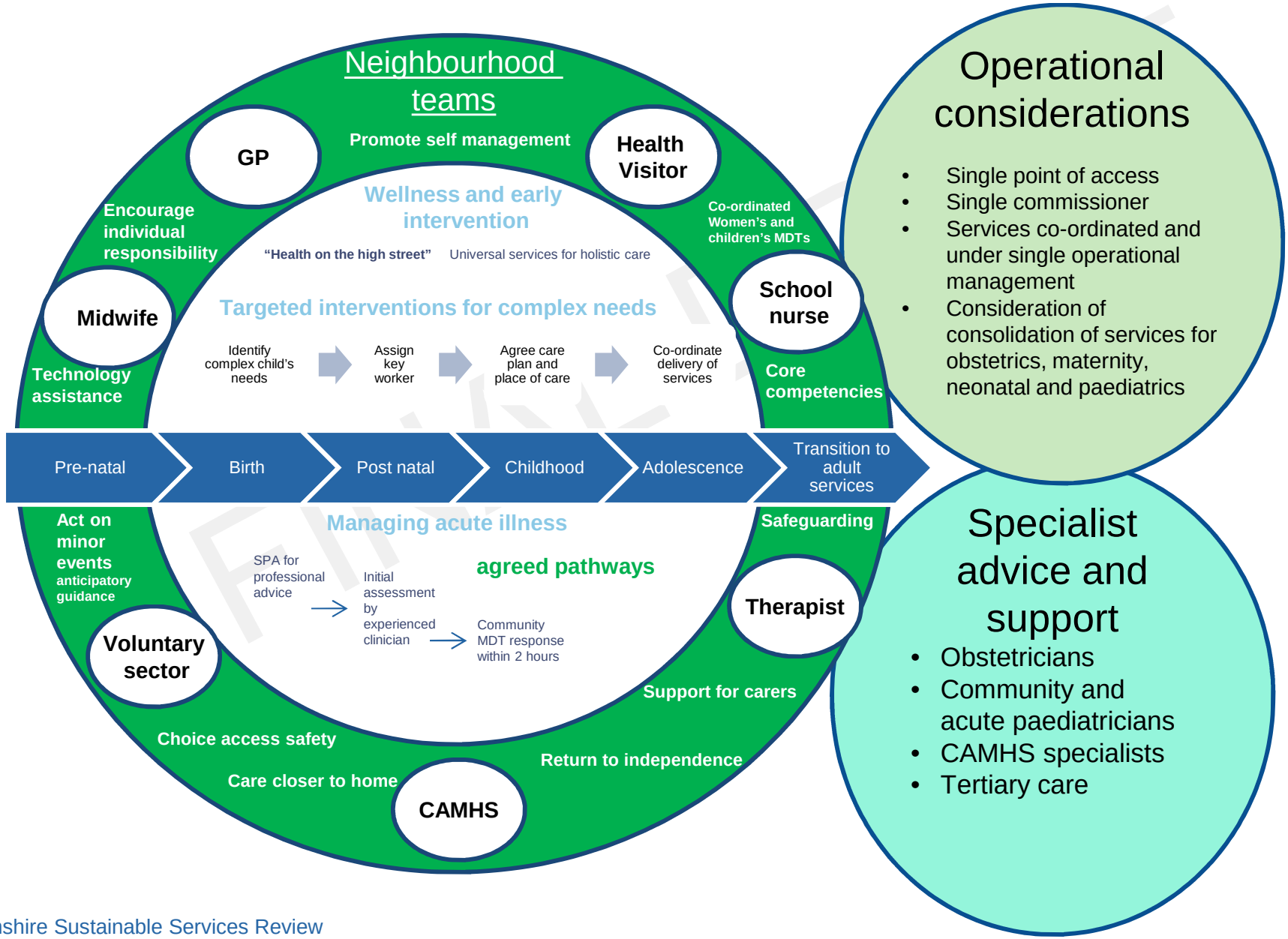
Women's & Children's	• The W&C's contribution to the system-wide financial deficit is not large with changes considered in order to provide coordinated services that enhance safety and quality whilst reducing fragmentation and duplication and maximise efficient use of workforce • Seven interventions have been developed from the Women's and Children's Care Design Groups covering commissioning and provision models, early intervention and admission avoidance and a network approach to delivering children's services around neighbourhood multi-disciplinary teams. • The group considered options around the consolidation of consultant led and midwifery led units on the same site (24/7 consultant available at all times) or consultant led and midwifery led unit on separate sites (24/7 Consultant cover at one site) • Consolidation was also discussed around paediatrics and neonatal services, including acute care, ambulatory care / paediatric assessment services, surgical units and Neonatal units
£2-6m	

Women's & Children's Care in Lincolnshire

- A number of the features described within the Women's and Children's Care Design Group overlap with those within the Proactive Care Design Group and the models are compatible and complimentary. Further work will be required during Phase 2 to illustrate how the future model for this care design group works with the proactive care design group.
- Care in Lincolnshire needs to focus on being proactive and on having early intervention programmes such as 'Health on the High Street'. This idea involved easily accessible venues that provide first line intervention e.g. testing for obesity, diabetes.
- Throughout the community there needs to be a focus on self management and encouraging individual responsibility through mechanisms such as telemedicine and promoting a 'wellness' rather than 'illness' focus.
- For those children with complex needs a single point of access will be key to ensuring children are seen by the right professionals and can help reduce hospital admissions.
- A single point of access is another common feature described within other care design groups and should be developed in a simple co-ordinated way to support care across all categories. This will need to be further developed during phase 2 detailed design
- Children whose needs a more complex may require stronger links with carers. A key worker can be used to co-ordinate nurses and agree a care plan for the patient.
- Women's & Children's Care in Lincolnshire needs to try and cover care from conception right through until the child is transitioning to Adult services
- Operationally it must be noted that Women's & Children's services have strong links to Gynaecology, Anaesthesiology, Mental Health Services etc… When considering the consolidation of services these will need to be kept in mind along with patient safety.
- Based on a national 1% decrease in obesity in children, saving the NHS/LA £1bn (according to CMO), having this as a priority for prevention in Lincolnshire, with a full supportive programme of work should be considered during Phase 2.

These concepts have been represented in the diagram in the following slide.

Women's & Children's Care in Lincolnshire



Operational considerations

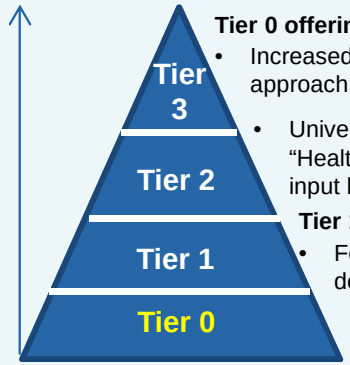
- Single point of access
- Single commissioner
- Services co-ordinated and under single operational management
- Consideration of consolidation of services for obstetrics, maternity, neonatal and paediatrics

Specialist advice and support

- Obstetricians
- Community and acute paediatricians
- CAMHS specialists
- Tertiary care

Design Detail – Women's and Children's

Women's and Children's: 1 – Early Intervention

What is the idea / option?	
	Tier 0 offering
	• Increased focus on managing demand downstream through earlier intervention comprising MDT / multi-agency skill mixed coordinated approach to LA First Contact / increased access for low level advice / intervention / supported by technology (web enabled portal)
	• Universal antenatal contact, Healthy Child programme, HV teams / GP / Children's Centres / 3rd sector involvement & volunteers, "Health on the high-street "concept / Public Health Interventions (obesity management etc. – use of non-traditional venues with input by all services
	Tier 1 offering
	• For children with a specific need identified through generic workers to support specialist teams e.g. behavioural / developmental / family support / safeguarding
	  • Single assessment via an MDT / Virtual Children's Development Centre / Network (see WC4)
	  • Managed referral in to Tier2 and 3 services

What service issues does this idea address?	• Managing demand downstream to coordinate care in an anticipatory way with targeted interventions where required • Promote self management and empower families through easier access to non-traditional points on contact • Reduced duplication and demand on specialist services
What are the clinical outcomes of this idea?	• Reduced demand on specialist services • Improved wellness (PH indicators breast feeding rates / imms rates / height and weight / school readiness etc.) • Prevention or reduction of mental health difficulties by early intervention • Reduced deterioration of functioning by early pickup of neurodevelopmental difficulties • Wider benefits from general awareness e.g. accident prevention, coping strategies for parents • Encouraging parents to engage and help social cohesion
What are the financial outcomes of this idea?	• System wide savings to public sector budgets including health, education, welfare reductions, crime, tax receipts etc • Reduced hidden costs of parent having to 'fight' for children to get help e.g. impacts on parent's health, time of work, • Careful financial modelling to reduce costs of service and identify interim measures of improvement from early intervention activities • Efficiencies by combining service provision (potentially under one operational model see W&C 6)
What are the challenges?	• Planning for workforce numbers and training • Co-ordination / transition of services / cultural shift • Clarity of specification / identification of core competencies • Demonstration of return on investment • Investment in perinatal mental health services

Design Detail – Women's and Children's

Women's and Children's: 1 – Early Intervention (cont.)

Demonstration of efficiency or return on investment
What else do we need to know?
	• What the service includes, its operating model, the workforce and competency requirements, training & CPD for development of core competencies
	• Demand factors:
	  – Birth rate / Child population
	  – Deprivation scores
	  – Ethnic minority variables
	• Risk stratification process for parental; child; early targeted support; links to Family Nurse Partnership Programme; Troubled Families
	• Domestic violence levels identification – Multi Agency Risk Assessment Conferences (MARAC)

What are the interdependencies with other Care Design Groups?	• The model designed within this care design group has consistent over-lap with Proactive Care / Neighbourhood MDTs and Single Point of Access as described in Urgent Care and Proactive Care. • Women's services are also provided through all other care design groups where they are not related to childbirth.
How does this idea fit in with existing initiatives?	Infant Feeding work with Home Start in Lincoln; Nursery Nurses delivery of public health interventions & packages of support more holistic care and fewer hand offs / referrals on – smoking cessation, weight management, chlamydia screening and early speech and language development support interventions as well as those around issues such as weaning, toileting, parenting etc. that they have traditionally provided.
How can this idea be delivered? (Time, stakeholders, dependencies)	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board • Need to liaise also with other neighbourhood resources i.e. Policing Teams / Neighbourhood management teams

- *"Early Intervention is an approach which offers our country a real opportunity to make lasting improvements in the lives of our children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending."*

Early Intervention: Smart Investment, Massive Savings. Allen, G. HM Government 2011

Design Detail – Women's and Children's

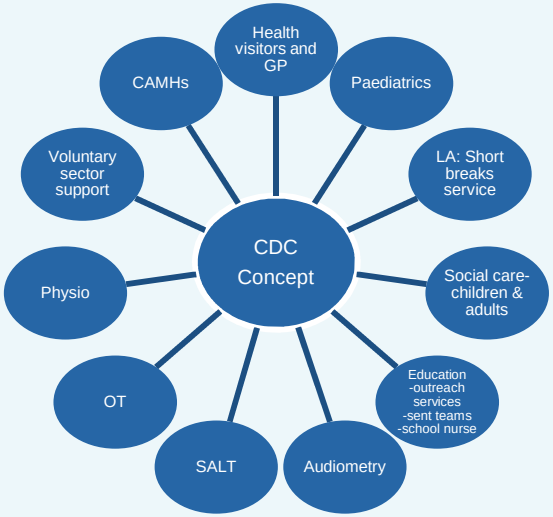
Women & Children's: 2 – Admission Avoidance for Children

What is the idea / option?	• Provide access to senior clinicians when first referred for possible admission
	  − currently more junior person, less experienced than the GP who makes the referral sees the child
	• On referral for possible admission, community based advanced nursing team to see child within 2 hours.
	  − If required, can then visit three times per day for a total of 3 days. (Kettering and Leics model)
	• Health visitor / MDT neighbourhood team members (potentially a care coordinator) to follow up A&E visit to support family.
	• Agreed care pathways for simple conditions are needed

What service issues does this idea address?	• Reduction of short stay hospital admissions that may be dealt with more effectively in a non hospital setting
What are the clinical outcomes of this idea?	• Empowerment of parents to care for their child independently • Child remains at home with family wherever possible • Family learn to manage short lived childhood illnesses
What are the financial outcomes of this idea?	• Reduced hospital admissions • Reduced hidden costs for parents and families
What are the challenges?	• Staffing – availability of senior clinicians
What else do we need to know?	• Paediatrics / Children's nurse needed at A&E / A&E local models • A liaison Health Visitor (HV) based in the hospital currently lets local HV know of an admission. However, HV currently only visits high risk families. There is a missed opportunity for advice, information and educational improvement to help prevent further unnecessary admissions.
What are the interdependencies with other Care Design Groups?	• Strong link with Urgent Care Design Group
How does this idea fit in with existing initiatives?	• Review pathways in existence and current models offered by e.g. Transitional Homecare Team who are a team of specialised neonatal nurses based at Lincoln County Hospital and Pilgrim Hospital, Boston providing support to parents taking their baby home from Special Care Baby Units (SCBU). • Existing Health Visiting services / community paediatric services and impending use of Family Nurse Partnership model • Explore links to children's centres and education services • Review palliative care services for children
How can this idea be delivered? (Time, stakeholders, dependencies)	• Further design during Phase 2 subject to approval at Programme Board and Health and Well Being Board to review roll out of existing initiatives and specification for models under single operational management structure

Design Detail – Women's and Children's

Women's and Children's: 3 – (Virtual) Child Development Centre / Network

What is the idea / option?	 All these services to be available in one place or co-ordinated as a single entity through a virtual network. The CDC network must include: • Co-ordinated IT • Co-ordination function • Facilities to teleconference – e.g. as for MDT meetings between hospitals Potential options: • Mobile CDC moving round the county (different places on different days of the week) • Potentially 1 main CDC centre, using existing facilities in other places as required. • Virtual CDC (for example for reviews) • It could also act as a hub for Tertiary Centres e.g. GOSH and could control referrals here, as Out of county tertiary Tier 3
What service issues does this idea address?	• Providing specific service for each child. • All functions available in one place or at one time • Reduces gaps in services
What are the clinical outcomes of this idea?	• Timeliness leading to quicker diagnosis, reduced uncertainty and to quicker interventions • Reduced duplication and waste due to co-ordinated care / assessment • A single assessment process which is better for families • Providing a holistic care plan for 0-25 years • Satisfying requirements of EHC plan (Children & Families Bill 2014) • Reduced "hand offs", supporting self management, care coordination
What are the financial outcomes of this idea?	• Reduced duplication of other processes e.g. Team Around Child would not be needed • Improved efficiency of appointments – less ping ponging around the system • Reduced number of referrals • One assessment visit to provide parents a summary, proposed therapies or other services input needed. (Ref: GOSH model) • Reduced duplication of other processes e.g. Team around the child would be needed to triage from targeted to specialist through hub

