Lincolnshire Health and Wellbeing Board

Lincolnshire Better Care Fund Narrative Plan 2022/23

Executive Summary

The Lincolnshire Health and Care System key deliverables for 2022/23

- The Lincolnshire Health and Care Leadership team are committed to recover from the COVID pandemic, deliver key transformation programmes and improving the efficiency and productivity of services through stronger integration and focus on population health outcomes and reduction in health inequalities.
- System partners have worked closely in Lincolnshire, against a backdrop of unique operational pressures, to develop our 2022/23 plans.
- What is presented in this BCF plan is a strong collective endeavour to deliver the BCF framework and meet the national conditions.

Our BCF key deliverables for 2022/23 are as follows:

Reduce the pressures on urgent & emergency care by building community care capacity –providing the right care, at the right time, in the right place

- The Lincolnshire system has undertaken an end to end review of the UEC pathway.to ensure that the commissioned services meet the needs of the population.
- In line with planning guidance and the systems Recovery Support Programme there is a continued emphasis placed on delivering our ambition for Care Closer to Home. Patients will be supported to access the most appropriate service for their needs, safeguarding emergency services for those that require that level of care.
- Key components of our plans include providing more co-ordinated care for patients in their home or in their local community that prevents unnecessary hospital attendance or admission; establishing a single specialist palliative care service with effective home-based support; ongoing implementation of the Somerset Discharge to Assess model, ensuring that all patients are discharged from an acute setting as soon as they are ready to do so, with the requisite reablement, rehabilitation & home care support
- The system has recognised the need to improve delivery of Pathway Zero. Increasing the proportion of people on Pathway Zero – at least to the regional average, where patients no longer have any care needs that require additional support. In addition to strengthening capacity in Pathway 1.
- Collectively these initiatives will result in the Lincolnshire population spending less nights in hospital, improve patient outcomes and experience.

Using our collective resources more effectively and equitably

In delivering the priorities it will require a shift in approach to focus on what 'matters to people' through personalised approaches, population health outcomes and improving the stability of our workforce.

More personalised care

- Relationships: making a positive power shift in relationships between people and professionals to one of equal, shared decision-making.
- Empowerment: respecting a person's right to lead their own health and wellbeing
- Mindset: having meaningful conversations with people to find their strength and assets, exploring what's important to them, their goals and aspirations

Population health management, prevention and health equity

- Using data and analytics in service planning and delivery, with a focus on targeting the most relevant patient cohorts and improving access and health equity for underserved communities. Specific 22/23 priorities: progressing the development of the ICS intelligence function and a PHM implementation roadmap; creating the supporting digital infrastructure
- Prevention: implementing tobacco dependency services in NHS services; establishing a CVD & respiratory prevention programme; Targeting weight management, alcohol.

Digital

- Exploiting digital technologies to transform the delivery of care and patient outcomes: initiating the Lincolnshire electronic patient record; expanding the care portal and patient portal; using the National Electronic Referral System; introducing care home remote clinical observation kits and new monitoring at home services; supporting virtual wards; establishing system-level sharing and governance of health and care data

Delivering the national ambition on integrated care

- Integrated Care System: The NHS will continue to work with health and care organisations across the county which will continue the journey to become a thriving ICS.
- Integrated Care Board: The ICB has now succeeded the CCG and has begun to develop its first ICS strategy, closely aligned to the pre-existing H&W Board Strategy and JSNA..
- Provider collaboratives: Continued development of the Lincolnshire Health & Care Collaborative and Lincolnshire Mental Health, Learning Disability & Autism Alliance provides oversight of further opportunities to strengthen integration between health, social care, housing services and our voluntary sector.

BCF Stakeholders and Governance

Bodies involved in preparing the plan

The challenging timescales for the 2022/23 BCF assurance cycle has meant that a wider consultation and engagement exercise on “The Lincolnshire BCF Plan” was not feasible. However in Lincolnshire we approach the BCF as a continuous process with ongoing engagement and coproduction throughout either on an individual scheme basis or the higher level objectives and strategic intention of the BCF. The following bodies have been involved in the production of the plan:

- NHS Provider Organisations: Lincolnshire Community Health Services; Lincolnshire Partnership Mental Health Foundation trust; the Primary Care Network Alliance, and United Lincolnshire Hospitals Trust.
- Commissioning organisations: Lincolnshire NHS Integrated Care Board and Lincolnshire County Council.
- Lincolnshire Health and Wellbeing Board and Housing, Health and Care Delivery Group (HWB Sub Group). Including Social Housing Providers (Lincolnshire Housing Forum), NHS organisations, 7 District Councils (City of Lincoln, West Lindsey, East Lindsey, Boston, South Holland, North Kesteven and South Kesteven), Adult Social Care and VCSE sector.
- Voluntary Engagement Team (VET) . Collaboration of Voluntary and Charitable organisations in Lincolnshire. VET are represented at the HWB, Lincolnshire Health and Care Provider Collaborative (LHCC) and the ICS Board. Representation includes St Barnabas (Hospice) and Age UK.
- Lincolnshire Care Association (LinCA). LinCA represents the social care provider sector and has representation at the LHCC and ICS Board.

Stakeholder Involvement

Individual BCF schemes are coproduced with relevant stakeholder to maximise the opportunity for success delivery. This is undertaken in the context of a well established strategy which is shared and adopted by stakeholders.

