NHS Lincolnshire Joint Forward Plan 2023 - 2028

Delivery Plans

v18/07/24

Contents

ⓘ For further information on the content of this document, individual project delivery plans and associated modelling, please contact Feargus Mack - f.mack@nhs.net

Executive summary

- NHS Lincolnshire Joint Forward Plan 2023-28 and where it fits within our strategic vision for health and care
- JFP Delivery Plan 2023-28 | Headline ambitions
- Summaries of the system transformation programme plans
- Delivering on the Joint Forward Plan priorities

NHS Lincolnshire Joint Forward Plan 2023-28

The national requirement

- The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and their partner trusts to prepare their Joint Forward Plan (JFP) before the start of each financial year.
- Systems have significant flexibility to determine their scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements

The Lincolnshire approach

Rather than cover all the national requirements in as single document, the Lincolnshire NHS agreed to develop separate documents, which are tailored to the target audiences:

- **NHS Lincolnshire Joint Forward Plan 2023 – 2028** [published June 2023]
  - a relatively concise public-facing document, which is easy to read and understand
  - articulating our new strategy for the NHS in Lincolnshire, co-produced with people and communities

This is underpinned by a number of more technical documents which are primarily targeting health and care staff but will still be publicly available:

- **Allocation of Duties and Responsibilities** [first published June 2023]
  - outlining how the legal duties and responsibilities of the ICB and NHS partner Trusts in Lincolnshire are exercised. This will be updated annually.

- **JFP Delivery Plan [this document]**
  - collating the delivery plans for the system service transformation and enabler programmes; the development of these will also be informed by further engagement with people and communities
  - Providing further details on how the five JFP priorities will be delivered

- **Activity, Workforce and Finance Plans** [currently in development]
  - Rolling, five-year projections (detail for Years 1 & 2; estimates for Years 3-5) that reflect the programme delivery plans as far as possible

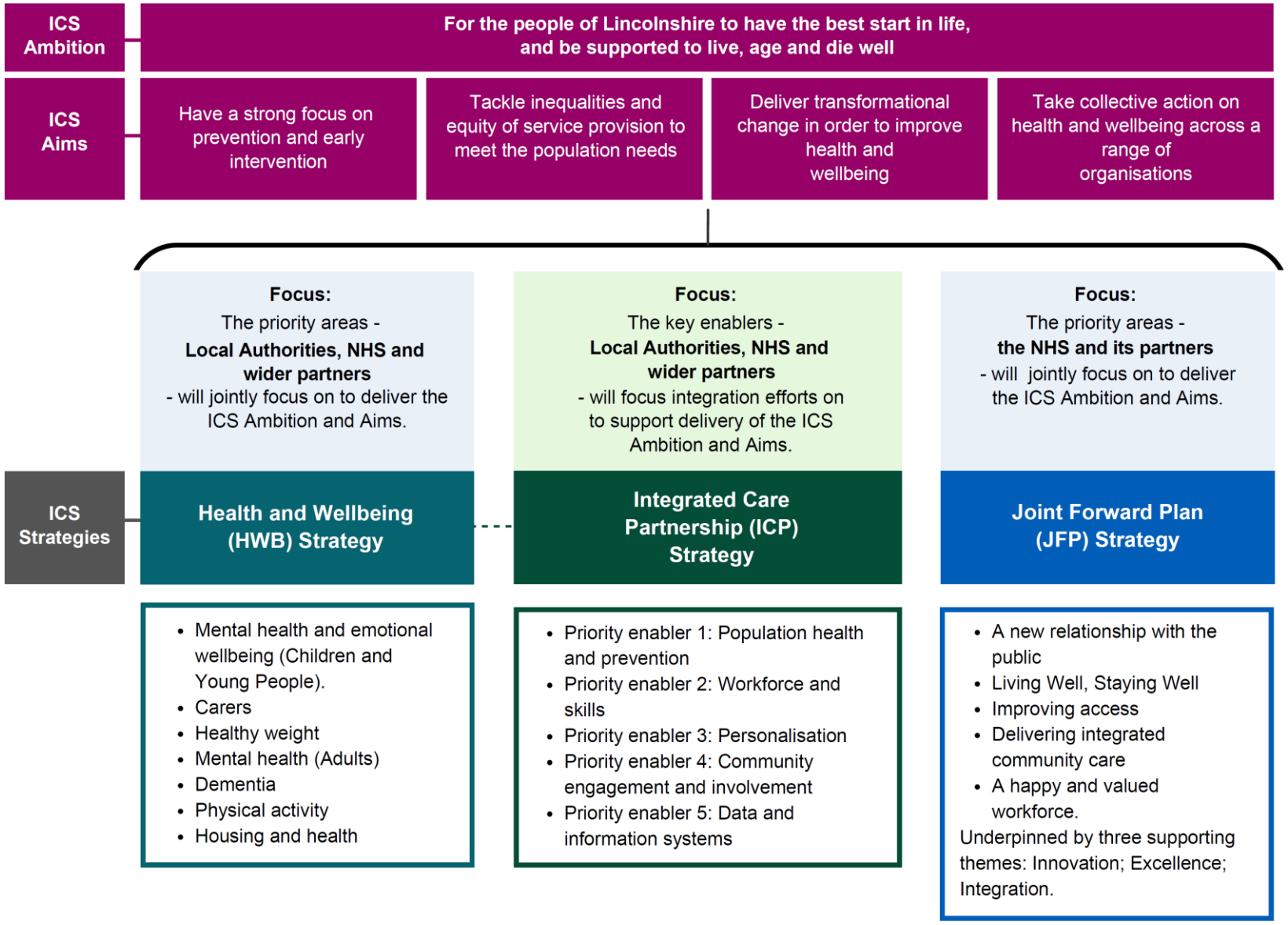
Key drivers

The key drivers informing the development of this plan have been

- Population insight: understanding the needs, causes, outcomes and disparities of our populations through analysis of population and public health data, along with patient and citizen feedback
- Current status of local services: service sustainability, efficacy and efficiency, including analysis of performance and benchmarking data
- System strategy: Health & Wellbeing Strategy, Integrated Care Strategy and the NHS Lincolnshire strategy
- National priorities, objectives & targets e.g. urgent and emergency care, primary care access, and elective and cancer care recovery plans