Design Detail – Women's and Children's

Women's and Children's: 4 – (Virtual) Child Development Centre / Network

What are the challenges?	• Not all children will require all services. Appointments planned will have the right services needed for specific child. • Where would you place one CDC – does having one physical building address the coordinated approach required for children's services? • It might be the case that several CDCs are needed in Lincolnshire due to rural areas, reducing its success
What else do we need to know?	• Where would a CDC be / how would it operate as a network / estates and capital planning consideration if no existing site available • Workforce planning that is needed to meet demand • Referral criteria and other pathways / protocols are required. • Learning from CDC model nationally – what would they do differently? • Involve Community Paediatricians in discussions to consider whether different ways of working would be appropriate. • Could there be a role for working with maternal or parental mental health in this CDC or there is a need for clear pathways to services?
What are the interdependencies with other Care Design Groups?	• Specifically linked to W&C intervention 2 – Early intervention
How does this idea fit in with existing initiatives?	• The Children's paediatric review by Chris Slavin developed a model for this type of arrangement. However, it was not costed.
How can this idea be delivered? (Time, stakeholders, dependencies)	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board • Detailed design options / virtual concept or pathway / standardised triage and service deployment • Identification of co-ordinated MDT approach / pathways • Review Paediatric Services Review and consider applicability and cost / benefits • Enablers e.g. IT – clear decision making and supportive tools fully agreed

Design Detail – Women's and Children's

Women's and Children's: 4 – Consolidation of Maternity and Obstetric Services

What is the idea / option?	• **Option 1**: No change in current configuration. Realisation of benefits through workforce and other productivity and efficiency improvements • **Option 2**: Consultant led and midwifery led unit on separate sites – 24/7 Consultant cover at one site • **Option 3**: Consultant led and midwifery led unit on the same site – 24/7 consultant available at all times	
What service issues does this idea address?	• Supporting choice for women through clear risk assessment and provision of safe and appropriate birth options, home birth / Midwifery Led Units / Consultant Units • Optimise safety, quality, productivity and efficiency by increasing volumes at chosen sites (including optimisation of theatre utilisation) • Improve numbers of midwifery led births in line with peers • Address recruitment and retention issues and meet CPD needs of staff in units more effectively	
What are the clinical outcomes of this idea?	**For Option 2:** • Less travel time issues if two sites are operating – site dependent • Discharge time to home could be reduced (site dependent) women encouraged to leave the unit earlier following birth. • Improved patient choice	**For Option 3:** • The CDG estimated that 30% of mothers prefer midwifery led services • Safer standards and more skilled & efficient staff due to the higher volume of patients / mothers • Better recruitment, retention & CPD in larger sites as higher volumes and skills development may attract staff. • Discharge time to home could be reduced (site dependent) women encouraged to leave the unit earlier following birth. • Improved patient satisfaction e.g. pain management options and rapid response to complexities in births on same site
What are the financial outcomes of this idea?	• Efficiencies achieved through consolidation (overheads / back office / economies of scale etc.) • Potential reduction in volume of activity (note: flows may go out of county) • Impact on site viability – dependent upon other use of estate from whole system solutions • Impact on patients due to travel time, safety & costs e.g. availability of transport links. • Changes to cost of ambulance / transport	
What are the challenges?	• Recent consultation process in Mid-Kesteven • Sustainability reviews in surrounding counties and impact of "hot" and "cold" site decisions in North Lincolnshire, Newark and Sherwood, Peterborough and Stamford • The impact of change on local patients / mothers and staff • Impact on provision of medical / nursing staff which are closely liked e.g. obstetrics and gynaecology • Decreased patient satisfaction – increase in SUIS / complaints • Managing the correct decisions about provision of neonatal units at level 1 and 2 – safe practice / correct locations / clinical adjacency issues	

Design Detail – Women's and Children's

Women's and Children's: 4 – Consolidation of Maternity and Obstetric Services (cont.)

What else do we need to know?	• Programme Board review with their statutory boards regarding What are the agreed design principles e.g. 1 or 2 sites • How will each option operate – staffing / operating model / access etc. • Which outcomes should be monitored for options e.g. volume of activity / maternity or consultant led deliveries / number of c-sections compared to vaginal deliveries / perinatal mortality / maternal morbidity and mortality / earlier discharge • Impact on cost of provision and contribution to reducing the system wide deficit • What are the considerations for movement of women to tertiary centres • Estates / capital planning required to ensure services provided in fit for purpose estate • Effect on EMAS and transport links would need to be quantified
What are the interdependencies with other Care Design Groups?	• Elective Care Design Group for gynaecology clinical adjacency issues. • Urgent care provision • Paediatric services decisions
How does this idea fit in with existing initiatives?	• Shaping Health Consultation commitments to relocation of the MMU to Lincoln County Hospital
How can this idea be delivered?	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board • Consideration of cost benefit and risk analysis • Equality impact assessment • Consultation process

Design Detail – Women's and Children's

Women's and Children's: 5 – Consolidation of Paediatric and Neonatal Services

What is the idea / option?	**Option 1**: One site offering paediatrics and neonatal services including acute care, ambulatory care / paediatric assessment services, surgical units and level 2 Neonatal unit. **Option 2**: Paediatrics and neonatal services on two sites – Level 1 SCBU and Level 2 neonatal unit (at different sites) • **Supported by:** • **"Spokes" / Virtual CDCs / Neighbourhood teams** offering combined MDT children's services across neighbourhood / localities – Potentially have three sites – specific services and consultant cover would have to be defined – Core competencies / opportunities for staff rotating through services • To include children's services staff from acute / community / primary care, CAHMS, therapies, dieticians, voluntary sector, education support services and adolescent services. • **Networks**: Potential to network with other centres / acute hospitals for procedures, particularly surgical procedures. This could allow joint appointments with other networked centres.
What service issues does this idea address?	• Optimise safety, quality , productivity and efficiency by increasing volumes at chosen sites (including optimisation of theatre utilisation) • Address recruitment and retention issues and meet CPD needs of staff in units more effectively
What are the clinical outcomes of this idea?	**For Option 1:** • Safer standards and more skilled & efficient staff due to the higher volume of patients • Consultant cover • Simplified referral pathways and clear Directory of Services • Better recruitment, retention & CPD in larger sites as higher volumes and skills development may attract staff. **For Option 2:** • Safe provision of services with greater local access but reduced volumes thus reduction in associated benefits outlined for option 1 • Care required to address safety and governance for acutely ill child including specialist paediatric cover at "spokes"
What are the financial outcomes of this idea?	**For Option 1:** • Greater efficiencies with consolidation on one site • Reduced locum spend if substantive posts filled more effectively • Avoid duplication of services • Standards satisfied through higher volumes and skills development • Reduced inappropriate admissions and decreased short stay admissions • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board **For Option 2:** • Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

Design Detail – Women's and Children's

Women's and Children's: 5 – Consolidation of Paediatric and Neonatal Services (cont.)

What are the challenges?	• Clinical adjacency issues with Obstetrics, Paediatrics, Neonatology and Anaesthetics • It should be considered whether there currently exists one site that could accommodate the shift in activity (dependent upon estates released through efficiencies in other CDGs e.g. elective and admissions avoidance schemes) were the one site option to be pursued. • CDG members at CDG 3 suggested consideration of new build in a central location e.g. Sleaford • Risk of loss in activity as the willingness to travel for generalist services is lower compared to specialist services
What else do we need to know?	• What are the agreed design principles e.g. 1 or 2 sites • How will each option operate – staffing / operating model / access / admission criteria / consultant cover etc. • Impact on cost of provision and contribution to reducing the system wide deficit • Safety of acutely ill children (option 2) – considerations for movement of infants and children to tertiary / specialist centres post stabilisation • Estates / capital planning required to ensure services provided in fit for purpose estate • Knock on effect on EMAS and transport links needs to be quantified
What are the interdependencies with other Care Design Groups?	• Links exist with Reactive / Urgent CDG / Maternity Services considerations
How does this idea fit in with existing initiatives?	• At present networks are being built with other centres to share workforce and services e.g. Boston are considering this. with Queens in Nottingham. • Shaping Health in Mid-Kesteven Consultation Process
How can this idea be delivered?	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board • Building upon the Shaping Health in Mid-Kesteven process, a community-wide decision would need to be taken • Consideration of cost benefit and risk analysis • Equality impact assessment • Consultation process

Design Detail – Women's and Children's

Women's and Children's: 6 – One Commissioner for Children's Services

What is the idea / option?	Having a single pot of money to commission children's services. This will: • Provide strategic oversight of all children's services to a single organisation / single responsibility for contract. • Potentially be expanded to women's services and health / care services and should cover health, social care, education and voluntary sector (covering the full spectrum from prevention to tertiary care). • Consider nationally commissioned services – role of NHS England / Area Team (to be confirmed) • Involve a small integrated commissioning group – perhaps no more than 20 people or so to remain fluid and efficient • Involve appropriate navigation of the political landscape and appetite for a single commissioner.
What service issues does this idea address?	• Whole life planning – transitioning children to adults
What are the clinical outcomes of this idea?	• Critical mass providing additional influence and negotiation power • Improvements in workforce recruitment • Improvements in community / social capital and cohesion • Repatriation of children in residential placements out of Lincolnshire
What are the financial outcomes of this idea?	• Decreased duplication of commissioning efforts, and associated costs • Pooled funding providing the ability for more effective use and potentially the commissioning of additional services • Standardise contracting, reporting, performance procedures
What are the challenges?	• Development of specifications and commissioning model • Impact on existing commissioning configuration
What else do we need to know?	• How would the services be specified • What commissioning model would be required • Timescales • What steps need to be taken to realise this ambition • Area Team perspective on neonates would need to be considered
What are the interdependencies with other Care Design Groups?	• Single commissioner model should be considered in finance and contracting options
How does this idea fit in with existing initiatives?	• Models in Liverpool, Derbyshire, Northamptonshire
How can this idea be delivered?	• Further detail to be explored in detailed design phase 2 subject to approval at Programme Board and Health & Well Being Board

Design Detail – Women's and Children's

Women's and Children's: 7 – Children's Services under One Operational Management Structure

What is the idea / option?	Either a single provider, or an alliance or consortium of providers. All service providers at all tiers will have one employer, with core competencies across service providers and increased interaction between differing professionals-a 'one stop shop'. • To include GPs – potentially through a 'virtual' locality team • This would need to leverage innovative service delivery models to be efficient – such as the use of Skype, telemedicine, etc. • The model could be used to up skill workforce through increased interaction with different providers
What service issues does this idea address?	• Duplication of services • Confusion for staff and patients • Information governance issues / information sharing • Standardised and comprehensive assessment processes in one service • Effectively manages increasing demand
What are the clinical outcomes of this idea?	• Decreased bureaucracy – services delivered based on need and less induced demand • Integrated / combined training of workforce • Decreased individual provider risk • Faster pathways with reduced 'ping pong' between providers • Improved information sharing and a single patient record – potential IM&T investment efficiencies • Decreased exclusion from services (greater coordination between services, leading to greater patient inclusion) • Opportunities to develop more specialist services • Decreased culture of dependence • Enhanced patient-provider relationships
What are the financial outcomes of this idea?	• Pooled resources for more efficient provision • Increased capacity for delivery through economies of scale • Avoid potentially 40% of A&E admissions through better community provision – an integrated provider model could contribute towards this • Decreased acute admissions through more appropriate community management due to better service provision
What are the challenges?	• Dominance of acute provider • Political challenge • Need to create the right incentives for providers • Issues for selecting the right provider in the market • GPs role may be significantly different
What else do we need to know?	• There is the potential to extend outside Lincolnshire and influence wider determinants • Significant cultural change is required for providers to effectively integrate their service offerings • Requires 100% consensus from all parties involved for the model to be effective.
What are the interdependencies with other Care Design Groups?	• Urgent Care CDG
How does this idea fit in with existing initiatives?	• Examples to look up: Nottingham City, and W&C model in Gwent.
How can this idea be delivered?	• Further detail to be explored in detailed design Phase 2 subject to approval at Programme Board and Health & Well Being Board

SECTION 5
Financial Summary

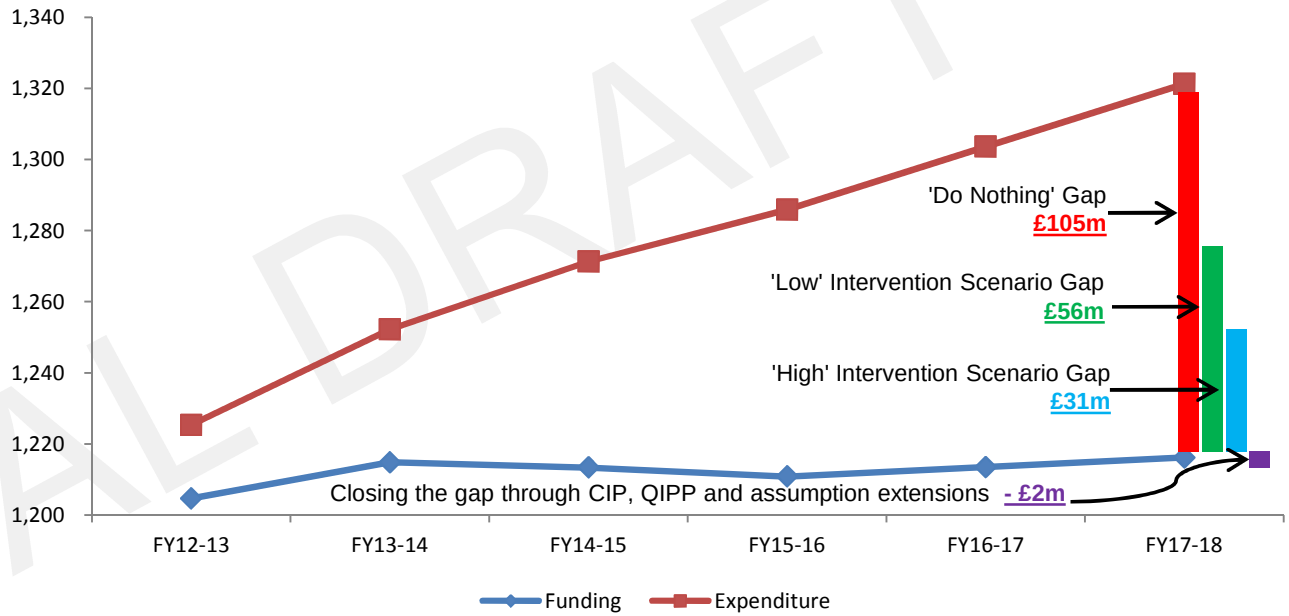
Narrowing the Financial Gap

The diagram to the right shows the financial gap explained on Page 13. If the new model of care is taken forward and the interventions are adequately implemented, high-level data modelling suggests that the estimated financial gap of £105m could be significantly reduced by between £74m and £49, depending upon which interventions will be undertaken and the extent to which they will be implemented.