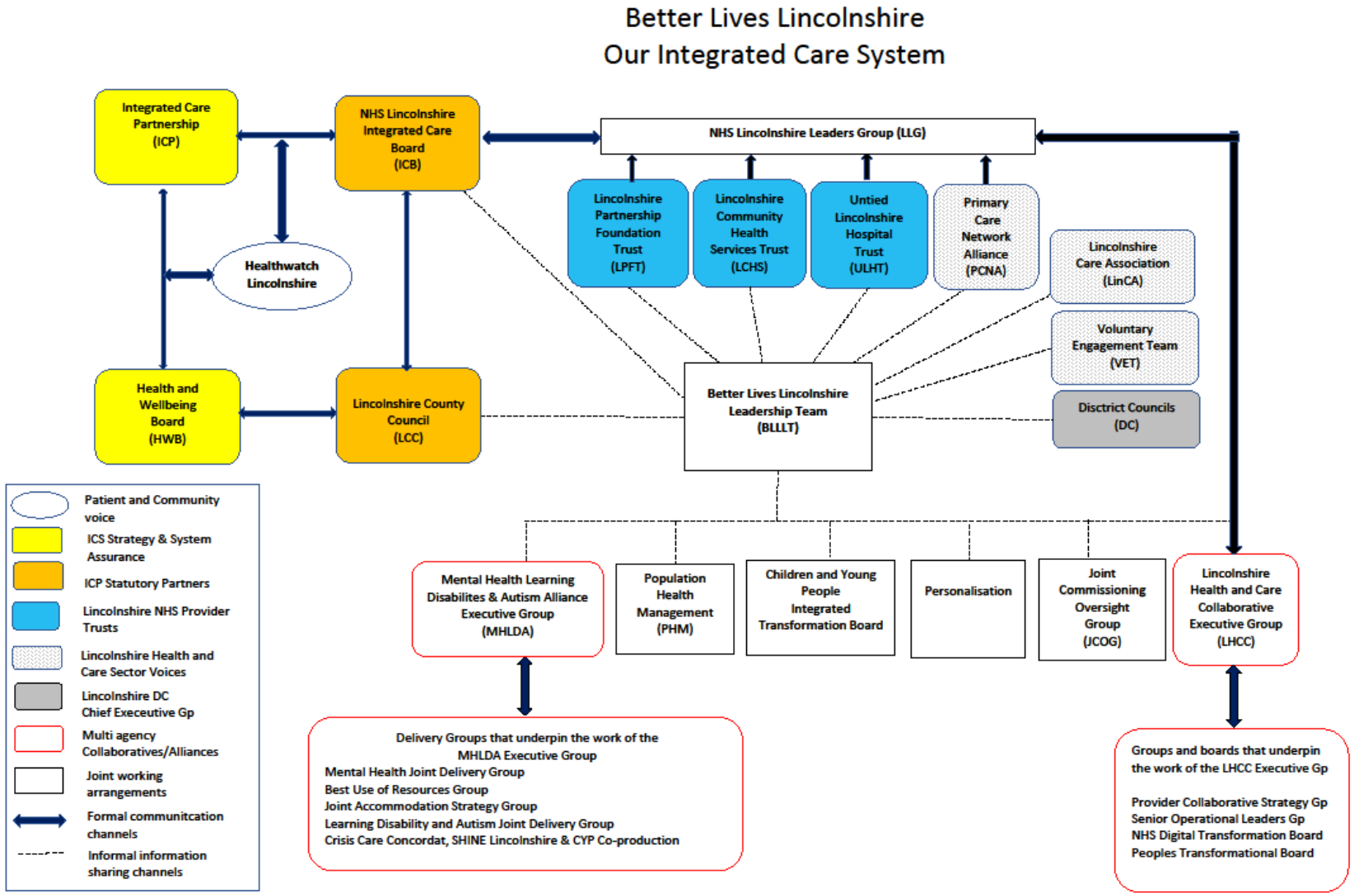
Lincolnshire has a history of successful BCF planning and delivery with oversight from the health and wellbeing board. Throughout 2021/22 and so far this year, there has been continuous involvement with all stakeholders to guide the development and ongoing iteration of the BCF plan for 2022/23. Specifically BCF schemes and objectives regarding hospital flow and discharge have been co-produced between adult care, Lincolnshire Community Health Services and United Lincolnshire Hospitals Trust. Several schemes have been provided or supported by Age UK or LinCA and the VCSE sector/independent social care provider sector, engaged in discussions.

Governance

The governance continues to evolve as the ICS and ICB becomes more established. Ultimately the H&WB continue to provide oversight of the BCF, however the ICB and LA also agree the plan as required.

The Lincolnshire governance map is provided on the next page. This demonstrates the relationship between system organisations, board and committees and highlights the involvement of these in the BCF development. There are formal, constituted relationships and reporting between boards, but also more informal communication and engagement routes to enable co-design in the widest sense.

BCF Governance



BCF Plan, approach to integration and implementing policy objectives

Better Lives Lincolnshire

There is a long history of joint working in Lincolnshire between the NHS, Local Authority Public Health, Social Care, the 3rd Sector, Housing and Children's Services, to address the factors that determine health throughout the life course and to seek to reduce demand on health care services in a more preventative and proactive manner. In the last 18 months these have been made even stronger.

- Lincolnshire' is a clear, well established and understood term. In the county there is :
  - Lincolnshire County Council (and 7 District Councils which together are coterminous with the County Council)
  - NHS Lincolnshire ICB (coterminous with County Council)
  - Three NHS Trusts – all with Lincolnshire in their titles (United Lincolnshire Hospitals NHS Trust; Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership Foundation NHS Trust)
  - 85 Lincolnshire GP practices
  - Lincolnshire Care Homes Association (295 care homes in the county)
  - Lincolnshire Voluntary Engagement Team (3rd sector grouping)
  - Alongside other key partners e.g. Lincolnshire Police

- The Better Lives Lincolnshire Alliance, the Lincolnshire ICS, is a shared partnership across the health, care and 3rd sector in the county, and is a joint endeavour.

- We believe that our focus should be on the outcomes that we can together deliver for people across Lincolnshire, and not structure. Form must follow function for us in Lincolnshire to be as effective as possible

placed to design an integrated care system which works in our geography and for our population. In doing so, we will continually compare our outcomes with those of others and learn from experience across the country.

- Across the broader health and care system in Lincolnshire we have a good track record with one of the largest pooled budgets in the country.

- This has particularly deepened, evolved and accelerated over the past 18 months in response to evolving national policy in relation to Integrated Care and due to a combination of key local factors:
  - Establishing a single NHS Clinical Commissioning Group in Lincolnshire
  - The successful establishment of the Lincolnshire Joint Working Executive Group (JWEG)
  - Strong and effective joint working and support through Wave 1 of the Coronavirus pandemic through the LRF.
  - Joint development of Town Fund Bids, One Public Estate and proposed Cavell Centre in Sleaford

- This has already delivered good outcomes for the population, evidenced by the recent CQC review of provider collaboration in Lincolnshire and joint working on a number of shared priorities.

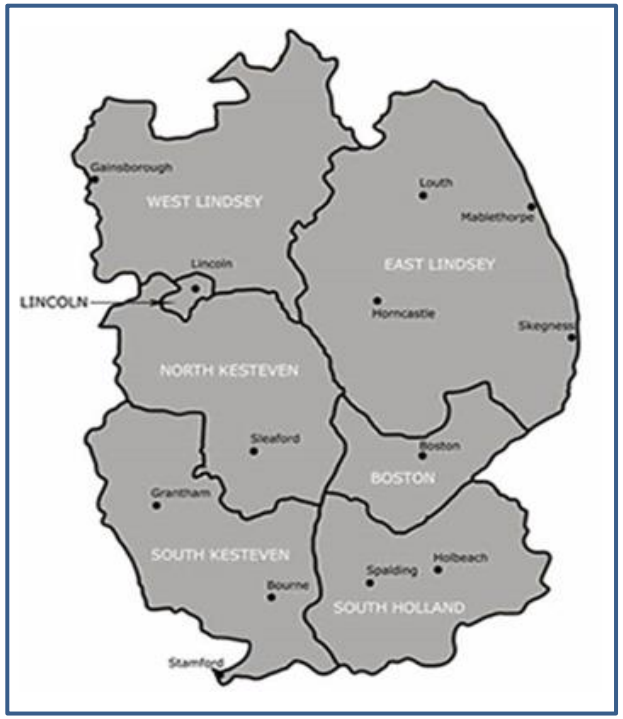
- Health and care partners in Lincolnshire believe that becoming an ICS- through the Better Lives Lincolnshire Alliance - is the next step on the ongoing evolution of this partnership and joint working as we seek to continue to deliver:
  i. Better health and wellbeing for everyone;
  ii. Better care for all people; and
  iii. Sustainable use of resources