These programme delivery plans will continue to be evolved in response to national policy (e.g. Major Conditions Strategy) and local developments (e.g. development of Community Primary Partnerships).

Where the JFP fits within our strategic vision for health and care



Five themes across the three strategies

- **Personalisation and a new relationship with the public**
- **Population health and Prevention**
- **Integrated Community Care for major conditions**
- **A happy, valued and supported workforce**
- **Data and digital technology**

Our five cross-cutting strategic themes

Personalisation and a new relationship with the public

At the heart of the Better Lives Lincolnshire strategy is the recognition that we need to establish a new relationship with the public.

Together with the people of Lincolnshire, we want to build a shared view and agreement on what the best wellbeing, care and health for Lincolnshire looks like.

This strategic theme has five key elements:

- Creating a shared agreement.
- Supporting shared decision making
- Developing and designing services together
- Working with people and their families to manage their own health and wellbeing
- Supporting people to feel connected and engaged in their local communities

Population health and Prevention

Population health and prevention is the 'golden thread' that runs through our strategies and underpins its focus on improving health and wellbeing and tackling inequity.

Addressing the wider determinants of health will help improve overall health by helping to improve the conditions into which people are born, live and work. Addressing these determinants throughout the life course allows us to consider the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

People have different needs at different points in their lives and we have specific ambitions relating to each life stage: Preconception, infancy and early years (0-5); Childhood and adolescence (5-19); Working age (16-64); Ageing well

Integrating community care for major conditions

Integrating primary care: delivering timely access to primary care – general practice, pharmacy, dental, optometry – today, while designing a sustainable future.

Integrating Specialist Care: delivering improved health outcomes, reduced health inequalities and reduced disease progression, enabling people to live well and die well. Implementing new models of care, via a one team approach, transcending organisational boundaries; adopting a more proactive and holistic approach informed by individual wishes and need; Focussing on prevention, early identification and diagnosis; Delivering both timely, urgent care & long-term ongoing care

Integrating community partnerships, developed around PCN footprints; supporting their ongoing evolution to provide person-centred care, delivered by multi-disciplinary & multi -agency teams, for local communities, reflecting population need

A happy, valued and supported workforce

We truly appreciate our people and everything they do. We also appreciate the link between an engaged, happy workforce who feel valued and the quality and efficiency of the care they are able to deliver.

Having the right workforce in the right place at the right time allows our services to meet the healthcare needs of people locally.

To continue to do this we need a constant flow of talented people from our communities into the organisations. We also need to provide good opportunities for training and development to encourage them to stay in Lincolnshire rather than move elsewhere.

To develop our workforce in Lincolnshire we will:

- Value our people
- Grow our people
- Develop our people
- Retain our people.

Maximising data and digital technology

As health and social care services face unprecedented challenges, data, digital technology will be at the heart of how we transform health services for the benefit of citizens, patients and staff.

There is significant potential for the transformation of health and social care through better widespread use of digital technologies. This includes a growing role for technology in supporting people to monitor and manage their own health and wellbeing and also enhancing people's experience of accessing services.

New and more integrated ways of providing care will require local health and care professionals to act and behave in different ways. This will include closer working with local people, carers and their families so they are more empowered to set their own care goals and manage their own wellbeing, being part of a multi-disciplinary team and delivering more responsive and proactive care.

JFP Delivery Plan 2023-28 | Headline ambitions

All Age

- By April 24 over 40,000 people will have had a *what matters to me* conversation
- By April 25, co-production is embedded in service redesign in 5 programmes
- By April 25, more of the workforce are aware of the personalisation agenda
- By April 2024 6080 people will have accessed a new group/service after social prescribing
- 85% of patients, who need a primary care appointment, to receive one within 2 weeks by 2025
- Reduce the prevalence of smoking across all social groups to meet the national smokefree 2030 ambition
- Healthy life expectancy a five year rise by 2035, with a narrower gap between local areas where hit is highest and lowest

Start Well

- Decrease smoking at time of delivery from 14.8% to 9.0% by 2028
- Increase breast milk at first feed from 65.5% in 2022/23 to 70% by 2028
- Childhood vaccinations above 95%, with equitable uptake by all areas & groups
- 95% of accepted CYP MH referrals assessed ≤ 4 weeks; no CYP waiting >12 weeks for treatment by March 2025
- 90% of children with Type 1 diabetes receive all 6 of the care process for diabetes
- 10% reduction in ED attendances due to asthma in 2024/25
- 10% reduction in unplanned admissions due to epilepsy in 2024/25

Live Well

- Increase % of adults on obesity register accessing healthy lifestyle offer from 5% to 10% by 2028
- 80% of the expected number of people with hypertension are diagnosed by 2029
- 500 patients over 24/25 and 25/26 achieve remission from Type 2 Diabetes
- 65% of patients 25-85 with a CVD risk score >20% on lipid lowering therapies by 2026
- Reduction in smoking among people with a severe mental illness from 40% to 35%
- 5% more COPD patients accessing pulmonary rehabilitation by 2025
- Increase diagnosis at stage 1 & 2 for lung & colorectal cancer to 75% by 2028