To achieve these benefits, significant effort and collaboration will have to take place across all the stakeholders in the health and care economy and some radical changes will need to occur. It is our view that both scenarios are achievable, although the outcomes will be contingent upon how the implementation of initiatives will be prioritised and co-ordinated.

The remaining gap of between £56m and £31m can potentially be closed through CIP, QIPP and further assumption extensions, as discussed on slide 22.

Lincolnshire Health Economy 5 Year Financial Gap Projection FY12-13 to FY17-18



'Low' Intervention Scenario Gap: cautious modelling assumptions

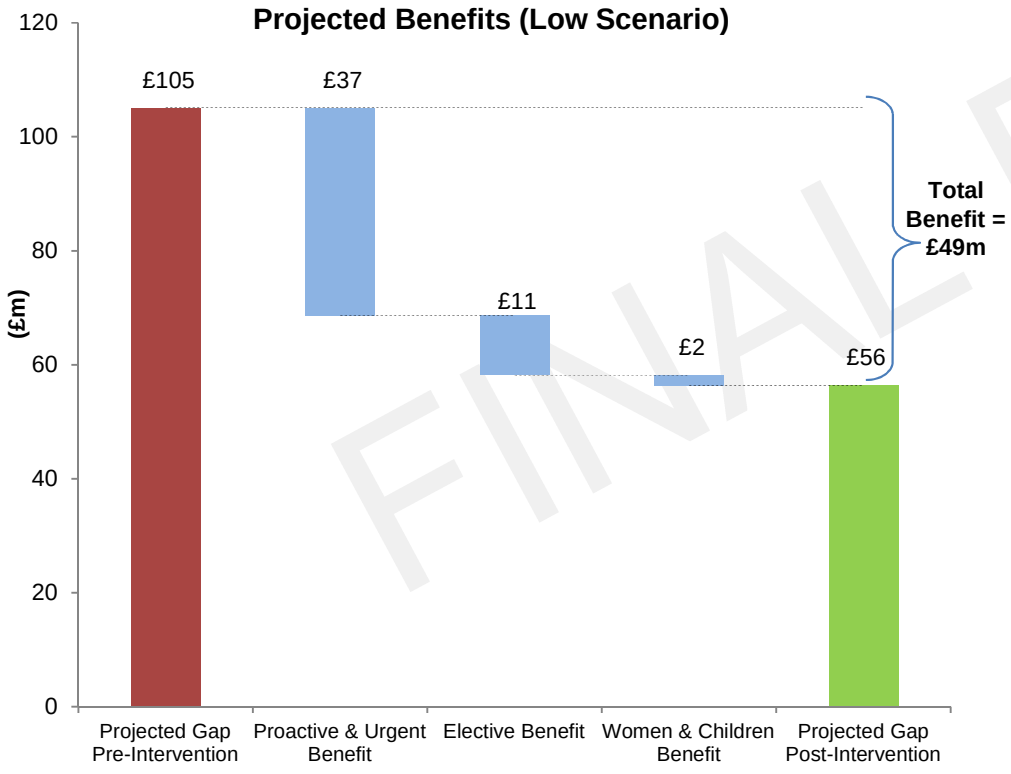
'High' Intervention Scenario Gap: achievable but ambitious modelling assumptions

Scenario modelling approach

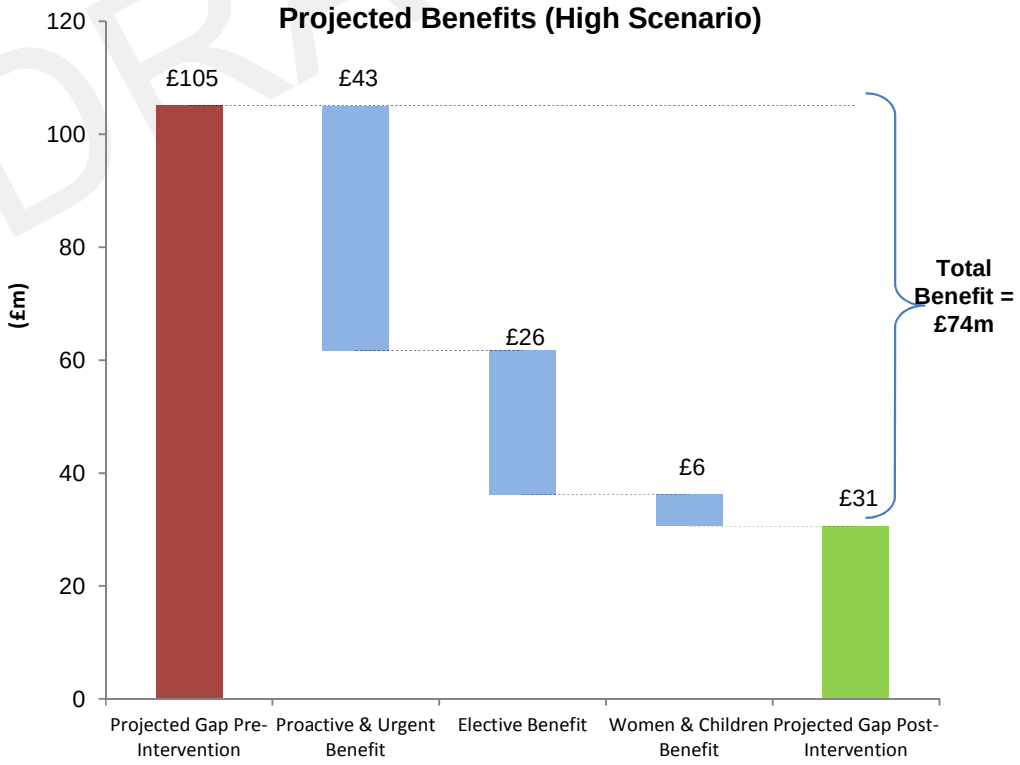
- The modelling has been undertaken against the counterfactual that no action is taken and services continue to operate as they currently do out to 2017/18.
- The modelled scenarios have been undertaken at a broad, system-wide level for the purposes of this report.
- High and low scenarios have been modelled with varying assumptions to provide a range of projected benefits.
- Assumptions have been collated from CCG workshop outputs, clinical input, published literature and experience from similar pieces of work.
- The modelled benefit scenarios are intended to provide insight into the possible costs that could be avoided through the interventions proposed, and demonstrate the need for action. More detailed analysis would need to be undertaken as part of a Business Case.

Intervention Detail – Financial Summary

A high-level modelling was conducted on the likely impact of interventions on Lincolnshire's economy. As the impact depends upon how these and to what extent interventions would be implemented, two scenarios were modelled. It is worth noting that both scenarios are achievable. The combined modelled initiatives could potentially provide between £49m and £74m in annual benefits by 2017 / 18, with proactive and urgent care initiatives providing the largest share of projected benefits. Although the gap would not be closed, in the high scenario it would be reduced by 71%. Additional measures would be needed in order to completely close the gap. These are analysed in slide 22**.**



'Low' Intervention Scenario Gap: cautious modelling assumptions



'High' Intervention Scenario Gap: achievable but ambitious modelling assumptions

Sources: HES 11-12; 2011-12 Reference Costs; ULHT, LPFT LHCS SLR 2011-12, Local Authority Personal Social Services Statistics, LCC

Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

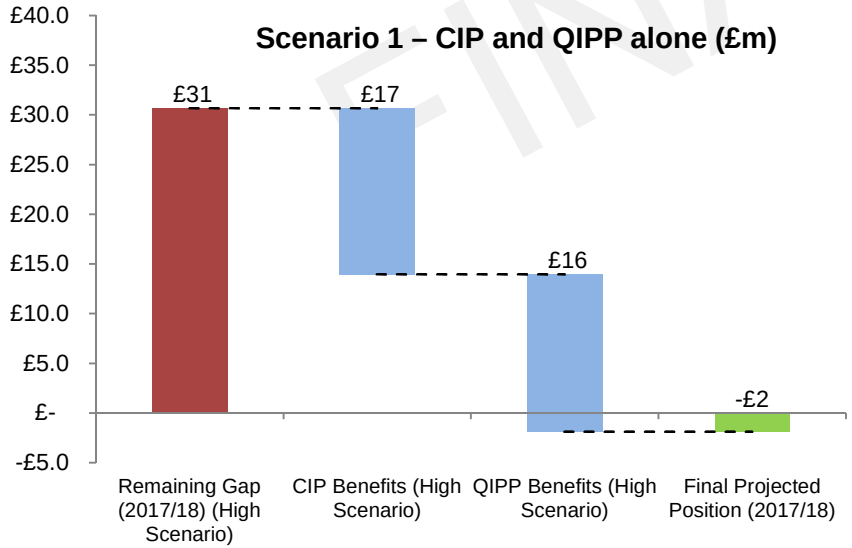
Closing the Remaining Gap Beyond the Care Design Assumptions

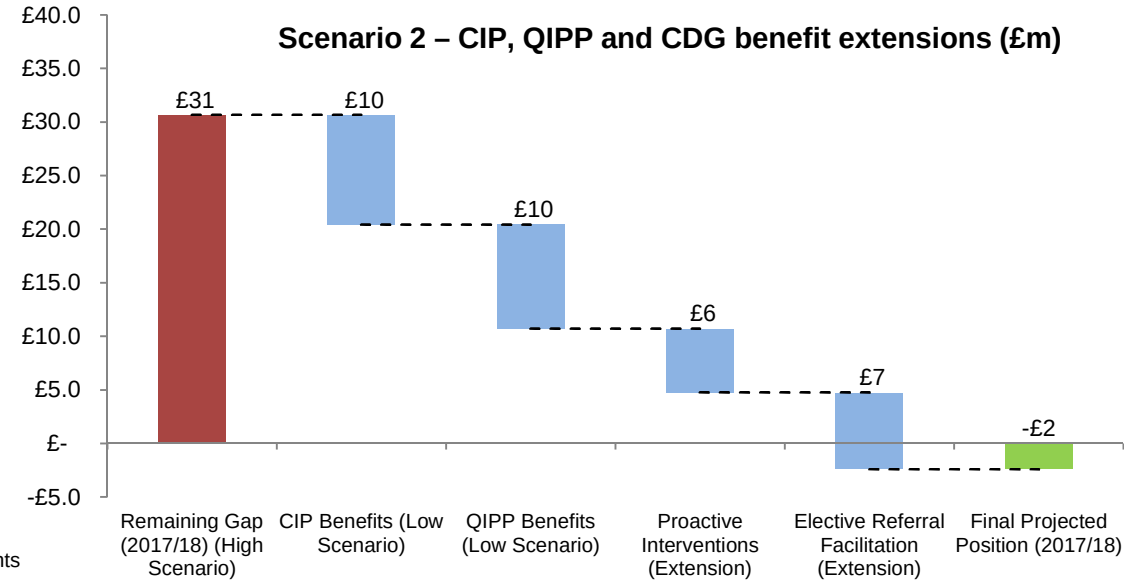
The interventions modelled across Care Design Groups could potentially provide annual benefits of between £49m and £74m by 2017/18. This alone would leave a financial gap of between £31m and £56m in 2017/18. We examined what it might take to completely close the high scenario gap (£31m) by considering two scenarios. The first scenario is one in which CIP and QIPP improvements alone are able to close the gap. The second is one in which a combination of CIP, QIPP and extensions to Care Design Group intervention assumptions.

In the **first scenario**, we include 40% of projected CIP and QIPP improvements, given that many of these align with proposed Care Design Group improvements, and so that we do not double count. In addition, past performance shows that approximately only between 47% and 76% of projected improvements are actually realised. In the first scenario we assume that 76% (of the included 40%) are realised to close the gap. This results in a positive net position of approximately £2m in 2017/18.

In the **second scenario**, we take 40% of the lower end of CIP and QIPP improvements realised (47%). To illustrate closure of the remaining gap, we project the benefits from extending the (high scenario) benefit assumptions for Proactive Interventions and Elective Referral Facilitation each by 5 percentage points. This results in a positive net position of approximately £2m in 2017/18.

Our baseline analysis had removed net non-recurrent funding. As such, if this is incorporated back in it could potentially improve the financial position even further. If CIP and QIPP initiatives are successful then there is a potential case for portions of this non-recurrent funding to become recurrent.





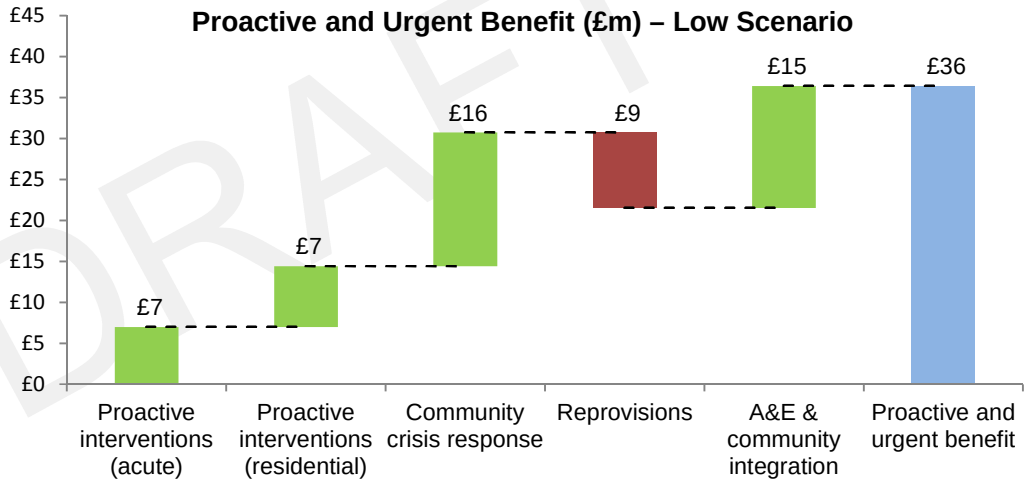
Note: figures may not reconcile precisely, as numbers have been rounded to avoid decimal points

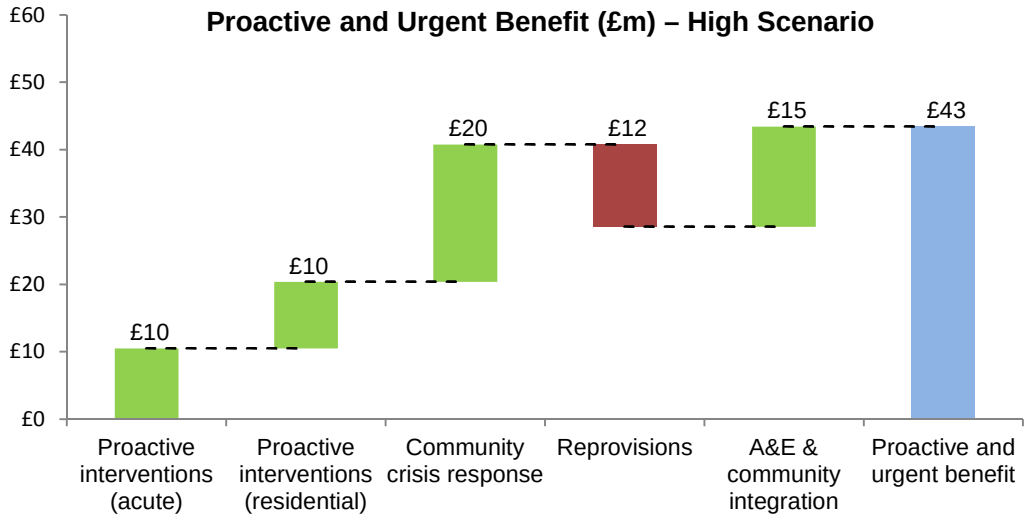
Intervention Detail – Financial Summary

Proactive and Urgent Care Benefit

Two scenarios are shown with the estimated impact of all Proactive and Urgent initiatives described in the previous section.