Lincolnshire COUNTY COUNCIL Working for a better future

- Single county council
- Responsible for the Lincolnshire Health and Wellbeing Board - aims to reduce health inequalities and improve people's health & wellbeing
- Delivers adult social care, children's care, support for carers, help to live at home, health and wellbeing programmes, safeguarding and support with disabilities

NHS Lincolnshire Clinical Commissioning Group

- Single NHS ICB planning, commissioning and developing healthcare services for the population of Lincolnshire
- Formed 1st April 2020, following merger of the four previous CCGs in Lincolnshire



NHS Lincolnshire Community Health Services NHS Trust

NHS Lincolnshire Partnership NHS Foundation Trust

NHS United Lincolnshire Hospitals NHS Trust

- One provider of community services, one provider of mental health services and one provider of acute hospitals services – with a track record of developing relationships and working together

Voluntary Engagement Team
Linking Differently to Health and Care

- The Voluntary Engagement Team is a partnership working together to further opportunities for the voluntary sector in the county.

Lincolnshire Care Association

- Supports care and support providers to ensure there is a sustainable choice of quality care services within Lincolnshire

Lincolnshire Primary Care Network Alliance

- The Alliance is general practice's unified voice at a system level, membership consists of all of the PCN (14) Clinical Directors in Lincolnshire

b) **Lincolnshire population overview**

Headlines

- Lincolnshire is the fourth largest county in England covering an area of 5,921 sq. km.
- 768,400 residents (2021), or 803,165 GP-registered patients
- Lincolnshire is predominately rural, with no motorways, little dual carriageway and 80km of North Sea coastline
- Our population is on average older than the population of England. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
- The greatest causes of ill health and mortality are cardiovascular disease, cancers, musculoskeletal conditions and mental ill-health. Musculoskeletal conditions and mental ill-health are the biggest contributors to 'the number of Years Lived with Disability' in Lincolnshire's population.
- The combination of an ageing population, a rural geography and areas of high socioeconomic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire.

Ethnicity

- The diversity of the population is gradually increasing as a result of new and emerging communities. As of the 2011 Census, 93% of residents identify themselves as White British with a significant 4% identifying as White Other. This 4% is primarily made of Eastern European communities.

Deprivation

- Urban areas and particularly the coast suffer higher deprivation, although there are pockets of deprivation across the county, including in rural areas which frequently suffer from issues of accessibility.

Housing

- Lincolnshire has 335,450 households. 21% of private housing stock is estimated to have a serious hazard likely to cause illness or harm
- There are around 200 caravan sites, and nearly 25,000 static caravans on the Lincolnshire coast (the largest concentration in Europe) with a permanent population of over 6,000 people. There are also smaller static caravan sites across other areas of the county; A report by Centre for Regional Economic and Social Research suggested 40% of caravan dwellers were in effect full-time residents in East Lindsey and that some others spent 40-50% of the year in their caravan. The report also suggested that 31% of local caravan residents were living with long-standing illness, disability or infirmity and nearly a quarter surveyed had health issues affecting mobility. 11% stated that they accessed local GPs as a 'temporary resident'.

Economy & Employment

- Lincolnshire has strong agriculture, manufacturing, food and tourism sectors, however these tend to provide lower paid and lower skilled employment than the national average. Lincolnshire as a whole is the largest single contributor to agricultural production in England, providing nearly 30% of the field vegetable crop in the country from its arable land.
- Unemployment in Lincolnshire is below national rates, however there is significant seasonal employment in relation to the strong horticulture and tourism sectors, particularly in the east and south of the county. Lincolnshire has one of the fastest growing rates of carers in the UK. Between 2001 and 2015, the county experienced a 27.5% increase in the number of carers, compared to the general rate of population growth of 6.2%.There are estimated to be over 84,000 unpaid carers in the county

Education

- Lincolnshire's school level attainment is broadly in line with national figures, and above regional figures, at GCSE level , and above both national and regional figures at A' level; The proportion of the working age population in the county qualified to NVQ level 3 and higher is below regional and national averages.

c) Key systemic issues faced by the Lincolnshire system

Performance issues in the acute care system

- The acute care system in Lincolnshire has faced performance issues in some areas for a number of years now, and struggled to consistently meet NHS Constitutional Standards. These areas are: A&E performance; Cancer; Elective care access/waiting times
- A key contributing factor to this situation is an over-reliance on hospital treatment, rather than on prevention and the interventions needed to keep people well at home.
- The Covid-19 pandemic has emphasised more than ever the need to ensure patients only attend urgent and emergency care services at hospital when absolutely necessary.
- For cancer and elective care the pandemic has focused the need to restore these services back to 'pre-Covid' levels, and better, as quickly as possible to ensure patients receive the care and treatment they need.

Financial Sustainability

- The health economy in Lincolnshire has been in financial deficit for a number of years (c.£100m 19/20). The majority of this has been attributable to the Acute Trust - ULHT, however more recently financial pressures began to manifest in the ICB.
- Key drivers are: Hospital service demand and the way services are configured across the county; The significant cost of maintaining three acute hospitals (in significant disrepair); The premium cost incurred in trying to attract the right mix of clinical and professional staff
- Whilst continuous efforts have been made to tackle these issues, they can only be effectively addressed by fundamentally changing the way in which healthcare services are delivered. This will mean investing in community, mental health and primary care and reducing costs elsewhere in the system.
- The NHS financial regime in response to the Covid-19 pandemic has meant the system has been close to break-even through 2020/21 and 2021/22. However when the NHS financial regime returns to 'business as usual' a reversion to financial deficit is expected.

Health Inequalities

- For many years, the health and care system in Lincolnshire has worked together to tackle health inequalities, recognising that, as a system we have an important role to play in the response to tackling this issue, both in terms of access to services and outcomes on life expectancy.
- In more recent times the gap has widened. It has been ten years since the publication of The Marmot Review. Over the last decade health inequalities have widened overall and the amount of time people spend in poor health has increased. Increases in life expectancy have slowed since 2010 with the slowdown greatest in more deprived areas of the country.
- The Covid-19 pandemic has further highlighted and worsened the inequalities that exist in Lincolnshire and the challenge to respond has never been greater.