Age Well

- Covid, flu & pneumonia vaccs increased among people with respiratory condition by 10% by 2028 in areas of greatest deprivation & ethnic groups
- Antibiotics in primary care: Broad-spectrum antimicrobials <10%; 75%+ of amoxicillin prescriptions are 5-day courses
- Increase the dementia diagnosis rate in people 65+ to 66.7% by 2025
- Frailty: reduce progression from mild-moderate and moderate-severe by 5% by 2028
- 70% of high-risk fallers have a proactive care plan in place by 2025
- 70% of people in the last year of life have a care plan by 2025, 80% by 2026
- 10% less people in their last year of life have an unplanned admission by 2026

Personalisation

KEY AREAS OF WORK

Culture and behaviour change

- Our Shared Agreement; Co-Production; Working with partners and people with lived experience to bring to life what a new personalised & proactive relationship between people and the health & care system could be

Workforce and People

- Focussing on people's strengths and assets, and 'what matters' to them, enabling shared decision making that encourages people to have more choice and control and to live their best and healthiest life.

Training Teams

- Training in new tools and techniques, coaching and motivational interviewing, strength-based approaches and analysing impact.

Toolkit/Resource Development:

- Ease and simplify ways of embedding strength based and personalised approaches into new pathways and service redesign.

Social Prescribing:

- Growing Lincolnshire's social prescribing model

Social Movement:

- Developing a network of champions, advocates & voices of personalised care

Areas of focus

- Working with stakeholders to understand the programme interdependencies around service redesign work and agreeing the implementation and delivery timescales. The areas of focus are: Frailty; Serious Mental Illness – Physical Health Checks; Musculo Skeletal pathways – Hip and knee (embedding personalised approaches); High Intensity Users of secondary care; Discharge Hubs and Intermediate Care; Reduction in people on MSK waiting lists

TARGET OUTCOMES

Experts by experience are an integral part of the health and care system:

- By April 25, co-production is embedded in service redesign in 5 programmes

There is increased awareness and understanding of Our Shared Agreement and Personalisation among both citizens and staff

- By April 24 over 3000 health & care staff will have completed a foundation in personalised strength-based approaches
- By April 25, all operational staff involved in service redesign will have completed the SDM & PCSP via the train the trainer programme; there is an increase in attendance & awareness of personalisation huddles and the person-centred learning network; champions of personalisation are present in all stakeholders

People feel valued whether that is as a carer, person accessing services or family member, and is considered an expert in themselves/their own care

- By April 24, 40,000+ people will have had a *what matters to me* conversation

People understand their own wellbeing needs and how to support themselves:

- By April 2024, 75% of people who complete a PAM and have their treatment/support tailored will see an improvement in their knowledge, skills and confidence to manage their own health and wellbeing;
- By March 2024 there is a reduction of people on waiting lists and outpatient follow ups following attendance at the Aches and Pains hub in Grantham
- By April 2028, people report that they are able to access the support that matters to them at the right time, including community-based support, peer support, self-help resources, advocacy or other specialist support

People feel more actively involved and in control of their health and wellbeing

People recognise & understand the value of connecting into their local communities

- By April 24: over 16,000 people will have been referred to social prescribing since 2019; 6080 people will have accessed a new group/service after social prescribing;

People feel able to take responsibility for their own care/health, and are able to self-serve/self-assess where appropriate

- By April 2028 ?% increase in the number of people using technology enabled care to stay independent and/or improve quality of life

Personalisation and a new relationship with the public | Population health and Prevention | **Integrated Community Care for major conditions** | **A happy, valued and supported workforce** | Data and digital technology

Health Inequalities & Prevention

KEY AREAS OF WORK

Embedding a system approach to health inequalities (HI)

- Implementing HI tools and embedding HI approaches within governance; providing a programme of HI Training & Development; developing HI leads/champions within NHS Trusts and PCNs; embedding within financial & contract arrangements

HI performance and intelligence

- Developing intelligence and insights to support understanding of health inequalities and prevention priorities; developing system HI metrics, KPIs & dashboards; improving data collection; utilise PHM approaches to address HI and work with system BI colleagues to develop HI elements of the joined data set reporting suite

HI in clinical areas and cross cutting themes

- Work with programmes to deliver against 5 national HI priorities and 5 clinical priority areas within Core20plus5 for Adults and Children & Young People. Ensuring people on the margins are able to access services and that any digital arrangements are inclusive and do not exacerbate Health Inequalities

Communication and engagement

- Collecting and using insights from Core20plus groups to reduce the gap in access, experience & outcomes; Co-production and engagement is a golden thread

Prevention

- Improving the population's health and preventing illness & disease; catching the causes of ill health as early as possible to prevent or reduce the chances of them leading to more serious conditions; supporting people to live well and stay well

Digital Inclusion

- Addressing digital exclusion and ensuring alternatives are available for those within our population who need them; adopting and implementing national guidance on digital inclusion through development of a system Digital Inclusion Strategy

Inclusion Health

- Improving access, experience, and outcomes for people in inclusion health groups by understanding their needs and delivering integrated and accessible services