Scheme	Assumptions
Proactive interventions: This covers all Proactive interventions explored in the previous section	• Decrease in A&E attendance and non-elective inpatient admissions for those aged >75 by 10% - 15% • 15% - 20%reduction in residential care home beds for those aged >65
Community crisis response: Rapid health and social care response for patients who would otherwise be admitted to hospital. This also includes the hub / single point of access model for urgent care.	• Decrease in A&E presentations and non-elective inpatient admissions for those aged >65 by 20% - 25%
Reprovisioning cost:	• We have assumed that 30% of the above benefits would be reprovisioned to provide additional funding to expand proactive services
A&E + Community integration: Stronger linkage between community services and A&E – including early discharge programs	• Shifting the average non-elective LoS for those aged 75 and over to 5 days (currently 7 days). Applies to multi-day admissions only





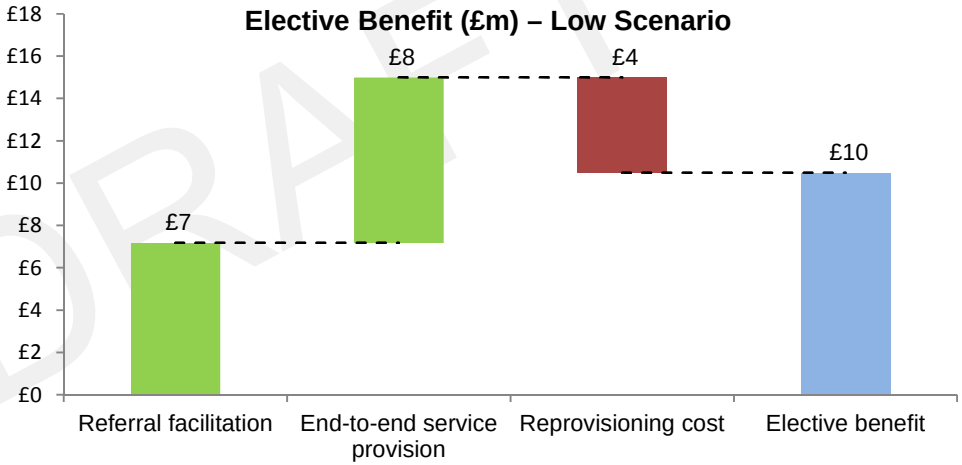
Intervention Detail – Financial Summary

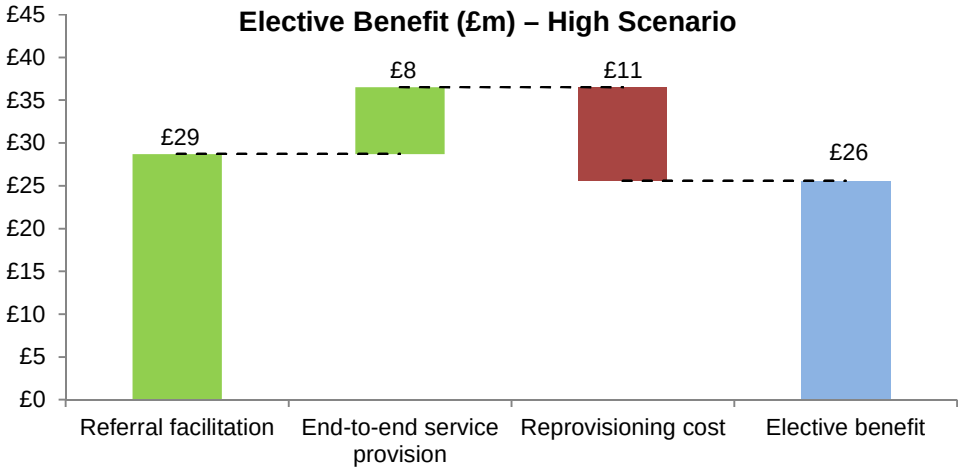
Elective Care Benefit

Two scenarios are shown with the estimated impact of all Elective initiatives described in the previous section.

Scheme	Assumptions
Referral facilitation: covering decision support, navigation and administration to reduce inappropriate referrals	• Reduction in overall elective activity by 5% - 20%
End-to-end service provision by specialty: increased community provision of services through an altered skill mix of staff delivering services	• As per CDG workshops, modelled the shifting of current acute provision to other care settings in line with discussed percentages (next slide) • We have assumed that provision in non-acute hospital setting would cost 25% less than in acute hospital across all specialties
Reprovisioning Cost	• We have assumed that 30% of the benefits would be reprovisioned to finance non-acute service provision

Note that we have not modelled the potential reductions in elective procedures that are cancelled due to spikes in urgent activity. If the Urgent Care initiatives were implemented well, this would likely flow through to significant reductions in elective procedure cancellations.



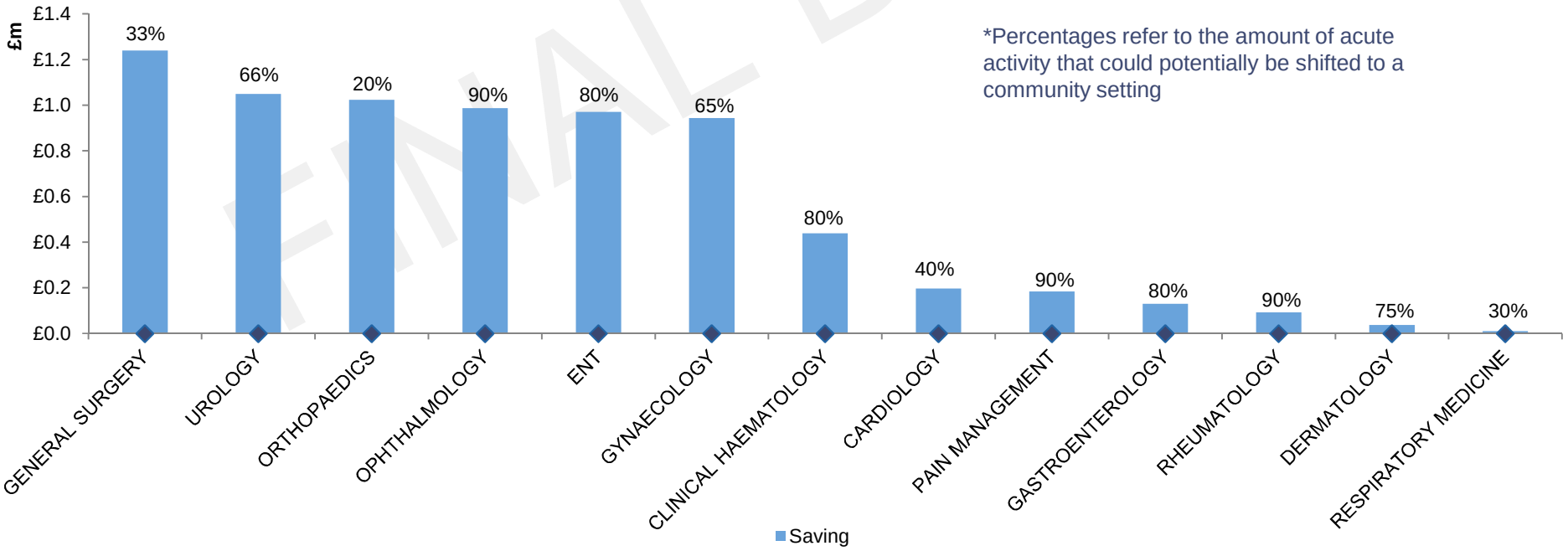


Intervention Detail – Financial Summary

Elective Care Benefit (cont.)

In modelling the impact of end-to-end service provision by specialty, we considered the main specialties by income based on the figures provided by the Care Design Group, available literature on end-to-end service provision by speciality and similar projects across the country. Our analysis focused on the impact a shift of a percentage of procedures currently delivered in acute hospital settings would have, where it to be delivered in alternative settings. Benefits would result not from the shift to alternative settings, but rather from the utilisation of an alternative skill-mix and a change in the delivery model. In doing so, we assumed, based on previous experience, that the altered non-acute provision would cost 25% less than on average across all specialties.

Potential benefits resulting from a shift of some of the acute hospital activity to other health care settings



Notes:
Breast surgery data was not modelled as no reference cost data was publicly available for this specialty

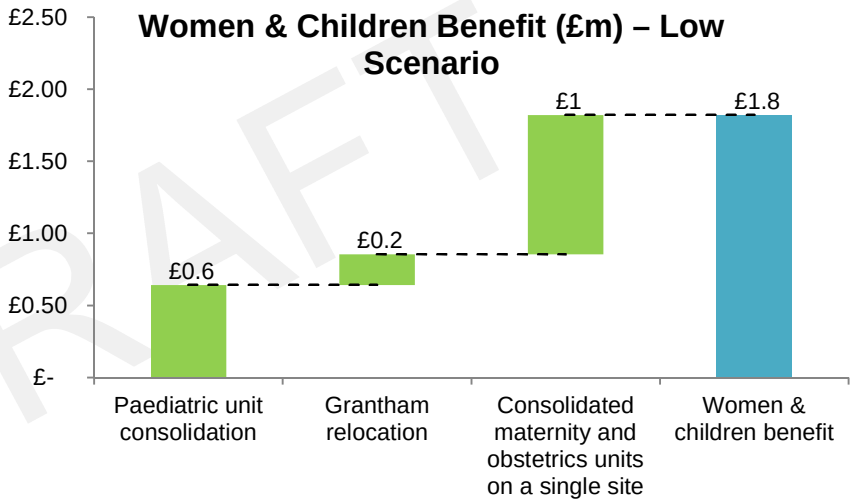
Intervention Detail – Financial Summary

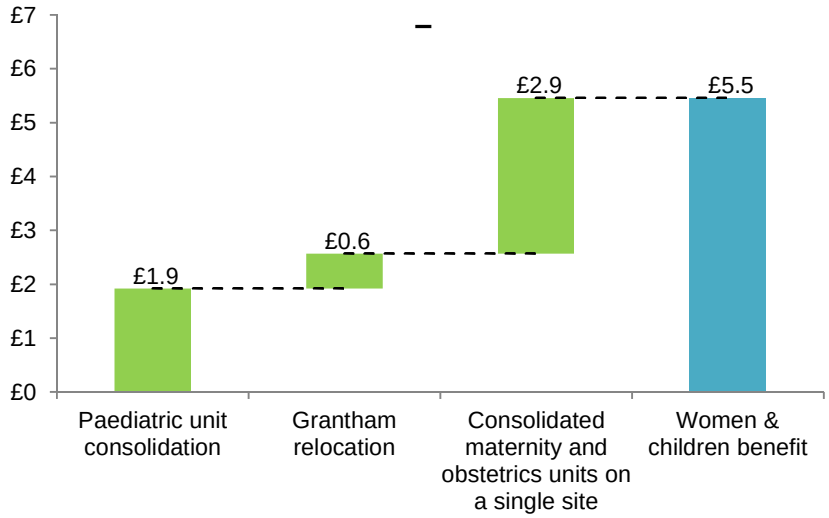
Women's and Children's Care Benefit (cont.)

- As part of the contribution to the system-wide financial deficit, W&C were not a large consideration and the reason for consideration of changes is primarily for safety and quality
- Whilst multiple options were discussed, we have modelled one approach to consolidation. Even with conservative estimates there are still some efficiency gains
- *Less than 2% of women are choosing to give birth at the Grantham Midwifery Led Birthing Unit. It is proposed to relocate the midwifery led birthing unit next to an Obstetric Unit, however all antenatal and postnatal care will remain at Grantham Hospital and there are no plans to change the home birth service.*

Scheme	Assumptions
Paediatric unit consolidation	• Consolidation of paediatric units to one unit in Lincolnshire • Between 10% and 30% cost efficiency
Relocation of Grantham's midwifery-led unit*	• Between 10% and 30% cost efficiency benefit • Patients are assumed to go to Lincoln, and not other counties
Obstetric-led unit and midwifery-led unit located at a single site	• Between 10% and 30% cost efficiency benefit • Patients are assumed to stay within Lincolnshire county and not travel to other counties for care

* Relocation of Grantham already taking place as described above. However the impact is modelled as it still contributed to closing the funding gap.





Note:

- Travel time analysis indicates that additional costs will be incurred through increased travel time. As such, subsequent phase work would need to consider the transportation implications and identify options to address these.
- Capital cost investment would be required for site consolidation. These costs have not been modelled as part of this phase of work.

SECTION 6
Enablers for Change

SECTION 6.1

Information Management and Technology (IM&T)

Enablers for Change

Information Management and Technology (IM&T)

Within this section we have outlined how current IM&T prevents joined up care for users and professionals within the current model of care and how this would change in the future model.