Workforce

- The Lincolnshire system experiences challenges in attracting and recruiting specific staffing groups, in part due to geographic and demographic challenges, leading to a historic high dependency on locum and agency - especially within the acute services.
- The health and care sector need to work differently. Never more so has this been evident than during the past 18 months. An agile workforce that can work to the top of their grade, across service and organisational boundaries with a digital mindset is crucial to deliver care closer to home in a dispersed and rural locality such as Lincolnshire.
- The Covid-19 pandemic has put a huge stress and strain on the health and care workforce, which the Lincolnshire system partners have came together to support and manage 'as one' brilliantly. However, in the medium to long term, the pressures of the pandemic on staff could have a further adverse effect on the availability, recruitment and retention of staff as people consider their future roles and careers.

Where we want to be

Working together, developing a thriving Integrated Care System

Shifting from a fragmented health and care system…

Commissioning activity is transactional
NHS Commissioners undertake a number of activities that are 'low value' and do not drive population health changes

Separate health and social care commissioning
Local Authority and ICB commission services separately and pool only very small amounts of funding associated with Better Care Fund

Limited integration across providers
Good working arrangements, however integration across care settings, including with social care, remains limited

Providers receive fees for services / parts of pathways
Providers predominantly incentivised to deliver distinct service components through activity-based contracts

Which for the people of Lincolnshire means:

- A lack of ownership of the overall, and continuing, health and care of people.
- A focus on reactive treatment, rather than proactive intervention and preventative action.
- People visiting different services, that are not entirely integrated and do not communicate with each other efficiently across the whole care cycle.

To a thriving integrated care system

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Supporting broader social & economic development

Integrated Care Partnership & Integrated Care Board

- Providing a whole system view of population health needs and inequalities
- Setting clear strategic direction using outcomes, KPIs and care standards for improvement
- Ensuring collective accountability between all partners for whole system quality, performance and finances

Shared accountability

Shared outcomes

Provider Collaboration & Partnership

- Deciding how outcomes, KPIs and standards will be delivered through operational delivery and service/pathway redesign & transformation
- Delivering outcome, KPI and care standards based contracts for specific populations incl. capitation, pool funds, and risk shares

Which for the people of Lincolnshire means:

- Services organised around patients that span professional boundaries – fewer hand offs and less bureaucracy for people to manage
- Care and support is focused on delivering the outcomes that are important to people
- Care providers are collectively responsible for the full cycle of care - their key objective is 'how can we best deliver outcomes for people together'?

Our core ambitions for health and care in Lincolnshire

The Lincolnshire Long Term plans links with the pre-existing Joint Health and Wellbeing Strategy and ICS which is development and due by December. The Lincolnshire Long Term Plan identified four core ambitions, which remain completely valid:

STP_full_plan_20161212_web.pdf (lincolnshire.nhs.uk)

Prevention:

- We want to shift the entire emphasis of the system from treatment to prevention and self-care.
- We want local people to have the best start in life, so they can live and age well by helping them to make healthier lifestyle choices and treating avoidable illness early on.
- We will work with partners to address the wider determinants of health.
- We will significantly increase the
- management of chronic
- conditions in a community
- setting to reduce unnecessary
- hospital admissions

Person-centred care:

- We want people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences. This shift represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be
- connected to each other and their
- communities. The emphasis is on
- self-management: supporting people to develop the knowledge, skills and
- confidence to manage their own health and wellbeing. We want people to die with dignity in a place of their choice. Communities and staff will be included in the design, delivery and assurance of services so that everyone truly owns their care

Working together:

- We want joined-up, co-ordinated services across the health and care system to better meet people's needs and improve their experience of care.
- This means operating as one integrated team that works together with the person and their family at the centre.
- We will work increasingly closely with local authorities, the voluntary sector and others to connect care across hospital and community care, physical and mental health care and health and social care.
- We will also work with other relevant agencies, (transport, housing and the justice system) to improve health and wellbeing.
- All planned and paid for once, with councils and the NHS working together to remove barriers created by planning and paying for services separately

Care closer to home:

- We want to deliver services as close as possible to people in their own homes.
- Wherever possible, services will be provided in the local community.
- Only when the safety, quality and cost effectiveness of care are improved will services be delivered elsewhere such as in hospitals and centres of excellence.
- Lincolnshire's rurality and dispersed population can pose a challenge for people getting to and from health facilities – we will tackle this through both telecare, care closer to home and innovative transport solutions developed in partnership with the local authority

Our Shared Agreement for the best health and care for Lincolnshire

We need to continue the journey we have started to ensure the best health and care in Lincolnshire and we know this needs to have the people of Lincolnshire and their communities at its core. This is being driven by the development of Our Shared Agreement for the best health and care for Lincolnshire - making it add up to better lives for all.

At the heart of Our Shared Agreement is the idea of a new relationship between the Lincolnshire health and care system and the people of Lincolnshire that:

1. Starts with people's needs
2. Is in a language people can understand
3. Resonates and is important to people
4. Shows what is important to people is being achieved
5. Engages local people in the process of analysing results and working out what this means for services, people and communities

This relationship is different to what has gone before and is key to our success. We want it to provide the foundation for meaningful ongoing engagement and dialogue with the people of Lincolnshire and empower them to be part of delivering the best health and care for the county

To make sure we deliver the highest quality public services a set of principles have been developed which underpin Our Shared Agreement, and it's suggested all organisations adopt these. How we work as an Integrated Care System to deliver Our Shared Agreement will be based on Our Shared Agreement Principles.

- Have a set of shared core values and behaviours
- Plan and deliver care and support with individuals to achieve the best outcomes for them
- A preventative, assets-based and population-health management approach
- Ensure everyone has the same opportunities and people feel like they belong and are included
- Support and empower everyone so they have the confidence, freedom and permission to do what will make a difference

Lincolnshire's Coproduction Alliance

Building on the co production work that is already happening in Lincolnshire we are looking to develop a Co Production Alliance with a strategic aim to ensure that people with lived experience are shaping and influencing the way services are designed, commissioned and delivered across the Health and Care System.

To do this..

- People with lived experience will have the skills, knowledge and confidence to operate across the Lincolnshire Health and Care system influencing the way in which Services are delivered.
- Support our workforce to have the skills, knowledge and confidence to build true co production values into their daily practice.
- Develop a range of techniques, methods and approaches to co production to ensure it is accessible to a wide range of people from across the county.
- Work with Strategic Partners who will operate as the knowledge base and experts/ consultants, provide impartial facilitation and independent quality assurance.
- Adopt Every-One's values and beliefs
    - **P**erson-centred: treating people as individuals.
    - **E**mpathy: caring and compassionate for people.
    - **O**ptimism: positive, brave, and agile.
    - **P**artnerships: developing and being part of networks.
    - **L**earning: evolving and innovating.
    - **E**ngaging: valuing people and the lived experience.

Care Closer to Home

Making care closer to home a reality - our blueprint for out of hospital care

Our vision is for a new integrated model of health and care, with the majority of care and support provided closer to home, from community settings and within people's own homes, rather than from acute services. Primary Care Networks (PCNs) are the key building blocks for care coordination, complex case management and long term condition management.