TARGET OUTCOMES

Increased equity of access, experience and outcomes

- for people from: 20% most deprived areas; Black, Asian and ethnic minority backgrounds; health inclusion groups; other Lincolnshire population segments experiencing worse access, experience and outcomes - measured through service/clinical data on service access, experience and outcomes
- e.g. Reduction in waiting times of people living in 20% most deprived to align with overall population rates in specialities where there is a variance; Increase in uptake of faecal immunochemical tests by 3% for 4 selected G.P Practices

Prevention of ill health:

- Equitable vaccination take up for children and young people in areas of greatest deprivation and ethnic groups
- Reduce the prevalence of smoking across all social groups to meet the national smokefree 2030 ambition
- Reduction in smoking among people with a severe mental illness from 40% to 35%
- Increase achievement of all 6 Health checks for people with SMI in areas of greatest deprivation from 47% to 60%; increase access by ethnic groups by 2028
- Increase achievement of reliable improvement for Talking Therapies in areas of greatest deprivation from 63% to 70% (to the level experienced in the least deprived) and increase access to NHS Talking Therapies for ethnic groups by 2028
- Increase of patients aged 40-59 years whose last BP reading is age-appropriate treatment threshold from 58% to 63%
- Increase the patients with hypertension treated according to NICE guidance from the most deprived population currently 65.2% to the least deprived 71.6%
- Reducing the difference in the premature death rate (under-75) between the 20% most deprived to the 20% least deprived (from cardiovascular disease mortality).
- Increase % of adults on obesity register accessing healthy lifestyle offer(s) from 11% to 13% ; 5% increase in uptake to the Digital Weight Management offer and Diabetes Prevention Programme in areas of greatest deprivation and targeted groups. Reduction in the gap in people with Type 1 and Type 2 diabetes receiving all 8 care processes in areas of greatest deprivation and targeted population groups by 2028

Reduction in the gap for healthy life and life expectancy and disability:

- A five-year rise in healthy life expectancy by 2035, with a narrower gap between local areas where it is highest and lowest.

Personalisation and a new relationship with the public | **Population health and Prevention** | Integrated Community Care for major conditions | A happy, valued and supported workforce | Data and digital technology

Primary Care, Communities & Social Value

KEY AREAS OF WORK

Integrating primary care

Integrating primary care and delivering access

- Maintain and develop BAU elements of primary care commissioning: general practice, dental, pharmacy and optometry
- Foster and develop Leadership across and communication between the LMC, LPC, LDC and LOC
- Improve access to community pharmacy services in line with Pharmacy First
- Empower patients to manage their own health by providing them with technology and information
- Improve access to urgent same day primary appointments and planned appointments in line with national guidance and Lincolnshire ambitions.
- Improve productivity and reduce time wasting activities across primary care
- Improve collection, accuracy and utilisation of primary care data

Developing Partnerships to Support Primary Care Integration

- Design and implement new sustainable model/s of integrated primary care
- Deliver the Primary Care People Plan
- Develop a Lincolnshire framework for enhanced services
- Enhance our primary care estate and develop our digital capabilities
- Transform the conversation between primary care and the public by through a comprehensive programme of comms, engagement and co-production

Vaccinations

- Develop & implement a Lincolnshire-wide Vaccine Strategy to deliver the ambitions detailed within of the newly published National Strategy
- Enable the ICB to assume delegated commissioning responsibility
- Support providers to develop an integrated staffing model

TARGET OUTCOMES

Integrating primary care

Access

- Deliver 5,371,967 appointments in General Practice
- 85% of patients, with an identified clinical need for an appointment, to receive one within 2 weeks of their contacting their practice by March 2025
- All patients will be able to communicate with someone within their practice, either virtually or via telephone, on the day they contact them and know how their enquiry has been dealt with by March 2025
- 100% of practices have enabled online patient appointment booking and cancelling, repeat prescriptions and access to care records by March 2025
- 100% of GP practices using CBT or system with the same functionality by October 2024
- 100% of practices using high quality online consultation tools by April 2025
- Deliver 1,070,025 units of dental activity over 2024/25

Transformation Integrating primary care

- Facilitate a big conversation between General Practice and its key stakeholders, including the public to gain a shared understanding of the future of General Practice to support development of the GP strategy
- Integrated Primary Care Strategy completed by June 2025
- Implement national General Practice pilot programme by 2026

Vaccinations

- Resilience: requisite central workforce in place March 2024
- Access: new delivery model in place & co-administration of vaccines the default model by April 2025.
- Uptake: Agree system-wide uptake targets for all vaccination programmes by March 2024; Meet all vaccination uptake targets by March 2027; Identify variation in uptake between PCNs and develop and implement mechanisms to close the uptake gap, focusing on continuous improvement and learning by March 2027

Personalisation and a new relationship with the public

Population health and Prevention

Integrated Community Care for major conditions

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Primary Care, Communities & Social Value

KEY AREAS OF WORK

Integrating community partnerships

PCN Development

- Develop different ways of working at PCN level to enable demand to be managed and/or capacity to be released and support improved access
- Fully implement the PCN DES with a view to supporting improvements to population health via proactive identification, care coordination and case load management of patients with longer-term health and social care needs,
- Further enhance leadership capability and capacity across the PCNs
- Continue to implement ARRS roles
- Develop and implement integrated pathways of care across primary and community care for therapy and nursing services to meet the specific needs of PCN populations
- Implement delivery plans for High Intensity Users and Social prescribing
- Build, implement and evaluate a Lincolnshire wide Quality Framework

Integrating Care

- Implement case management and care co-ordination model to support delivery of PCN integrated primary and community teams
- Further develop the role of integrated neighbourhood teams, in line with the Fuller recommendations, with a view to enhancing the delivery of multi-disciplinary, multi-agency personalised care and improved patient outcomes and experience for the most complex patients
- Deliver Integrated community teams (community nursing & community therapy)
- Develop and implement the Integrated Communities Strategy
- Codesign and implement a framework for working in partnership with the voluntary sector

Integrating community partnerships

Additional Roles Reimbursement Schemes (ARRS)

- Lincolnshire will have 392.50 WTE ARRS roles in place (this is Lincolnshire share of the 26,000 WTE manifesto commitment) by March 2024. At Month 8 Lincolnshire has 496.64 WTE, well above the end of year target.