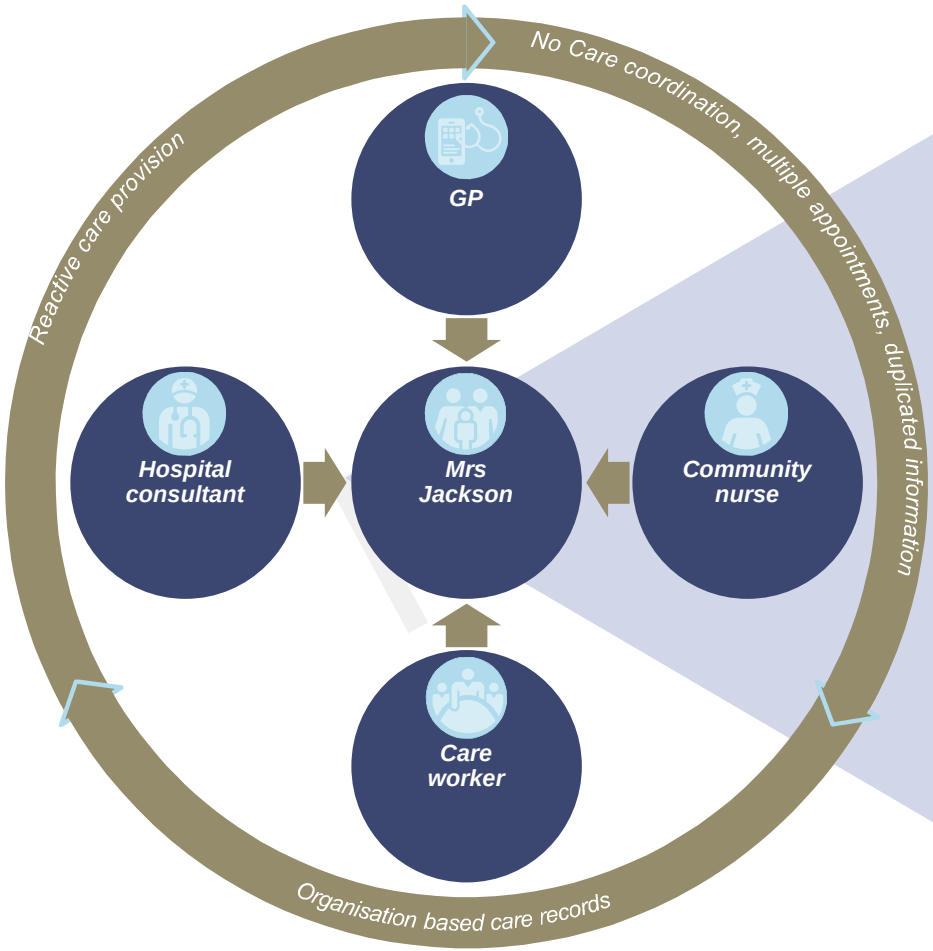
In order to enable the changes set out in the future model of care, information management and technology (IM&T) infrastructure will need to be addressed. The requirements for this will be:

- A single, coordinated point of access to services, across the appropriate channels;
- Access to comprehensive patient / service user information to allow informed decision making;
- Ability to record all actions taken and share this information with other professionals;
- Ability to provide appropriate urgent response quickly and effectively for both medical and social care episodes;
- Effective identification of candidates for early discharge processes to accelerate their discharge to a community setting;
- Ability to provide appropriate community medical and social care services and measure their effectiveness; and
- Access to appropriate risk stratification tools to support targeting of services.
- Lincolnshire are already working towards this goal in some areas and a bid is in progress for a web enabled portal.

Mrs Jackson – Fragmented Care

Mrs Jackson, aged 80, suffers from diabetes and chronic obstructive pulmonary disease attends her GP with stomach pains, and is referred to her local hospital with a suspected stomach ulcer. Mrs Jackson is recently bereaved, and is suffering from low mood.

Now



- Letter from Choose and book to ring and make appointment, but no real data to support choice except distance and waiting time
- Receives another letter from hospital out patient department giving appointment
- At the hospital, she spends time performing a detailed assessment
- After appointment, the GP letter is copied to her; she doesn't fully understand her diagnosis or treatment plan
- Separate appointments with Community Nurse and Care Worker; on every occasion she must provide a history and go through some level of assessment

- Uses own GP system and Choose and Book
- Difficult to access any real quality data except waiting times
- Receives a monthly email with attachment listing patients at higher risk based on hospital attendance – Mrs Jackson does not appear on this list.
- Doesn't know what has happened to Mrs Jackson unless she comes in for another appointment

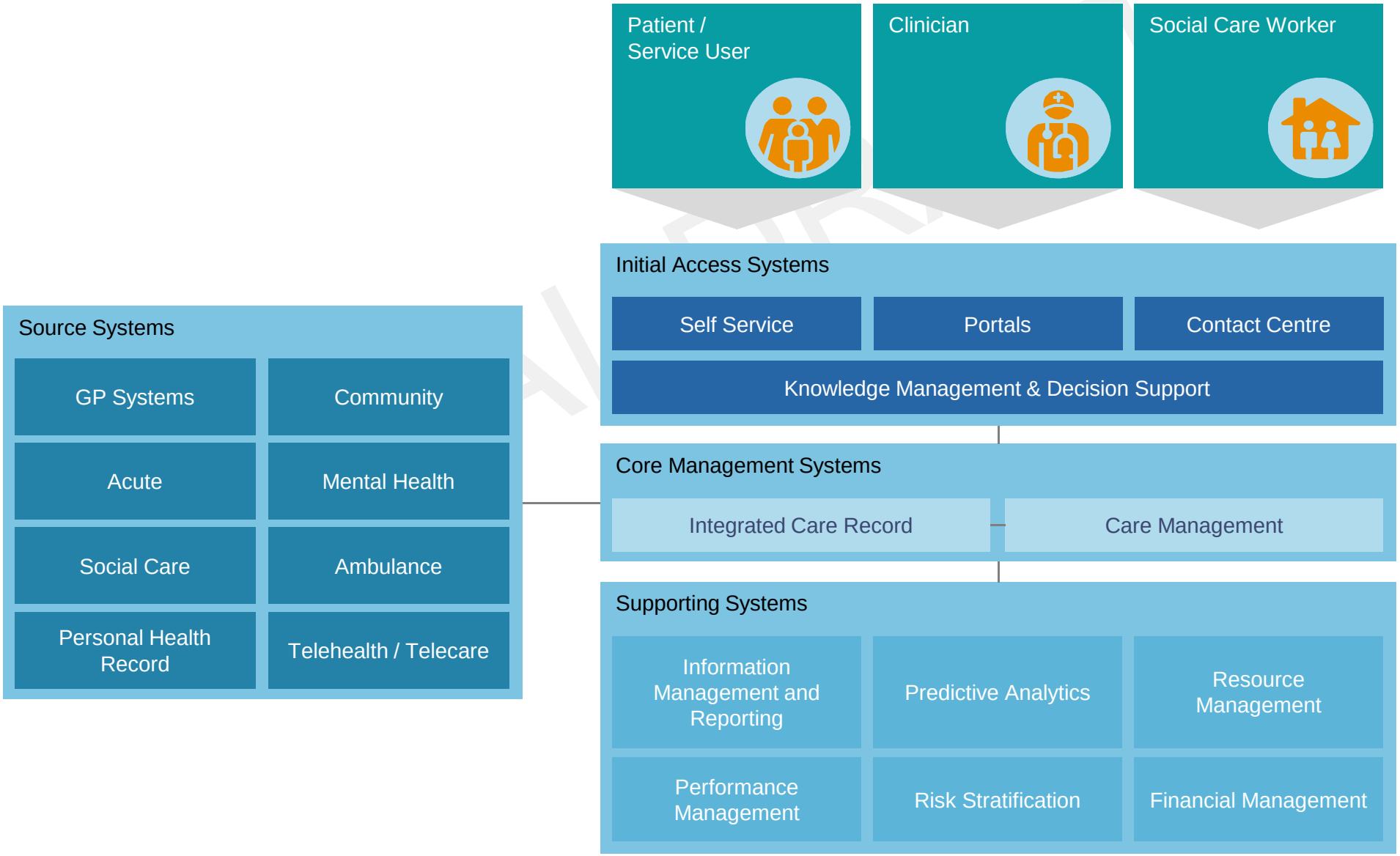
- Own paper records at patient's home, then inputs data into two different systems – the GP system and the Community system
- No knowledge of this referral until Mrs Jackson mentions it
- Thinks Mrs Jackson may be depressed but not sure what GP is doing

- Own written care record
- No knowledge of this referral or any other medical information except what Mrs Jackson and her daughter have told her
- Does not know about low mood

- Own written notes
- Has access to previous record of attendance at A&E after a fall
- GP letter with attached computer summary of medical problems
- Not aware recently bereaved but notices she has a low mood

How Do We Realise Integrated Care through IM&T

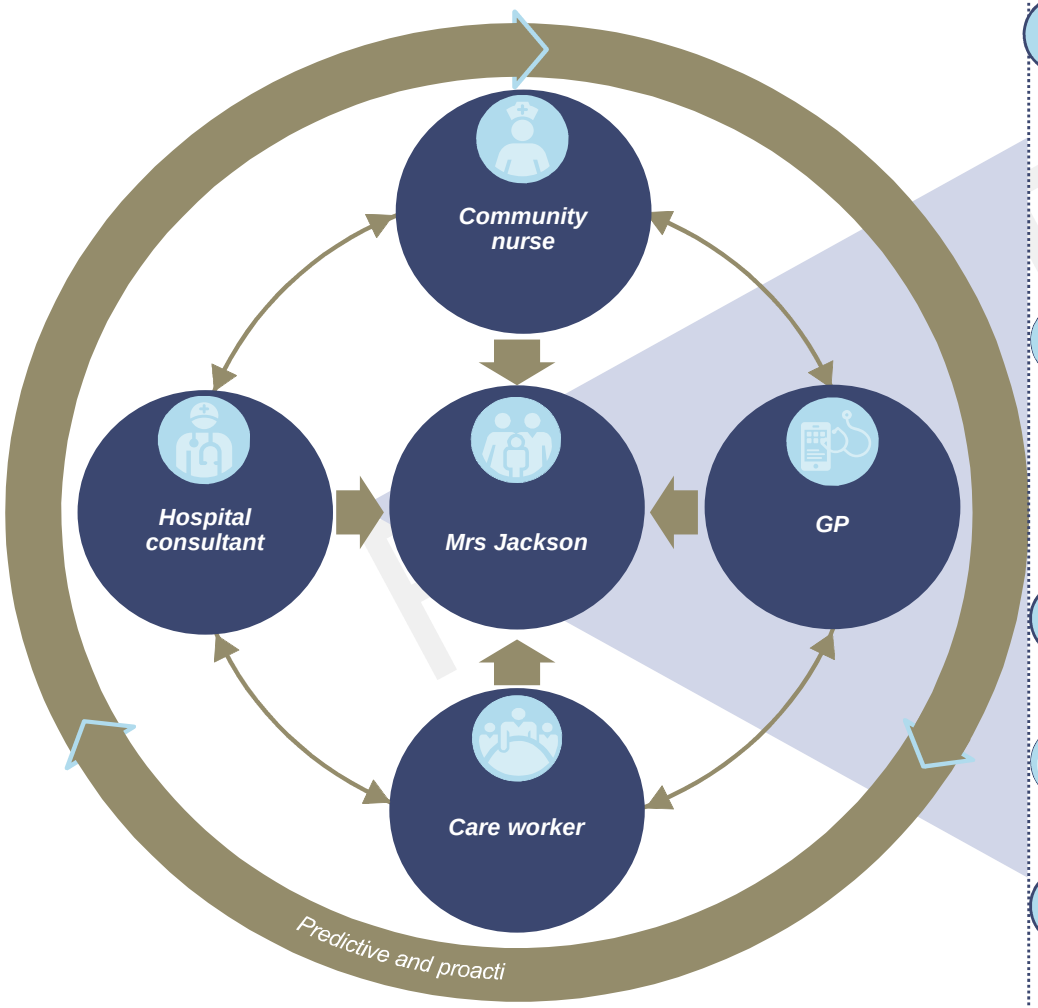
A possible conceptual architecture for Integrated Care



Mrs Jackson – Integrated Care

Mrs Jackson, aged 80, suffers from diabetes and chronic obstructive pulmonary disease. Mrs Jackson is recently bereaved, and is suffering from low mood.

Future



- Health and Care risk stratification identifies Mrs Jackson as high risk of deterioration. A Care Plan is developed and the Community Nurse assigned as Care Co-ordinator
- Manages Mrs Jackson's Care Plan with the Neighbourhood Team
- Mrs Jackson's integrated care record includes key hospital admissions, community and mental health treatment and social care packages, along with details of her medication, allergies and advanced directives – which the Community Nurse accesses through a mobile device
- Alerted if Mrs Jackson's conditions deteriorate, and manages the response with her

- Early signs of a stomach ulcer and depression are spotted and treated in the community
- When any new care needs develop, Mrs Jackson initially accesses her care record and plan through the patient portal
- Manages her schedule electronically, in consultation with care coordinator
- She uses Teleheath and Telecare devices to monitor and provide updates on COPD, diabetes and depression
- Can provide access to her Personal Health Record to other care settings

- Involved in the creation of Mrs Jackson's Care Plan, and then has access to the Care Plan and Integrated Care Record
- Alerted directly by the system if Mrs Jackson's conditions deteriorate – informed by diagnoses, treatment, Telehealth and Telecare

- Involved in the creation of Mrs Jackson's Care Plan, and then has access to the Care Plan and Integrated Care Record, with limited access controlled through role based access agreement – which she accesses through a mobile device
- Alerted if Mrs Jackson's conditions change, and impact on care needs

- Involved in the creation of Mrs Jackson's Care Plan, and then has access to the Care Plan and Integrated Care Record, with limited access controlled through role based access agreement
- Assessments and history much reduced – and hence the time Mrs Jackson spends in hospital.

SECTION 6.2
Finance and Contracting

Finance and Contracting

Finance and Structure - Key Considerations

It is important to acknowledge that the challenge of developing a system wide organisation agnostic future model is beneficial but complex . At a recent Westminster Health Forum three key factors were outlined by a successful integrated system in Christchurch New Zealand as being critical to the success of delivering such an integrated model of care; creating the vision; sustained investment in staff and skills needed to innovate and supporting them to do so and alliance contracting. "one budget one service".