We understand the significant sustainability and quality challenges facing healthcare delivery across Lincolnshire and embrace the need for a fundamentally different operating model. The future target operating model (TOM) is a high quality, financially affordable system underpinned by: population health management at scale; care coordination; self-care and personalisation; addressing health inequalities; integrated budgets; and with technology in place to facilitate this delivery. Finance and contracts, where incentives are aligned to deliver outcomes, will shift the focus of delivery towards a preventative and proactive offer of support. It will be based on effective system partnerships.

Lincolnshire's future TOM will be based on prevention, self-care and joined-up local community services, at PCN and PCN Cluster (Place) levels, supported by specialist services in acute hospitals at countywide (System) level *(1).* There will be a range of health and care functions that will build upon the existing PCNs. With a strong local focus, communities will be equipped with the necessary tools, information and resources to understand and improve the health and wellbeing of their population. This increased knowledge will enable targeted interventions to specific groups of patients. A well-connected infrastructure of voluntary services within local communities, that are seen as key delivery partners, will deliver a range of health and wellbeing initiatives including: social prescribing; care navigation and coordination; carer support; patient education for specific conditions/pathways and volunteering groups.

In the future state, people will be able to access services via mobile app, web, phone or face to face. This will be supported by a digital infrastructure, such as shared patient records, real time service directories and disease registries for population health.

An integrated primary, social, community and third sector function will offer joined-up delivery of wellbeing services, primary care, social care, community and voluntary services. These integrated service teams will be available in each PCN to deliver a range of care to local people e.g., long term conditions, post-operative rehabilitation, mental health & end of life. These teams will have rapid access to urgent community responses at PCN Cluster level and specialist services at countywide level when necessary. This will be built around the established PCN structure.

A significant number of A&E attendances and admissions could be prevented through MDT working, care coordination and proactive, anticipatory care at PCN level. Urgent community responses would be provided at PCN Cluster level by a range of professionals working together to deliver a rapid response, to enable people to be cared for in their own home/communities.

There will still be times when residents will require acute or emergency care and this will be provided by appropriately resourced services delivered from their local hospital. Access to high quality acute hospital services will be provided for residents when they need specialist intervention. The acute services review programme has determined the new reconfiguration for acute care in Lincolnshire.

Use of an integrated patient level data set (population health management) will be central to care provision and delivery. The dataset and associated insights will be used by front line teams to define daily and weekly clinical priorities, identify patients whose health and care can be most impacted if supported proactively and to understand how incentives can encourage the collaboration and behaviours that will achieve best patient outcomes, workforce engagement and a sustainable financial position.

The development and implementation of this new operating model is the foundation of all our system transformation work.

1 – further timescales & targets to be added

Care Closer to Home: Integrating care

Our vision is for a new integrated model of health and care, with the majority of care and support provided closer to home, from community settings and within people's own homes, rather than from acute services. Primary Care Networks (PCNs) are the key building blocks for care coordination, complex case management and long term condition management. The development and implementation of this new operating model is the foundation of all our system transformation work.

Future state

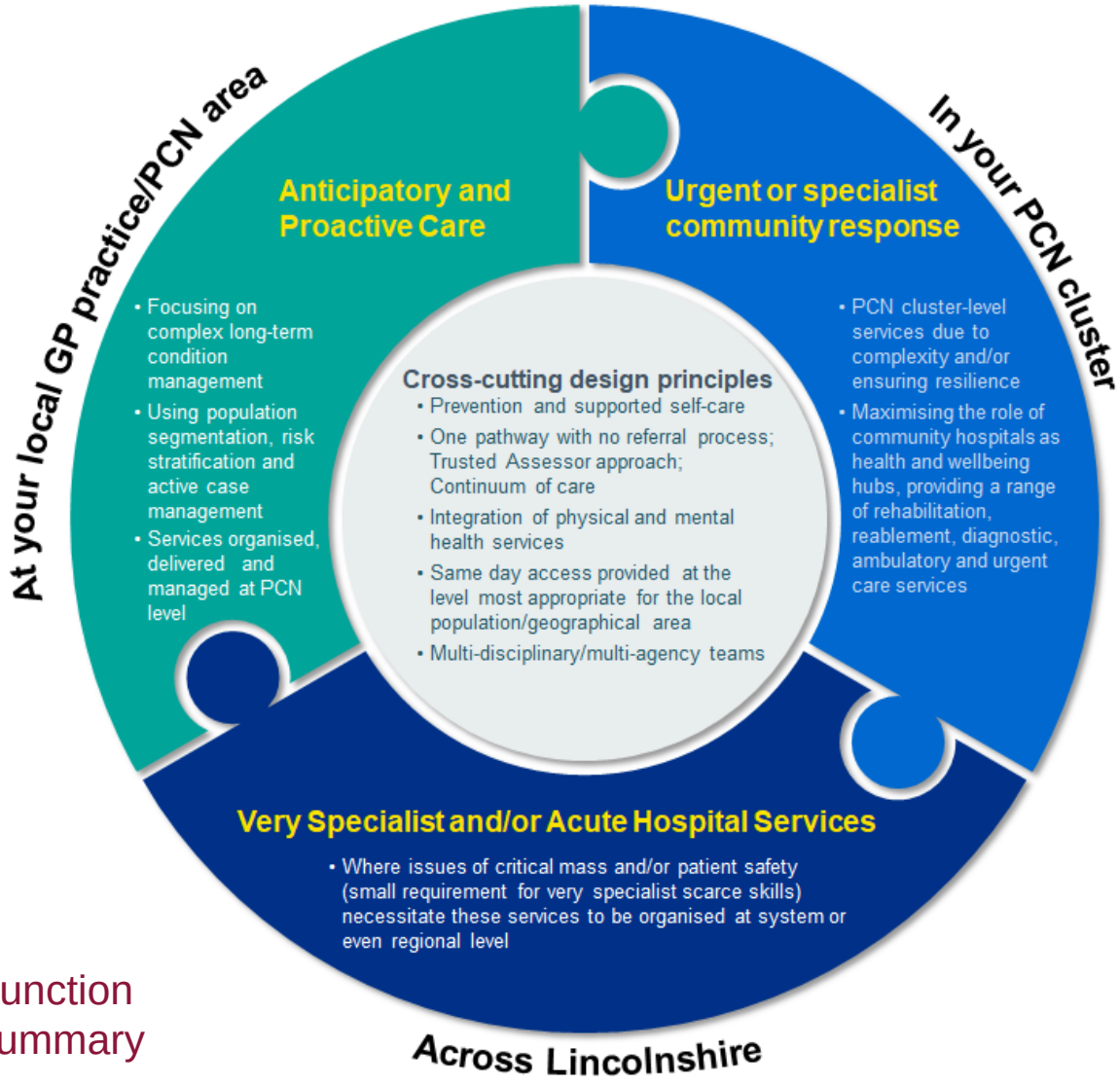
The advent and development of PCNs, coupled with digital improvement accelerated by the response to the COVID-19 pandemic, has led the Lincolnshire system to re-think its approach to how it integrates the delivery of care.