High intensity Users

- 3 PCNs will be offering a High Intensity User Service by March 2025
- By August 2024, we will have reviewed other HIU provision to ensure it is in line with the national HIU framework

Social Prescribing

- A refreshed Social Prescribing model to be developed and commissioned from 1st April 2025

Primary Care Networks

- All PCN will have in place agreed objectives, aligned to system objectives by December 2024
- All PCN managers will have undergone a Leadership Programme delivered through an independent specialising in PCN Manager development by March 2024

Partnerships

- Strategic partnership model between ULHT/Primary Care/ICB agreed by March 2025
- Strategic partnership model with VCSE (LVET) agreed by March 2025
- Model of MDT working in place in every PCN by March 2027
- Integrated delivery models in place for community therapy and nursing in every PCN by March 2027
- Implement quality framework across all PCNs by March 2027

Personalisation and a new relationship with the public | **Population health and Prevention** | **Integrated Community Care for major conditions** | **A happy, valued and supported workforce** | **Data and digital technology**

Primary Care, Communities & Social Value

KEY AREAS OF WORK

Ageing Well and Long Term Conditions

Ageing well – Older age

- Implement the Lincolnshire Frailty Strategy and associated delivery plans
- Fully delivery the local Lincolnshire and national aspirations for the Enhanced Health in Care Homes (EHCH) programme
- Fully implement the Lincolnshire-wide Palliative and End of Life integrated care model supported by a strategic commissioning framework.
- Deliver proactive/primary care elements of the Lincolnshire Dementia strategy including the recovery of the dementia diagnosis rates. This work is led by LPFT.
- Implement the Lincolnshire Falls pathway: people with the potential of falling are proactively identified and ~~are proactive~~ managed by timely and effective multi-disciplinary interventions including an effective falls response.

Long Term Conditions – Working age

- Develop, embed and evaluate a Lincolnshire-wide Long-Term Condition Strategic Framework with a view to supporting: Prevention and management of risk factors; Early and accurate complete diagnosis; Proactive care; Clinical Pathway Review; Integrated pathways of care;
- Deliver Transformation, Targeted and Transactional programmes of change in line with national "must do's" & guidance, best practice and local clinical priorities
  - Major conditions identified in the NHS LTP – Cardiovascular disease (CVD) including Stroke, Diabetes and Respiratory
  - Other long-term conditions where opportunities are identified

TARGET OUTCOMES

Ageing Well and Long Term Conditions

Frailty

- Reduce progression by 5% by 2028
- Reduce the growth in numbers of beds by 70 beds by 2028

Enhanced health in care homes

- Reduce unplanned admissions of people living in a care home by 5% by 2026
- 90% of people living in a care home to have a PSCP in place by 2026

Palliative & end of life care

- 70% of people in the last year of life to have a care plan by December 2025, 80% by December 2026
- 65% of patients identified as being for palliative or end of life have a ReSPECT conversation recorded at least 6 months before the end of their life by March 2026
- 10% less people in their last year of life have an unplanned admission by 2026

Falls

- 70% of high-risk fallers will have received a holistic falls assessment by Dec 2026
- 10% more patients stay at home post fall response by 2025

CVD

- 85% of the expected number of people with AF are diagnosed by 2029
- 80% of expected number of people with hypertension are diagnosed by March 2025
- 80% of t people diagnosed with hypertension are treated to target as per NICE guidelines by March 2025

Diabetes

- NDPP – No. of patients referred to service and No. of patient who achieve at least the first milestone on the programme (contract ends Nov 25):
- Remission - 250 patients per year/ 500 24/25 and 25/26

Respiratory

- Increase the number of patients with a diagnosis of COPD accessing pulmonary rehabilitation by 5% by December 2025
- % COPD patients where diagnosis confirmed by spirometry (% and delivery date TBC)

Community Waiting Lists

- Community services waiting times: reducing over 52 week waits by 80% by March 2025

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Urgent & Emergency Care

KEY AREAS OF WORK

10 High Impact Interventions:

- Same Day Emergency Care (SDEC); acute frailty service provision; Inpatient flow & length of stay; Community bed productivity & flow; Care Transfer Hubs; Intermediate care demand & capacity; Standardising and improving care across all virtual ward services; Increasing usage of Urgent Community Response services; Single point of access - facilitating whole system management; Acute Respiratory Infection Hubs

Ensuring achievement of key performance standards:

- Programme of work with executive oversight to deliver the 4-hour standard & improve the 12 hour wait in ED position; Focus on reducing conveyance & increased support to patients in community (review of community pathways of care to ensure integration of services that support people in their own homes & increasing availability of alternatives to ED). Improving the efficacy of Virtual Wards - ensuring that the requisite specialist community provision and digital infrastructure is in place. Maximising the use of SDEC

Mental health: Working with the Adult & CYP Mental Health programmes

- e.g. MH UEC pathways review; 111 option 2; Boston liaison; MHUAC all-age

Frailty: Working with the PCCSV programme on supporting the frail cohort, nursing and care homes and end of life care

- UEC-focussed frailty initiatives include Frailty SDECs & Frailty Assessment Units (increasing capacity & geographical coverage in line with population need) and Falls Response

Lincolnshire system approach to Intermediate care:

- **E**xploring joint commissioning opportunities & making best use of available resources (including BCF discharge funding). Moving towards a system-wide and outcome-based model which prevents unnecessary acute hospital admission, supports timely discharge and maximises independent living through reablement & rehabilitation.