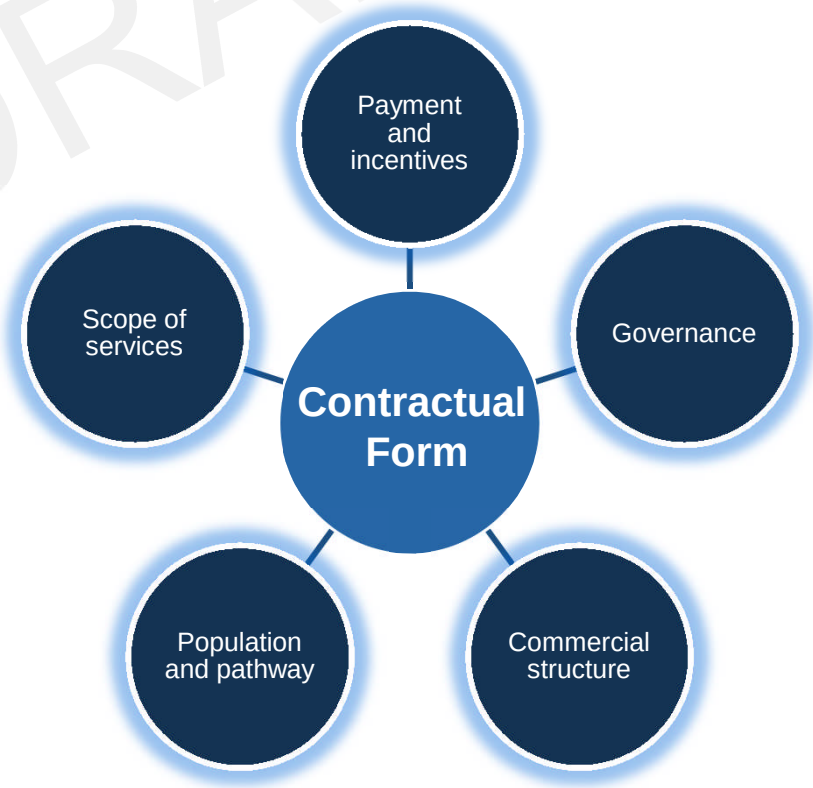
Nationally work is underway on the NHS standard contract to free commissioners up to award work to a “prime contractor” for five to ten year stints from 2014/15 to support service development models for a whole condition or a whole population over a longer period than currently allowed.

This will be key to enabling Lincolnshire’s blueprint delivery. The contracting mechanism needs to promote provider collaboration to allow a more cost effective integrated delivery model that drives value for money and improved clinical outcomes.. The three models often presented for consideration are :

- The Prime-Contractor model – CCG or a Joint Commissioning body holds the commissioning contract with the Prime Contractor;
- The Joint Venture (JV) – Commissioning management board holds the commissioning contract with the Joint Venture Provider; and
- The Alliance Contract - All parties would share the Alliance agreement, with common objectives and outputs.

The options appraisal for the preferred contracting model will be undertaken as part of Phase 2 of the Lincolnshire Sustainable Services Review.

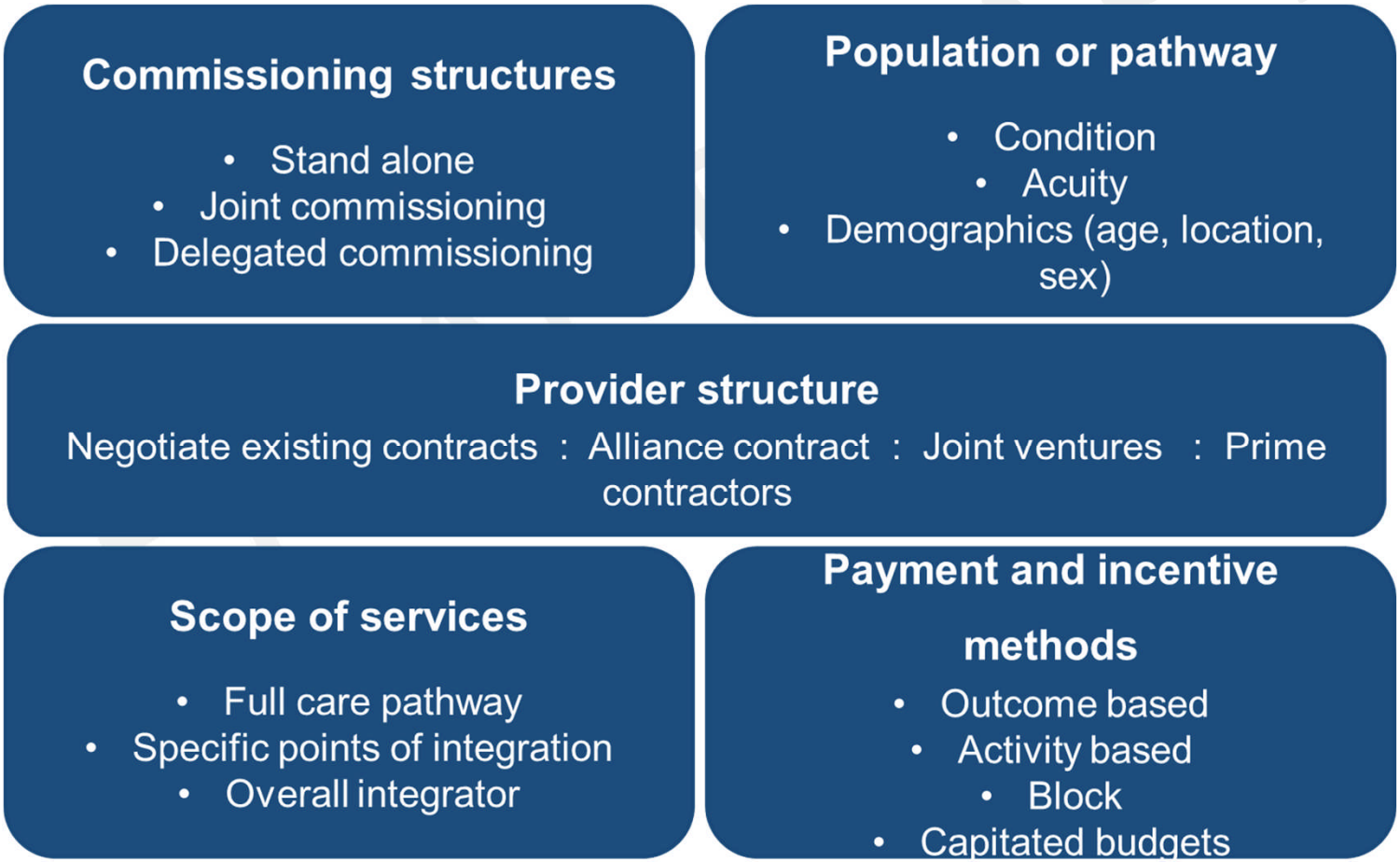
We can describe the overall structure that an Integrated Care System might take as its “Contractual Form”. To develop it some key supporting elements need to be understood.



Finance and Contracting

Key Components for Consideration

In other health economies a range of solutions have been discussed:

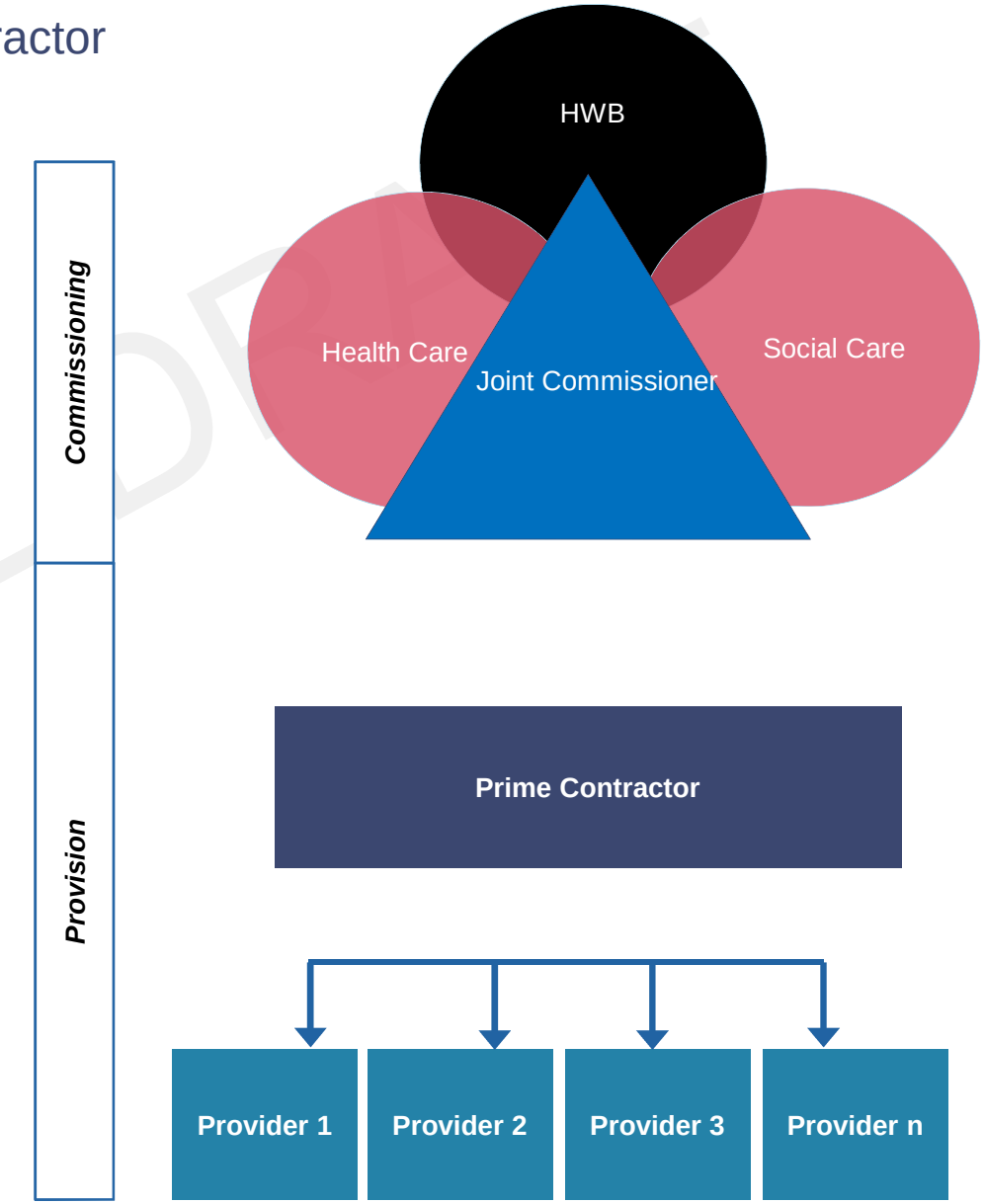


Finance and Contracting

An example contracting model – Prime Contractor

A health economy looking to generate a step change in investment and focus for Older People

- A joint commissioner to finance and regulate
- A Prime Contractor takes on the “integrator” role
- Sub-contracts delivery to providers



Finance and Contracting

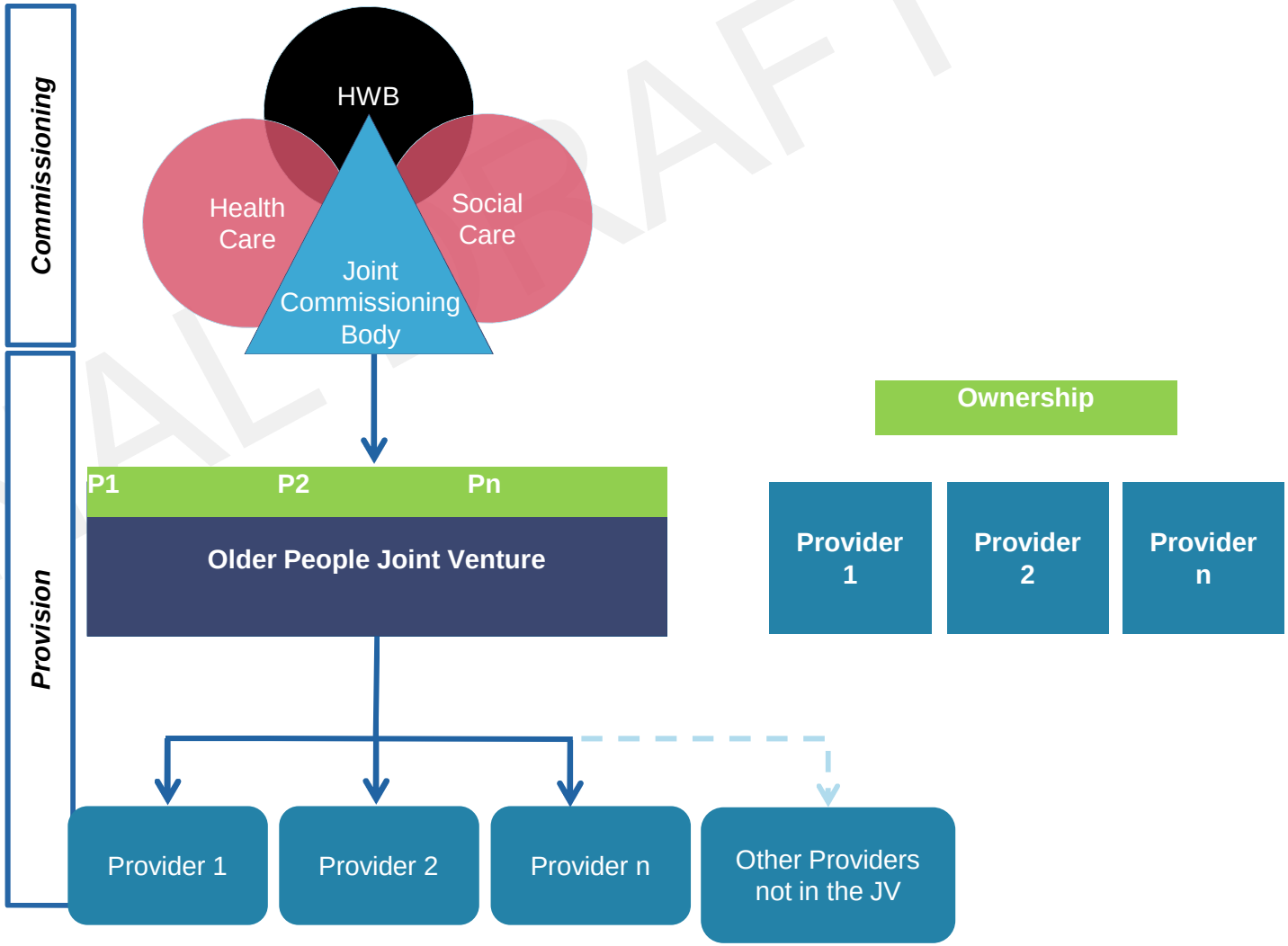
An example contracting model – Joint Venture

A health economy looking to share risk and investment in care for older people across the range of current providers.