A key element of the Care Closer to Home rapid transformation programme *(2)* has been to develop a new Target Operating Model for alignment of services based on function at PCN, PCN cluster and ICS level.

It should be noted that the scope of this work to design the blueprint for the out-of-hospital model of care is adults with or at risk of identified health needs. It is the intention to expand this to children and young people in the future.

The plan summarises the work to date, based on discussions with system partners. We will continue to engage and refine over the coming months.

The diagram on the right provides a high-level summary of the functions that will be delivered at PCN, PCN cluster and ICS level.



Function summary

2 – Proposed timescales and outcomes to be added.

Care Closer to Home: Discharge to Assess (Patient Flow & Discharge)

Context

On 8th December 2021 the Better Lives Lincolnshire Leadership Board session asked the newly appointed System Flow Director to look at the feasibility of implementing 'The Somerset model for intermediate care' which is recognised nationally and regionally as best practice for Discharge to Assess (D2A).

This model requires that all patients are discharged home as the default pathway from an acute setting as soon as they are ready to do so, and that reablement / rehabilitation / recovery / home care support is wrapped around the individual in their own home (or usual place of residence) with the aim to a return to the quality of life they had prior to their hospital admission.

- Home First D2A is a model that is used to discharge people from hospital when it is safe and appropriate to their own home wherever possible and onward assessments, care and support are tailored to their individual needs
- Implementing a D2A model where any assessments are undertaken out of the hospital and following Home First principles where going home is the default pathway, ensures the best possible outcome for patients
- To successfully deliver home first D2A one of the first steps is to define pathway 1 as the most dynamic home based 'Rehabilitation, Reablement, Recovery' service in the system which aims to deliver better ASCOF (Adult Social Care Outcomes Framework) outcomes than 'institutional bed based rehabilitation'
- Definition of pathway 1 in the national policy – allowing someone to return home with new, additional or a restarted package of support from health and/or social care and every effort should be made to follow home first principles, allowing people to recover, re-able, rehabilitate or die in their own home.

Future State

A self assessment against the updated High Impact Change Model for managing transfers of care has been undertaken and actions for improving future performance agreed:

- Lincolnshire will implement the Somerset D2A model (3) as soon as practicable, and a detailed plan is being created.
- As part of the implementation of the Somerset model, there is an emphasis on increasing Pathway zero discharges to 85% of those patients no longer meeting the criteria to reside (to be discharged pre-midnight). To facilitate this, it was agreed that patients admitted from Care Homes and other supported settings should be able to return to their home setting without further re-assessments taking place.
- There was a recognition that the health and care system currently have insufficient Pathway 1 capacity and is over investing in beds. Partners agreed to work together to find creative solutions to resolve this gap. Current pathway 1 capacity is estimated at supporting 8 Discharges per day (4 community rehabilitation and 4 reablement) against a required discharge capacity for 21 discharges per day (16 for ULHT and 5 for other Acute Providers).

The Joint Commissioning Oversight Group (JCOG) is progressing discussions on the implementation of the Somerset Model for the system linked to oversight of the allocation and impact of the Discharge Fund. This will ensure alignment and oversight of this work programme to avoid duplication and support shared delivery ambitions.

3 – Timescales to implement to be added

Care Closer to Home: Discharge to Assess (Patient Flow & Discharge)

Implementation and key milestones:

Pathway 0

Impower external support is in place to ensure the full implementation and embedding of the national hospital discharge policy moving towards the Lincolnshire version of 'The Somerset model' and increasing home based assessment following a period of rehabilitation, reablement and recovery wherever possible.

Pathway 1 D2A Service

The Lincolnshire Pathway 1 offer has previously been provided solely by the Local Authority through a prime provider model using Lincolnshire Reablement Service (LRS) and Domiciliary Home Care, both commissioned from the external market.

Until December 2021 there was no health commissioned offer for Pathway 1 but this was introduced from 20th December via Lincolnshire Community Health Service (LCHS) NHS Trust. Initially a Therapy-to-Therapy discharge service but now includes full-service implementation at Pilgrim Hospital Boston (PHB) with expansion to Lincoln County Hospital (LCH). This has been achieved through redeployment of existing therapy teams while recruitment to scale-up the service continues at pace and with some success. The service has partially reduced the capacity gap taking up to 20 patients every 2 weeks currently with substantive recruitment ongoing *(4)*:

The key priority remains onboarding, training and competency sign-off for the new starters to ensure independence for the staff. This is likely to be an average 6-week period for new starts with no previous experience.

Integrated D2A Hub

To facilitate the rapid roll-out of the LCHS Pathway 1 D2A service, a preliminary referral 'hub', based at PHB was established, to support the referrals process across the county. This initial service continues to have good engagement from LCHS, ULHT, ASC and LRS colleagues to offer joined up working and clinical discussion regarding the most appropriate course of action for patients deemed Medically Optimised in the acute setting.

Development of the long-term '**Integrated Discharge to Assess Hub**' is in the planning phase with aims for completion c. September '22. Equipment has been purchased and recruitment is being initiated.

Other actions already progressing

Main principle is that we move to a personalised and strength based approach rather than a total focus on flow. Person centric approach which is driven by 'what matters to me' rather than 'what is the matter with me' and plays to my strengths as an independent person. IMPOWER have been recruited to perform in depth analysis into this within our acute sites and are devising a prioritised strategy to support.

- Interim Pathway 1 referral service and the development and use of a simplified 'Transfer of care' form which describes need, rather than prescribes care.
- Establishing a weekly dashboard utilising information from the discharge policy sit rep and a shared minimum data set collected across the pathways
- Better integration of existing operational therapy services to enable better transfer of information and smoother transition Across services & pathways
- MADE events scheduled for acute and Community Hospital sites every 2 months
- To develop a portfolio of metrics that can be used to establish our internal benchmarks for the implementation of D2A, and subsequently monitor performance
- To embed personalisation and strength based approaches into hospital discharge
- To develop a Directory of Services specific to Patient Flow and Discharge, utilised by partners system wide

4 - baseline figures/timescales to be added

Enabler input | People Plan

Harness new ways of working in delivering health & care

Key tasks

- Approach Health and Wellbeing as a system modelled and promoted by leaders to optimise capacity of Workforce to make sure the right staff with the right skills are in the right place at the right time
- Supporting the Strategic Delivery Plan in clinical redesign of Care Closer to Home
- A clear approach to harness the opportunities within the ICS to promote and expand the volunteer workforce.
- Making the most of the skills in the wider workforce such as bank workers
- Develop a plan for system wide programmes and initiatives such as NHS cadets or reservists in conjunction with the Talent Academy
- Support organisations to harness the effort of the wider workforce the 3rd sector, other volunteers and carers in developing the workforce in delivering new models of care
- Lead the system collaborative bank programme
- Optimise the capacity of the current workforce by ensuring the highest level of attainment set out by the 'meaningful use standards' for e job planning and e rostering