2026-28

- Continued delivery of national performance standards relating to UEC; increasing care closer to home, reducing the requirement for patients to attend EDs to access acute & community services; Evolution of simplified access for both patients & professionals; Increased integration of services across pathways of care; Move towards commissioning of pathways of care rather than individual services

TARGET OUTCOMES

Improved patient experience

- Reduction in complaints from patients and professionals, reduction in long waits in EDs and in community for ambulance attendance. Reduction in the number of patients accessing acute services via Eds

Improved patient outcomes

- Increase in the number of patients returning to their own home, reduction in long term care requirements, reduction in incidents reported within the UEC pathways

Reduction in waiting times

- In both UTCs and EDs with delivery of the 4-hour performance target and the wider time to first assessment and triage metrics

Reduction in readmissions

- Fewer patients requiring re-admission following discharge from hospital

Supporting care closer to home

- **I**ncrease in the number of patients supported at home avoiding attendance at ED or hospital admission

Reduction in acute length of stay and acute bed occupancy

- Ambitions to be developed as part of the planning round

Workforce and financial impact

- Reduction in agency/bank and locum spend

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Planned Care

KEY AREAS OF WORK

Waiting List Reduction:

- *Eliminate 65 week waits by March 2024 and 52 week waits by March 2025*; Mutual aid will continue to be delivered predominantly from independent sector providers for challenged specialties, particularly for Gastroenterology and Dermatology; A new ENT weekend working proposal is to be implemented at ULHT - this will be evaluated and rolled-out to other specialties.
- *Increase patient choice*: Implement a system level plan for patient choice which ensures compliance with the regulatory requirements and raises the profile of patient choice. Promote the Patient Initiated Digital Mutual Aid System which allows us to offer patients the ability to more easily and proactively 'opt-in' to move provider when they have been waiting over 40 weeks for care and meet the criteria. This will be extended to all patients waiting over 18 weeks by Sept 2024. Promote the use of the Elective Activity Coordination Hub (EACH) which offers choice to all planned care patients both at point of referral and via PIDMAS.
- *Increase Activity*. ULHT will develop an overall clinical service strategy and establish a rolling programme of specialty clinical service strategies; Expand implementation of Getting It Right First Time (GIRFT) programme to other specialties; Expand the range of services and procedures to be delivered in the community and moved away from secondary care; Work with independent sector providers to deliver additional capacity where there are challenged specialties at our NHS providers; Expand the programme of out-patient transformation and theatre utilisation to maximise capacity and efficiencies to reduce waiting times; Maximise capacity at the recently accredited Grantham Surgical Hub using HVLC principles as well as the planned increase to 2.5 session days.
- *Demand Management*: .Review to determine the future priorities of the EACH for 2024-28 to maximise on opportunities to re-direct to more appropriate services; promoting self-care and increasing activity within community services

TARGET OUTCOMES

Waiting List Reduction:

- Eliminate 65 week waits by March 2024 and 52 week waits by March 2025;
- All patients in the 65-week 'cohort' will be given a first outpatient appointment before 31/10/23 in most specialties to ensure their treatment pathway is completed by March 2024. Those more challenged specialties will be working towards a deadline of 31/12/24 to ensure all patients have had their first outpatient appointment
- Decreased waiting list – measured weekly via WLMDS submission.
- Decreased waiting times in line with, or better than, national trajectory - measured monthly via the national My Planned Care platform and the national electronic Referral Service.
- Reduction in harm caused by long-waits (measured through evaluation of harm reviews by Quality team)
- Increase in choice of Provider where appropriate – measured though the EACH and e-Referral Service (e-RS) reports.
- Care closer to home where community services can be increased.
- Increasing the utilisation of the EACH gives patients a single point of access for all appointment queries – measured through EACH Practice utilisation reports and Practice visits.
- Impact on system partners is being worked through as part of the current planning round and will be discussed when the annual planning guidance is released

Personalisation and a new relationship with the public | Population health and Prevention | Integrated Community Care for major conditions | A happy, valued and supported workforce | Data and digital technology | Recovery/Access

Planned Care

KEY AREAS OF WORK

Outpatients:

- *Virtual Consultations:* Monitoring on a specialty level to ensure those specialties who are not meeting the target increase their virtual consultation usage
- *Patient Initiated Follow Ups (PIFU)*: maximising utilisation where PIFU is already live; explore where it can be rolled out to the smaller specialties; explore opportunities to utilise available system funding for Remote Patient Monitoring
- *Specialist Advice:* Reviewing response times by specialty for A&G through e-RS for all providers – address where this is outside of the 48-hour response period.; review the conversion rates of A&G to referral; development of an A&G tracking tool by ULHT to support specialities not hitting the 16%.
- *Increasing Clinic Utilisation*: Implement the 6-4-2 process for booking patient slots; Expand directly bookable functionality to all major specialties and use full digital functionalities to reduce Missed Appointments

High Volume Low Complexity & Day Case Rates

- ULHT theatre productivity programme: increasing day case rates, increasing theatre utilisation and improving pre-operative assessment.
- Gateway reviews and action planning for all six HVLC specialties, working with the GIRFT team
- Grantham surgical hub : the intention over the next 4 years is to increase the range of specialties and procedures that take place in the hub and to support neighbouring systems with their elective recovery. Weekend working and 2.5 session days will become BAU to maximise efficiency; Increase day case surgery rates to ensure compliant with British Association of Day Case Surgery (BADS).
- Ophthalmology: Scoping the potential to use Louth Hospital as an ophthalmology hub.