A joint commissioner to finance and regulate

A Provider JV – share incentive and risk

Providers sell services to JV “at cost”

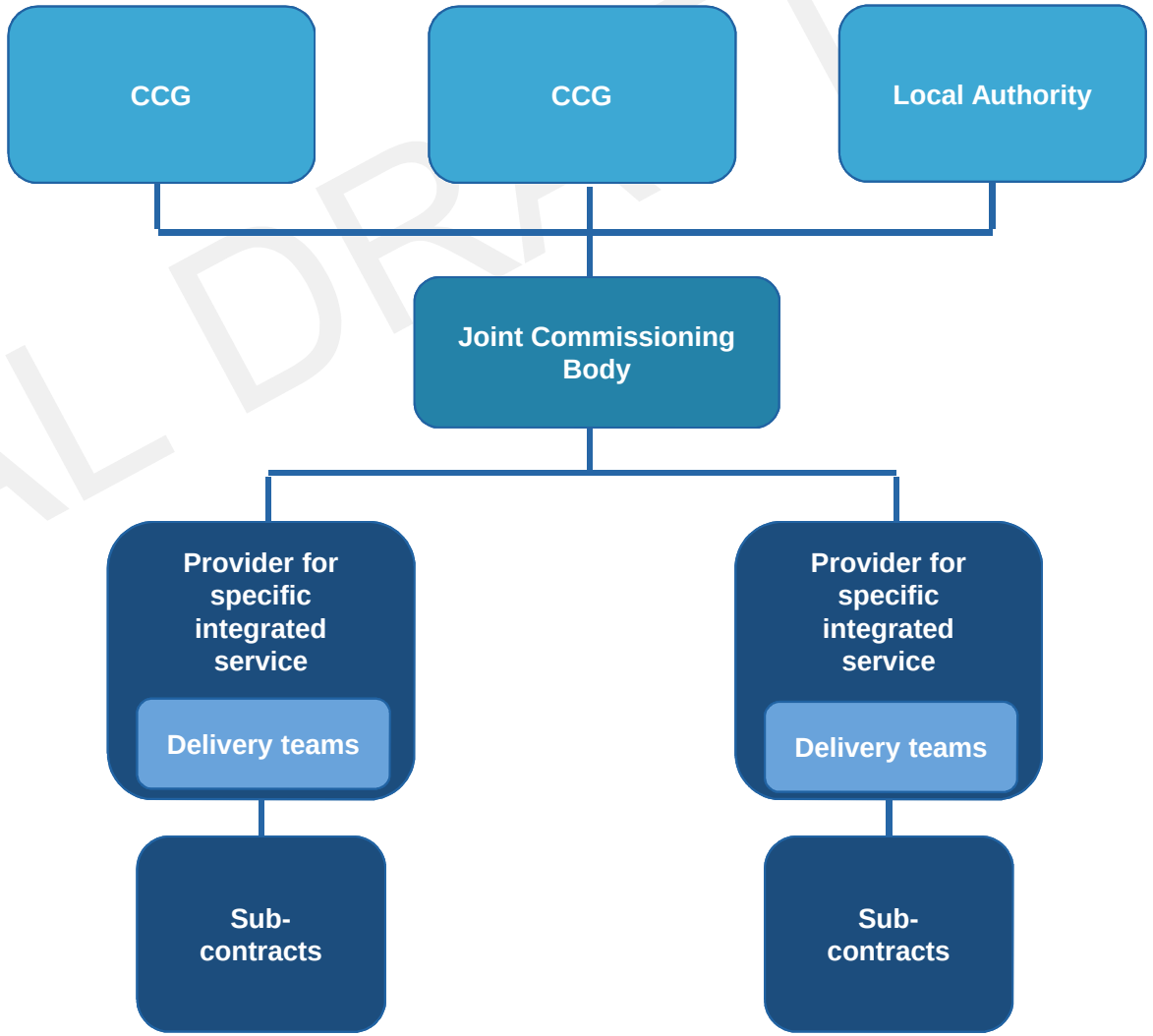


Finance and Contracting

An example contracting model – Integration service providers

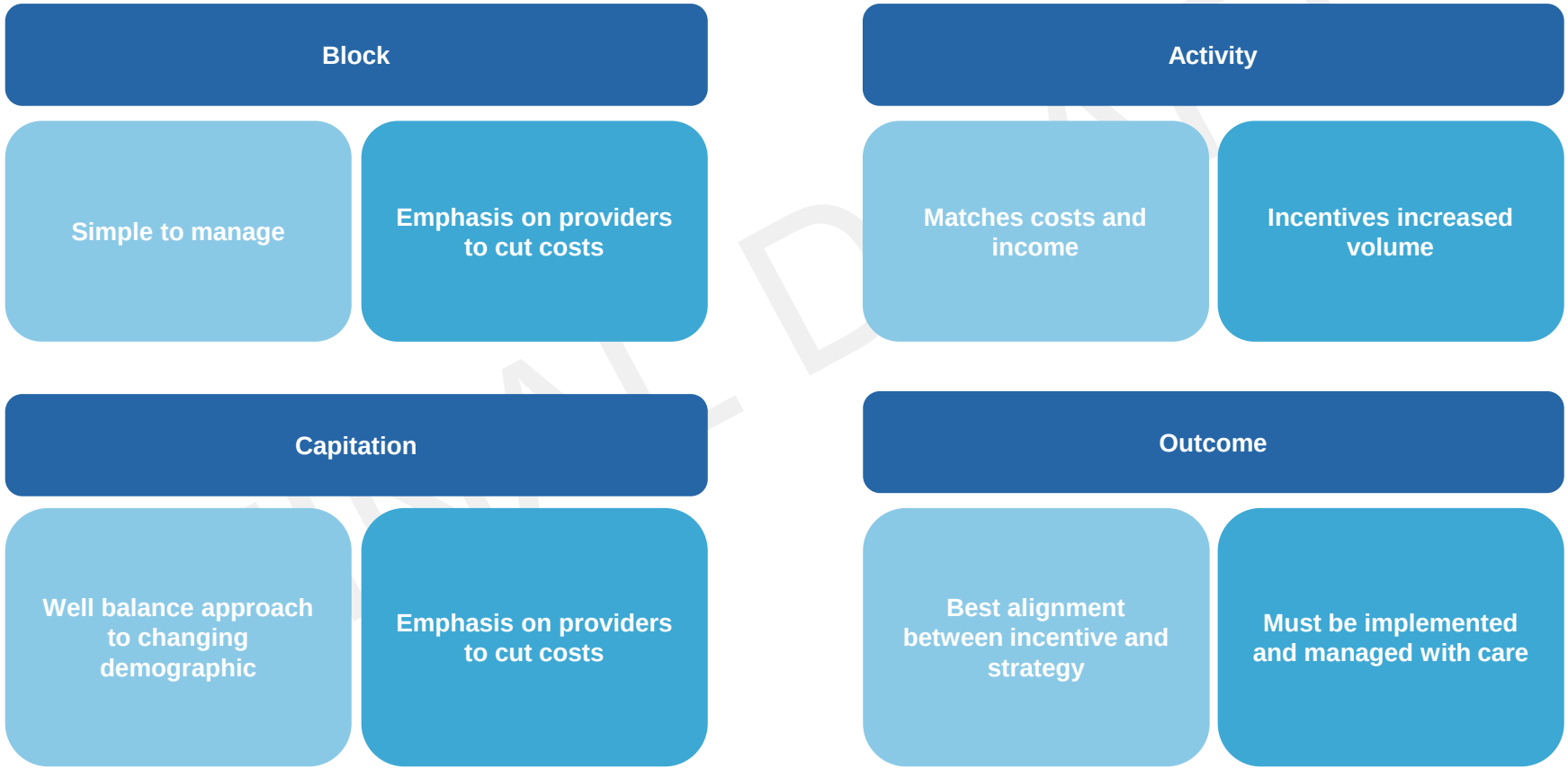
A health economy looking to implement integrated responses to high levels of A&E admission

- A joint commissioner to finance and regulate
- Key services designed a new “integrated providers” procured
- Sub-contracts to other entities in the system



Finance and Contracting

Examples – Payment Mechanisms



A well designed system might use a simple, but well considered mixture of mechanisms.

Finance and Contracting

Considerations for Next Steps

Clearly defining and agreeing the goals and the limitations of the process will enable the “filter” to be constructed and the proposal to be refined. Some of these may be understood. Others will develop through an integration programme.

Who makes investment and where is it realised?

What are the “no-go” areas for stakeholders?

Should prevention be actively promoted?

What is the required timetable for implementation?

Who is best placed to take financial risk in the system?

How does the system ensure appropriate competition?

How incentivisation and innovation be captured?

What is the financial stability in the system?

Which structures could be considered to achieve system governance?

What are the fixed financial constraints in the system?

Finance and Contracting

The most important consideration…. the balance between impact and risk

SECTION 6.3
Estates

Enablers for Change

Estates

During Phase 1 there was discussion during care design groups regarding the implications of Lincolnshire's blueprint development and the fitness for purpose of the estate across the local health and social care economy. Estates utilisation was not reviewed in this phase of work however, a paper submitted to the PMO by NHS England Leicestershire and Lincolnshire (Harness, J, 2013. A Catalyst for Change?), suggests that little real attention has been given to how this huge resource could help to improve efficiency, move more care out of hospitals and exploit new technologies. Models of care remain designed around buildings. The question is posed - could rethinking the way the NHS manages its estates catalyse service change?

It is acknowledged that nationally the NHS has many underused properties and a significant amount of its estate is in poor condition or unfit for its current purpose. The cost of clearing the maintenance backlog is significant. Some of the newer estate developed to deal with maintenance backlog and as part of service developments in the past decade, has created new problems such as investment in buildings in the wrong places, or those that now appear surplus to requirements or are rapidly becoming out of date as care and treatments change.

Estates management function has been largely concerned with the maintenance and operation of buildings. There has been little development of more entrepreneurial property management skills. Building use is often not actively managed. However, this is not the case in all ex-PCT estate as it is often common practice for buildings to have multi occupancy with booking systems etc.

The NHS is not unique in experiencing these problems. Many other industries find estates and property difficult to manage. However, there are some useful illustrations from Germany, the Netherlands and Finland on how health services estate can be managed differently. While all of this means there are unexploited opportunities for improving value for money, perhaps the most important concern is that opportunities for commissioning new models of care are not being maximised and that the existing estate is an obstacle to innovation.

The objective of any change is to support and encourage new or improved models of delivery bringing acute, community, mental health, primary care and social care together in a more integrated way.

During Phase 2 consideration should be given to:

- The current position for estates management within Lincolnshire
- Estates implications arising from the blueprint interventions and future model of care
- Possible options for estates providers e.g.
  - Become prime contractors
  - Exploit the, "shop in shop" model
  - Encourage clinicians to become independent contractors (i.e. social enterprises) providing total care pathways
  - Break down the barrier of property ownership to increase competition

- This work will require careful scoping to identify what is being reviewed within both health and social care.

SECTION 6.4
Workforce

Enablers for Change

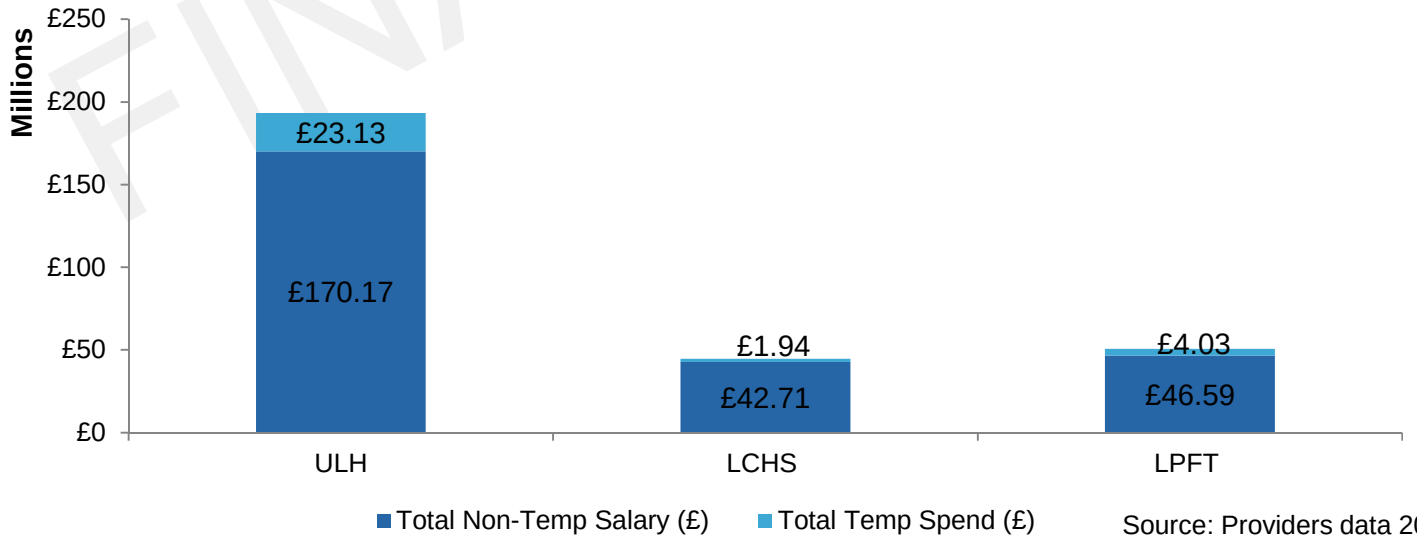
Workforce

- The delivery of effective integrated care within Lincolnshire will require a system wide workforce model which delivers optimum capacity, capability, flexibility, as well as maximises workforce efficiency and value for money.

- The current position report of the existing workforce profiles, models, staffing spend and productivity across Lincolnshire has highlighted some key challenges, issues and opportunities for the development of future services, including:

    1. The 'big supply challenge' – inability to recruit adequate numbers of skilled and talented clinical staff, particularly medical staff and GP's, this is reflected in high temporary and locum expenditure (see below);
    2. Optimising the deployment and utilisation of workforce capacity – productivity measures and metrics used highlight the opportunity to increase efficiency and associated ROI across a range of staff groups, i.e. our analysis has highlighted a potential opportunity to deliver significant efficiencies based on the existing staffing models across Lincolnshire;
    3. Implementing new ways of working – traditional roles currently dominate the provider landscape, new roles and ways of working will be essential to enabling system transformation.

Non-Temporary and Temporary Spend (2012-13)



Source: Providers data 2012-13

Enablers for Change

Workforce – Emerging Themes for Lincolnshire

1. **Workforce Supply challenges:**
   - Staff recruitment is difficult in many areas, particularly medical staff and GP's;
   - Supply challenges have driven high temporary staff and locum spend, which also undermines high quality care;
   - Local recruitment issues are amplified by national shortage of certain professional groups e.g. paediatric staff
   - Continuity of services – staff moral/recruitment & retention

2. **Difficulties in attracting and retaining talent:**
   - Restricted talent pool, with low turnover and minimal highly skilled 'new entrants' to the local health system, particularly in Urgent Care;
   - Limited (integrated) professional training and education provision.