Key outcomes/metrics

- Volunteer/reservist capacity/activity
- Proportion of clinical staff deployed using e roster and utilising e job plan
- Collaborative bank strategy with all system partners engaged

Growing our workforce planning and modelling

Key tasks

- Create detailed system workforce plan to identify and prioritise current workforce gaps across all system organisations.
- Secure expertise and / or WF planning system to address the planning requirements for modelling future needs
- Identify an effective platform for workforce modelling
- Introduce predictive analytic reporting to inform workforce planning across the system partners (NHS providers in 22/23)
- Agree system metrics to track progress against workforce plans and review to inform priorities.
- Engage with system partners for future wider implementation of workforce planning
- Building capacity and capability to inform workforce planning and modelling across all system partners

Key outcomes/metrics (5)

- Robust workforce plans/projections – including alignment with activity and finance

5 – Proposed timescales and outcomes to be added.

Enabler input | Supporting unpaid carers

There are a range of BCF schemes in Lincolnshire which support unpaid carers. Some are directly providing short breaks and identified within the plan, however all services are working to identify unpaid carers and provide appropriate support.

- BCF funded primarily the Health Team (including Hospital in Reach at Boston, Lincoln and Grantham)
- In addition, support was provided to increase the management team by one, to support the monitoring, evaluation and approval of personal budgets under £1000
- An additional Benefits Advisor was employed in order to manage demand and reduce waiting times

Health Community Support Advisors (CSAs)

From January 2018 to the 31st of March 2022 , the Carer's First Health team in Lincolnshire supported over 3,227 carers. These carers have been identified from the following health settings/organisations:

- United Lincolnshire Hospital Trust (ULHT Acute & Community Hospitals)
- General Practice/Primary Care Networks
- Neighbourhood Teams
- Voluntary Health Services
- Lincolnshire Community Health Services
- Palliative and End of Life Services
- Mental Health Services

Carers First Health CSA's co-located within a range of Health settings in order to engage directly with informal carers.

During the pandemic lockdowns the team worked flexibly to support Hospital Discharge and remote and community based Carer Wellbeing Support to 940 Carers.

Benefits Advisors

Carers First has a well-developed Benefits Advice Service delivered by a team of three trained and experienced Welfare Benefits Advisers. They provide group/1-2-1 benefits workshops, benefits checks, form completions, appeals and income maximisation including applications for additional grants alongside website info/tools e.g. the Turn2us benefits calculator is embedded on Carers First website.

This dedicated team has helped Lincolnshire Carers gain an additional £5.8m in benefits since the start of the contract *(6)*. Additionally, membership of Carers Trust has enabled Carers First to secure £66,942 for Lincolnshire Carers over the last three years to pay for items such as washing machines, cookers, beds, food, carers breaks and transport costs and Carers First is a District Council selected referrer to the Household Support Fund.

Carers Personal Budgets (Additional Manager supported by BCF)

Carers First is highly experienced at assessing needs and has processed, monitored and evaluated £2.6m in Carers Personal Budgets to date in a timely manner.

6 – further timescales & targets to be added

Enabler input | Disabled Facilities Grant (DFG) and wider services

Approach and context
Lincolnshire recognises the importance of having a safe, secure and warm home on people's health and wellbeing. The focus on this in the JSNA has been enhanced with 2 chapters on 'Housing Standards and Unsuitable Homes' and 'Insecure Homes and Homelessness'.

Lincolnshire is a strategic partner with the national Centre for Ageing Better and has been involved in the Good Home Inquiry that it commissioned and published. Numerous workshops, focus groups and interviews have been held to better understand what residents want and need and to define and map 'housing' services *(7)*.

Several new posts shared across the System have been created: Strategic Lead – Healthy and Accessible Homes and housing intelligence officers. In addition, the district councils are funding a County Housing [Homelessness] Partnerships Co-ordinator.

In 2021 the Housing, Health and Care Delivery Group reviewed its membership, terms of reference and delivery plan. It also published Lincolnshire Homes for Independence – a blueprint for helping people with care and support needs to live independently in a home of their own. Objectives in the blueprint are arranged in to four categories:

1. Understanding needs and opportunities;
2. Housing for people with care and support needs;
3. Helping people remain in their current home;
4. Helping people find and move to a new, suitable home

The delivery plan contains actions to help achieve the above objectives. Numerous actions are of relevance to the Better Care Fund plan, including updating the market position statement on homes for working-age adults with care and support needs; and updating the extra care housing delivery programme, continuing to progress this programme.

DFG and wider services
There has been a common Lincolnshire Discretionary Housing Assistance Policy developed with the intention that all district councils will adopt this under the Regulatory Reform Order. This supplements mandatory DFG making provision to top-up the maximum of £30,000 and for a range of aids, adaptations, and improvements to ensure people stay safe, warm and well. This can help to move to a suitable home (relocate) and help reduce delayed transfers of care (DTOC).

District councils can also retain additional discretionary policies under the RRO, such as to waive the means test for mandatory DFG for works costing below a certain level; which some do.

In 2022/23 the system is procuring a new integrated community equipment service. This will be a combined opportunity with the wheelchair service, which will join the service in 2024. An agreement has been made with the District Councils to include the provision of equipment type adaptations, traditionally provided via a DFG or the HRA. In the first instance this will be limited to stairlifts and modular ramps, with a view to increase the scope in the future. This approach will commence 1 April 2023 with districts who do not already have a stand alone stairlift contract, and the remainder of the county joining the agreement at expiration of existing contracts.

In 2022/23 the DFG funding has been passed in its entirety to the District Councils. This is in-line with the approach taken in previous years.

In 2022/23 there is a programme to integrate community occupational therapy across the system. This will increase the number of practitioners who are able to make recommendations via a DFG i.e. community NHS occupational therapy teams will no longer need to make an inter professional referrals for social services to progress the adaptation recommendations.

7 – Proposed timescales and outcomes to be added.

Enabler input | Personalisation

It's all about people :: Lincolnshire STP (itsallaboutpeople.info) - **A place for our Lincolnshire health and wellbeing workforce to reflect, learn and share how together we support people to live their best life.**

Culture and Behaviour

- Embedding a workforce culture of feeling comfortable and confident having strength-based person-centred conversations with people and understanding the tools and techniques that can be used to tailor responses and decisions to meet people's goals and agreed outcomes.
- Preparing people to have confidence to ask questions about their treatment, their health and wellbeing.