TARGET OUTCOMES

Outpatients:

- Continue to perform better than the national target of 16% of new outpatient attendances; and work towards increasing the provider level usage. Where specialties are meeting the 16%, stretch targets will be agreed.
- Improved patient experience – reduction in complaints from patients and General Practice queries
- Reduction in waiting times – to support the national ambition to eliminate waits of 65 weeks of more by 31st March 2024
- Improved RTT performance – to support the national ambition to eliminate waits of 65 weeks of more by 31st March 2024
- Reduction in DNAs - this has been part of the national 'Action on Outpatients' programme and is embedded as a key enabler in ULHT's Integration and Improvement Plan
- Reduction in agency / bank and locum spend.

High Volume Low Complexity & Day Case Rates

- Patients will have a reduced wait for an outpatient appointment.
- Patients will have a reduced wait for a surgical procedure.
- Improvement in quality outcomes
- Increased productivity in day case procedures – completing more activity than before in the same time.
- Reduce the number of bed nights by utilising day case.
- Reduce LOS following elective surgery by implementing discharge plans on admission e.g., for hip replacement – physio and OT in place to mobilise patient on return from surgery, ensure appropriate adjustments had been made at home.
- If GIRFT principles are followed - it will ensure a positive impact on system partners in terms of increased activity, engaged workforce, reduce financial pressures improved patient satisfaction.

Personalisation and a new relationship with the public | Population health and Prevention | Integrated Community Care for major conditions | A happy, valued and supported workforce | Data and digital technology | Recovery/Access

Diagnostics

KEY AREAS OF WORK

Community Diagnostics Centres (CDCs)

- Ongoing development and implementation of the CDC facilities across the county, with ULHT being identified as a lead provider.
- Continued engagement strategy to ensure that the views, opinions and insights from stakeholders are at the core of the decision-making process to improve diagnostic provision and ensure that the needs of the community and the system are met. This will contribute to the ambition to address health inequalities, as well as being aligned to the Lincolnshire Joint Forward Plan ambition to improve access and support the public in understanding how best to access services.
- Continued review and interrogation of demand and activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities, and to support optimal locations are identified for future CDC sites.
- Continued consultation and collaboration with existing and new system partners, including those from the independent sector, to ensure services are delivered effectively, efficiently and as productively as possible.

Endoscopy

- Work with the system main provider to ensure that development of the new endoscopy and PET CT facilities are delivered as planned.

Electronic booking

- Implementation of a 6-month trial of the SwiftQ booking process; support ULHT and EMRAD to progress an electronic booking process across the Trust as required.
- Implementation of the Rad Cockpit software
- Progress the bids for AI funding to trial AI software in radiology.

TARGET OUTCOMES

- Meet the aim to provide diagnostic tests to 85% of patients within 6 weeks by March 2024 and to 95% of patients by March 2025.
- Planned CDC activity for 2023/24 is likely to be in excess of 32,000 tests across 6 of the main modalities, with significant increases planned for 2024/25 and 2025/26 as the two new CDC facilities become fully operational, where it is anticipated that activity will be in excess of 150,000 tests in total for all three sites.
- Improving population health outcomes and address health inequalities by increasing the availability and accessibility of services through expansion of the Grantham CDC and development of additional facilities in Lincoln, Skegness and potentially Boston.
- Increasing diagnostic capacity to reduce waiting times, address unmet need and improve performance metrics. This will be for planned and unplanned care, as well as cancer pathways. By moving outpatient diagnostics off the main acute sites, capacity will be created to improve UEC pathways and for more complex patients include cancer and cardiac tests.
- Improve productivity and efficiency through the transformation of clinical pathways, with the provision of co-ordinated diagnostic testing and inclusion of new technology.
- Increase in digital interoperability and connectivity across the system to provide greater information sharing between system partners and enable improved management of complex cases, in addition to providing patients with more choice when booking their appointments through an electronic system and at CDC sites which are closer to home and easy to access

Personalisation and a new relationship with the public | Population health and Prevention | Integrated Community Care for major conditions | A happy, valued and supported workforce | Data and digital technology | Recovery/Access

Cancer

KEY AREAS OF WORK

Backlog reduction and performance improvement

- Improve performance against the headline 62-day standard to 70% by March 2025
- Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
- Number of people referred onto a non-specific symptom pathway- 333 in 2024/25
- 85% of Lower GI Suspected Cancer referrals with an accompanying FIT result

Service improvement/pathway redesign

- Improve productivity in priority pathways; lower GI (≥80% of referrals accompanied by FIT result), skin (teledermatology) and urological cancers (nurse-led biopsy; risk-stratification tools in prostate cancer)
- Establish, where not already in place, breast pain pathways and unexpected bleeding pathways for women receiving HRT, for patients who do not require a full clinical assessment on an urgent suspected cancer pathway
- Support the delivery of NHS-wide early diagnosis programmes, including the expansion of targeted lung health checks, by ensuring sufficient CT-guided biopsy, endobronchial ultrasound & treatment capacity; commissioning the required phlebotomy capacity to support the Multi-Cancer Blood Test Programme
- Work with NHSE to increase screening colonoscopy capacity, by optimising symptomatic GI and screening services
- Work with NHSE to increase contrast-enhanced MRI capacity for the Very High-Risk NHS Breast Screening Prog
- Work with NHSE to increase uptake and coverage of NHS screening programmes - including use of community diagnostic centres and women's health hubs
- Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways
- Implement new (Cancer of unknown primary) CUP pathway