3. **Workforce capacity limitations**
   - Lack of senior decision makers in A&E from the start
   - Lack of sufficiently qualified and competent staff
   - Lack of reliable and responsive emergency midwifery support for EMAS

4. **Capacity limitations (cont)**
   - Unable to flex resources and capacity to meet system demands;
   - Existing staffing resource models fail to provide the capacity for development and improvements in delivering truly proactive and preventative care services.

5. **Workforce leadership**
   - Alignment in the leadership and management of services, pathways and workforce across the system will provide the leverage to drive re-design, improvement and greater efficiency.

Enablers for Change

Workforce – Key Priorities for Phase Two

Drawing from the Current Position Report and the active engagement that has been secured through Care Design Groups 1, 2 and 3 alongside the Care Summit, a number of key workforce areas can be prioritised as being critical to establishing an integrated future model of care across Lincolnshire, these include:

1. Working closely with the range of providers and stakeholders from across the system will be critical, including the East Midlands LETB, NHS England, Monitor and TDA.
2. Establishing optimum staffing and employment structures and mechanisms to enable new and integrated models of care;
3. Implementing new ways of working, including:

    - new job roles
    - integrated multidisciplinary team structures and leadership models;
    - flexible employment models/vehicles;
    - enhanced education, training and development across the health and social care workforce

4. Integrated and targeted system-wide recruitment, resourcing (including greater workforce mobility), staff development and retention programmes, which attract high calibre clinical staff to work and develop their careers within the new system;
5. Establishing truly integrated training and education commissioning, informed by a strategic health economy wide workforce plan, resourcing and deployment strategy;
6. Defining the key OD levers and enablers.

SECTION 7
Transition / Change Management

Transition / Change Management

This section outlines the requirements for a high level Change Management Strategy to support the realisation of the benefits of the Lincolnshire Sustainable Services Review. The following will need to be carried out in Phase 2 and 3 of the programme:

- Identification of the key change challenges for the LSSR program
- A high level change impact assessment per key stakeholder group
- Alignment with local change management frameworks, principles and approach (working closely with the range of providers and stakeholders from across the system, including the East Midlands LETB, NHS England, Monitor and TDA).
- Short term change priorities for the LSSR program to help achieve the business benefits
- Governance, roles and responsibilities in relation to managing change

The strategy will provide overall guidance as to how to manage the change impact of the LSSR interventions at a programme level. It will not detail specific change strategies and activities for each LSSR intervention.

The LSSR programme will bring about a major change to the systems in the local health and care economy. Whilst the systems aspect is a key component of the transformation the “people” impact on ways of working, organisational structure, job roles & responsibilities across existing business units is a critical element of the changes proposed and one that requires careful management. By way of an example, the nature of the work of some people may change from an organisationally specific model to a whole patient / citizen journey model delivered in neighbourhood multi-disciplinary teams under a single operational management structure across organisations. This not only requires that people have sufficient capability to do so, but also that they have the appropriate mind-set to get as much value out of the change in way of working as possible.

The intent of the LSSR future change management strategy is to ensure the “people” risks of the LSSR programme are clearly outlined and managed, in order to minimise the risks and maximise the benefits as outlined in this Blueprint and in the future Business Case.

Following review of the draft blueprint document there was a recommendation to develop an integrated, multi-professional, multi-organisational leadership programme that addresses key issues in the Lincolnshire health and social care economy. It is unclear whether this work is already underway and this should be clarified as part of Phase 2’s change management and organisational development programme.

Change Challenges and Mitigation

Change challenges	Mitigation strategies
Significant overlap in involvement of critical stakeholders for different interventions and other programmes in train within the system (and outside of the county).	• Clarify type and duration of involvement of key stakeholders early on and allow stakeholders to plan for it / delegate to others
The LSSR program is as much a systems change as it is a change to people's ways of working across business units and organisations (new reports, new processes)	• Clarify gap between as is and to be ways of working • Involve whole system business unit representatives in shaping the new situation and managing the impact of the change
Each separate project will bring about changes in organisational structure, job roles & responsibilities and potentially the performance evaluation processes	• Involve HR Managers early on to manage impact in a way that fits with both the future model and organisational / new system 'way of doing things' • Establish a working group to manage impacts in an integrated way across interventions
Function of finance and contracting required to support the future model may change	• Involve the LSSR Programme Board (Leadership Team)in shaping future • Ensure Programme Chair and Executive sponsors are delivering a consistent message on their collective commitment to achieve the LSSR benefits & goals • Take opportunity to reshape role of finance and contracting working with NHS England, Monitor and the TDA to deliver an integrated sustainable system (in line with emerging national policy)
The success of the LSSR program me will also be measured by the adoption of the new solutions. This means people have to trust the (new) systems & processes	• Ensure people are willing, able and supported to adopt the changes • Through communications; manage expectations of the LSSR on delivery of programme interventions • Continue to involve key stakeholders in "bottom up" design, build and implementation to create ownership and buy-in • Establish and utilise change agent network across Lincolnshire building on the leadership developed in phase 1 to help manage the change
Current mindset not focused on the value of the future model of care	• Design internal marketing & communication approach that considers how to influence mindset changes to: o Foster awareness of how individual's work affects both service users and others in the whole system o Encourage people to engage with others in understanding their integration points within the future model of care o Bring about a focus on continuous improvement • Program me Chair and Executive Sponsors to begin conversations that stimulate a 'value chain mindset' • Together with HR, design approach to link performance and reward / incentives at all levels to foster focus on moving towards the integrated future model of care • Remediate capability gaps in understanding of the benefits of integrated approaches to care
Limited clarity around change impacts of other programs which have interdependencies with LSSR (in and out of county)	• Work with other programs to understand interdependencies, change impacts of these interdependencies and key risks • Pro-actively manage interdependencies

High Level Change Impact Assessment

Taking into consideration the key change challenges highlighted on the previous slide , it becomes clear that the changes proposed could have significant impact on staff groups across the Lincolnshire Health and Care Economy.
A detailed analysis of the impact of the changes brought about by the interventions outlined in this blueprint (subject to approval to be taken forward to detailed design and business case development by LSSR Programme Board and overseen by the Health and Well Being Board) will be required.

A mutually agreed model for impact analysis will need to be agreed for use at programme level by the Programme Board (on behalf of the constituent organisations). This will need to show the type of impact each intervention has on each group of stakeholders and the level of support needed in areas which have a high level of influence on the success of the LSSR's goal of sustainability.

A simple example of considerations is shown below.

Low support	Minimal involvement		**Low impact**	Way of working hardly affected
Medium support	Some responsibility for change		**Medium impact**	Way of working changes
High support	Support is key to success of change		**High impact**	New ways of working

Change Management Approach

Including Short Term Priorities

Agreement on the approach will ensure that change is managed in a consistent yet flexible manner. It will also need to be consistent with current organisational or system change frameworks.

The changes the LSSR programme proposes are complex on different dimensions:

- Multiple organisations and business units are effected
- We are shaping the new environment while “business as usual” continues
- Multiple aspects of people’s ways of working are to change (width)
- Some ways of working and organisational structures will change fundamentally (depth)
- Aside from having to comply with the new ways of working, we need people to adopt the mind-set of getting the real value out of the change
- We are bringing about these changes in an already challenging environment, impacted by both national and local changes to the commissioning and delivery of health and social care services thereby making it even more complex.

Given this complexity, the change approach should focus on the involvement of key stakeholders, patients and carers in shaping the new environment and the road to that new environment.

This approach assumes that those impacted by the change know best how to shape its purpose, direction and implementation approach (i.e. bottom up). This type of change suits transitional or transformational projects, such as the LSSR programme.
Stakeholders will be involved in planning, design and change management activities to help achieve buy-in, ownership and commitment rather than driving compliance. Each intervention will need to tailor the approach to their specific objectives to meet the overall programme aims.

Short Term Priorities

- Agree this blueprint and communicate the vision
- Agree continued executive sponsorship and leadership
- Communicate with the key stakeholders around what is expected from them in terms of their input and time involvement going forward (identify resource to manage the change)
- Develop the Care Design Groups further to co-create more detailed design to facilitate understanding of workforce requirements to support the development of a business case and specification
- Communicate (and consult as appropriate) with broader groups of stakeholders (including patients and carers)
- Undertake readiness for change assessments that lead in to skills audit and identification of OD requirements to support the Future Model of Care

Appendix 1

Lincolnshire Care Design Group Sample Mapping

Care Design Group Name	Definition
Urgent Care (Reactive)	• Accident & Emergency; • Non-elective inpatients (excluding maternity and children); • Critical care; and • Emergency services (spend for Lincolnshire and interventions which impact on current and future design options).
Early Intervention and Prevention and Long Term Conditions (Proactive)	• Recovery, reablement and rehabilitation (including physio and occupational therapy / Integrated Living Team & Intermediate Care services); • Primary care; • LTC management; • Screening; • Health promotion activities; • Palliative care; • Community-based nursing; • Care homes (nursing and residential); • Relevant mental health activity i.e. when it impacts upon general health e.g. dementia services or impacts on general health services e.g. primary care or A/E; and • Health and social care for the frail elderly.
Elective (Planned Care)	• Elective (including all day cases and elective Gynaecology); • Outpatients; and • Sexual health; and • Specialised Services – NHS England.
Women's & Children's	• Maternity (Obstetrics and Midwifery but excluding Gynaecology); • Children (Paediatrics – inpatients and outpatients and non-elective activity); • Social care for children; and • Relevant mental health services e.g. CAMHS.
Key Notes	• Diagnostics will be a consideration across a number of care design groups.
Scope Exclusions	• In principle, specialist care for mental health and learning disabilities, and education services has been identified as out of scope. • The Care Design process is to have sufficient scope so as not to reduce creativity regarding future design whilst supporting delivery of a design blueprint within the specified timescale. • The potential exclusion of services will be discussed and agreed in Care Design Groups and is subject to review by the Programme Board with any significant changes managed through the defined change control processes

Appendix 2
List of documents that informed the Care Design process

- Allen G. (2011) Early Intervention: Smart Investment, Massive Savings HM Government
- Bardsley M., Georghiou T. and Dixon J. (2010) Social care and hospital use at the end of life, The Nuffield Trust
- Bardsley M., Steventon A., Smith J. and Dixon J.(June 2013) Evaluating integrated and community-based care, The Nuffield Trust
- Clements M. (2010) How can we be confident in the new NHS architecture for Children & Young People? Whole Systems Work in Emergency & Urgent Care NHS Institute for Innovation and Improvement
- Coulter A., Roberts S., Dixon A. (October 2013) Delivering better services for people with long-term conditions, The King's Fund
- de Silva D. (May 2011) Helping people help themselves, The Health Foundation
- Fernandes A. (August 2011) Guidance for commissioning integrated URGENT AND EMERGENCY CARE: A 'whole system' approach
- Glendinning C., Jones K., Baxter K. et al. (November 2010) Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study) Working Paper No. DHR 2438, Social Policy Research Unit, University of York
- Ham C., Walsh N. (March 2013) Making integrated care happen at scale and pace, The King's Fund
- Harness, J., (July 2013) A Catalyst for Change, NHS England Leicestershire and Lincolnshire
- Imison C. and Naylor C. (2010) Referral management: Lessons for success, The King's Fund
- Imison C., Poteliakhoff E., Thompson J. (August 2012) Older people and emergency bed use, The King's Fund
- Lincolnshire County Council Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018
- Munton T., Martin A., Marrero I., Llewellyn A., Gibson K., Gomersall A. (June 2011) Evidence: Getting out of hospital?, The Health Foundation
- National Audit of Intermediate Care Report 2012
- NHS Institute for Innovation and Improvement (2013) Making improvements in maternity services
- NHS Institute for Innovation and Improvement (2012) Excellence in Maternity Services Maternity Improvement Programmes April 2011 to March 2012
- NHS Kirklees (March 2009) Self care toolkit for professionals working with people with long term health conditions
- Nicholson D. (October 2013) Planning for a sustainable NHS: responding to the 'call to action'
- Pennine Partnership msk Ltd (February 2013) Generic Pathway for patients with a musculoskeletal problem

Appendix 2
List of documents that informed the Care Design process (cont.)

- Purdy S. (December2010) Avoiding-Hospital-Admissions, The King's Fund
- Ross S., Curry N., Goodwin N. (November 2011) Case management: What it is and how it can best be implemented, The King's Fund
- Royal College of Obstetricians and Gynaecologists High Quality Women's Health Care: A proposal for Change (July 2011)
- Royal College of Paediatrics and Child Health (January 2009) Short Stay Paediatric Assessment Units
- Royal College of Paediatrics and Children Health http://www.rcpch.ac.uk/emergencycare
- The Children Act 2004 Act of the Parliament of the United Kingdom.
- Timmins N., Ham C. (2013) The quest for integrated health and social care, The King's Fund
- Turning Point (February 2010) Benefits realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care
- Wittenberg R., Hu B., Comas-Herrera A. and Fernandez J. (December 2012) Care for older people, The Nuffield Trust

Further Reading:

- Darzi a (2007) Our NHS Future - next stage review interim report, Department of Health
- Department of Health (April 2003) Getting the right start: National Service Framework for Children, Young People and Maternity Services
- Healthcare Commission (2007) Improving services for children in hospital
- Intercollegiate Committee for Services for Children in Emergency Department (April 2007) Services for Children in Emergency departments
- Lord Laming, HMSO (2003) The Victoria Climbie Inquiry
- NHS Institute for Innovation and Improvement (2006) Delivering Quality and Value: Focus on: Short Stay Emergency Care
- Nursing and Midwifery Council (2007) Nursing: Towards 2015
- Royal College of Nursing (2007) Preparing the child health nurse – fit for the future
- Shribman S (2007) Making better: for children and young people - clinical case for change, Department of Health
- The Royal College of Paediatrics and Child Health (2006) A guide to Understanding Pathways and Implementing Networks
- The Royal College of Paediatrics and Child Health (2007) Modelling the Future: A consultation on the future of children's health services

Prepared for Dr. Tony Hill LSSR Board Chair (on behalf of leaders of the Lincolnshire health and social care system)

By the Programme Management Office
Lincolnshire East Clinical Commissioning Group
NHS Lincolnshire East Clinical Commissioning Group
Cross O'Cliff
Bracebridge Heath
LN4 2HN
Tel: 01522 513355
Mob: 07808105895