Key Milestones

Q1/2

- Recruitment to a jointly funded workforce development lead – hosted by the LA.
- Roll out of motivational interviewing to specific cohorts of staff
- Rolling out strength-based person-centred approaches with trial teams at Lincoln County, Pilgrim hospital and a community hospital to support the hospital discharge experience for people.
- Developing and launching a 'just ask' campaign to support the MSK programme.
- Phase 1 and 2 of the Better Lives Lincolnshire Shared Agreement engagement campaign
- The inaugural 'it's all about people' conference will be held

Q3/4

- Development of a curriculum for personalisation that is coproduced with partners and people with lived experience
- Business case for the delivery of the personalisation curriculum
- Further roll out of strength-based person-centred approaches across hospital sites
- Phase 3 and 4 of the Better Lives Lincolnshire Shared Agreement engagement campaign
- Rolling programme of virtual events building on the 'It's all about people' conference
- Lincoln Uni evaluation programme of Coaching for Health and Wellbeing to start

Activity

- 132 clinical staff to be trained in personalisation (66 in ULHT, 66 LCHS, LPFT) NHSE MOU Target
- 400 clinical and non-clinical staff to be trained in personalisation – Local Target
- 10 personal stories per quarter from staff will be captured and shared on the 'Its all about people' website *(8)*

Social Prescribing and community-based development

Key milestones

Q1/2

- The launch of the Lincolnshire Social Prescribing Partnership – to include localised commissioning arrangements, agreed outcome / performance framework and a community of practice model.
- Working with the Lincolnshire Social Prescribing Partnership to develop a shared local plan for social prescribing using PHM data and partnership working with commissioners, LAs and VCSE organisations.
- To continue to work with PCN's to actively recruit, retain, support, and develop Social Prescribing Link workers.
- To interface Social RX, the CRM system for Social Prescribing, onto primary care systems enabling online referrals and business intelligence reporting at practice level.
- NHS Charities together – social prescribing initiative to launch services for people with long covid.
- To embed social prescribing into the MSK service redesign work

Q3/4

- Implementation of the shared local plan with an agreed cohort of people from each PCN.
- Lincolnshire social prescribing partnership to agree the commissioning arrangements for social prescribing.
- Social Prescribing to be an active offer built into the MSK pathway
- To explore the opportunity of developing the social prescribing link workers / community connectors in Urgent Care services.

8 – Proposed timescales and outcomes to be added.

Enabler input | Health inequalities and prevention

Programme Overview

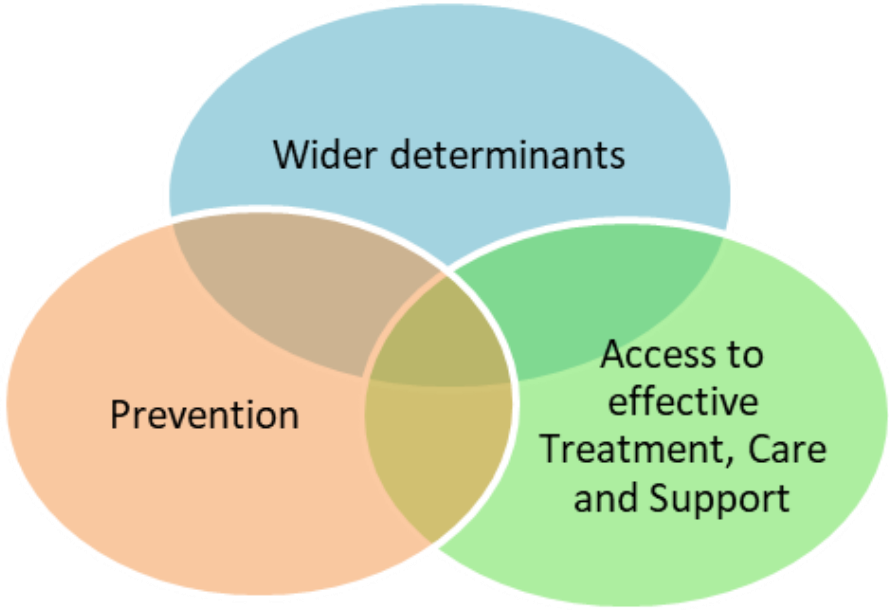
The vision of the Health Inequalities programme *(9)* is: to increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county.

Our Health Inequalities Framework for Action, developed in partnership with stakeholders, sets out the principles which underpin this work and how we will use our resources to take practical action to reduce health inequalities and provide exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes.

We will tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire in order to achieve our ambition - a year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire

We will achieve this through action to address:

- Wider determinants: Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and best start initiatives.
- Prevention: Actions to reduce the causes, such as improving healthy lifestyles – for example stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity.
- Access to effective Treatment, Care and Support: Actions to improve the provision of and access to healthcare and the types of interventions planned for all



9 – Proposed timescales and outcomes to be added.

Enabler input | Health inequalities and prevention

Workstreams include :

– Embedding a system approach to health inequalities: Implementing HI tools such as the Health Equity Assessment Template (HEAT) and embedding within governance arrangements; providing a regular programme of HI Training & Development; HI Community of Practice and regular HI conferences; HI Champions within NHS Trusts and PCNs; Development of differential/allocative resourcing to address HI;

• Prevention: Tobacco Dependency Services (Acute inpatients, MH & LD services, smoke-free pregnancy pathway); Weight management; Tuberculosis; addressing the barriers to diabetes prevention in Mablethorpe (HEPP Project); CVD and Respiratory

• Intelligence, data and analytics: support programmes with access to HI data; develop system HI metrics, KPIs & dashboards; improve data collection such as ethnicity data; needs of inclusion health groups and intersectionality; HI metrics within internal and public performance reports;

– Development of HI Strategy: agreeing key HI priorities and plan for ICS; Channel Strategy/Approach to ensure equitable access and mitigate against digital exclusion; Development of differential/allocative resourcing to address HI.

Support to Programmes and Change Initiatives:

- Support Change Initiatives with undertaking HEAT reviews, identifying and optimising opportunities to reduce the Health Inequalities gap and mitigating against any potential adverse impacts
- Work with programmes to review access arrangements, ensuring people on the margins are able to access services and that any digital arrangements are inclusive and do not exacerbate Health Inequalities

– Work with programmes to support 5 national HI clinical priority areas within Core20plus5: Continuity of Carer (Maternity); SMI Health Checks; Chronic Respiratory Disease – COPD ; uptake of vaccines (Covid, Flu, Pneumonia); Hypertension case finding

– Use of HI data to support inclusive approach e.g. Elective Care waiting lists

Supporting delivery of the Strategic Delivery Plan

• Support Change Initiatives with undertaking HEAT reviews, identifying and optimising opportunities to reduce the Health Inequalities gap and mitigating against any potential adverse impacts – CVD is already one of our HEAT pilots

• Prioritise HI data analytics capacity to support

Key delivery milestones

NHS Tobacco Dependency Services:

Workstrand	Service Start	Service Fully Established
Smoke-free Pregnancy Pathway	Jul 2022	Mar-24
Adult Mental Health	Sep 2022	Mar-24
Physical Acute	Q3 – 2022/23	Mar-24
Community	Q4 – 2022/23	Mar-24

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