TARGET OUTCOMES

Backlog reduction and performance improvement

- Reduce number of patients waiting over 62 days to 141 by March 2025
- Return performance back to pre-covid levels (and beyond) by March 2026
- Ensure 28FDS performance reaches 75% by the end of March 2025
- Return focus back to 62-day performance and meeting 62-day targets as laid out in new constitutional standards

Service improvement/pathway redesign

- Finalise Galleri Trial 2024
- Roll out of the targeted lung health check programme
- Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.
- Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028..
- Scope, develop and commence transition of PFUP protocols and models of working to support other long term condition specialities aligning with PIFU
- Scope and commence transition of personalised care models of working to support people living with other long term conditions in Lincolnshire
- Colorectal HI Programme will focus on improving uptake of Faecal Immunochemical Testing in the seven most deprived practices
- Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening

Lincolnshire Maternity & Neonatal System

KEY AREAS OF WORK

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans
- By 2024, specialist care including pelvic health services and bereavement care when needed; Publish equity and equality plans in 2023/24 and take action to reduce inequalities in experience and outcomes.

Supporting our workforce to develop their skills & capacity to provide high-quality care

- Meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents with regular review of process to ensure continued transparency and learning
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed. This will be implemented by increased surveillance and assurance though the LMNS

Meeting & improving standards & structures that underpin our national ambition

- Implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.
- By 2024, enable women to access their records and interact with their digital plans.

TARGET OUTCOMES

Headline ambitions

- Reduction in smoking in pregnancy from 14.8% to 9.0% by 2028
- Increased breastfeeding: Increase breastmilk at first feed from 65.5 % in 2022/23 to 70% by 2028
- Improved metrics for maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births.
- Implementing the recommendations of the Neonatal Critical Care Review; improved neonatal cot capacitty by 2025;
- **Allied Health Professional (AHP) Provision by end 2024 – Business Case ongoing since Dec 2020. Proposal to move this forwards by end of year needs focus.**
- The pre-term birth rate ambition - to achieve a 25% reduction in preterm birth rate to 6% in 2025. Be on track to make a 50% reduction in Neonatal death, Neonatal Brain injury by 2025.. PERI-Prem and NEWTT2 implementation by 2025.

Listening to women and families with compassion which promotes safer care

- Perinatal pelvic health services and perinatal mental health services are in place.to support the number of women accessing specialist perinatal mental health services
- Maternity and Neonatal services achieve UNICEF BFI accreditation.

Supporting our workforce to develop their skills and capacity to provide high-quality care

- Achieve target establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses

Developing and sustaining a culture of safety to benefit everyone

- Improved scores in the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey for midwifery, obstetrics and gynaecology

Meeting and improving standards and structures that underpin our national ambition

- Minimising for the gap on these metrics for people from: 20% most deprived areas; Black, Asian and ethnic minority backgrounds; health inclusion groups; other Lincolnshire population segments experiencing worse access, experience and outcomes.

Personalisation and a new relationship with the public | **Population health and Prevention** | **Integrated Community Care for major conditions** | **A happy, valued and supported workforce** | **Data and digital technology**

Children & Young People

KEY AREAS OF WORK

Co-ordination of health information sharing into safeguarding children's front door Strat discussions
- Improve processes for the sharing of health information at multi-agency strategy discussions to ensure robust local arrangements are in place

Diabetes
- Reduce variation of care; Increase CYP utilising technology; access to psychological support services

CYP Child Protection Medicals
- Review and revise health model so it has the capacity and capability required to consistently deliver timely Child Protection medicals to required standards

Clinical Intervention in Schools Review
- Provide a robust health offer to meet the needs of CYP with SEND in Lincolnshire's 'All Needs' special schools.

Asthma
- Implementation of NHSE National Asthma Bundle; Access to diagnostic hubs, community spirometry & FeNO testing; Increased access to training for staff; Increased access to resources for CYP & families to support self-management

Epilepsy
- Improved access to: Epilepsy Specialist Nurse; appropriate mental health and psychological support services; tertiary neurology as required

CYP Therapy Review
- Develop an integrated CYP Therapy Service that provides specialist physio, SALT & OT for CYP with complex physical or speech, language & communication needs

Children's Community Nursing (CCN) Review.
- Develop new service model that meets best practice and offers an on-call service; direct nursing care and PEOL care to all children on the CCNS caseload

Palliative End of Life Care for Babies, Children & Young People
- 24/7 out of hours specialist clinical support/advice rota for professionals

Integration of assessment processes and support for CYP with SEND.
- Integrating EHC SEND, Independent Placements & Continuing Care processes

TARGET OUTCOMES

Co-ordination of health information sharing into safeguarding children's front door Strat discussions
- Improved risk assessment and subsequent decision-making regarding children at risk of harm

Diabetes
- CYP have equal access to all care processes (December 2024.)
- CYP have improved management and control of their Diabetes (March 2025)

CYP Child Protection Medicals.
- Improved support for CYP who are potential victims of abuse and neglect

Clinical Intervention in Schools Review
- CYP getting the right health, care and education, in the right place, at the right time, as close as possible to where they live

Asthma.
- 10% reduction in ED attendances due to asthma in 2024/25

Epilepsy.
- 10% reduction in unplanned admissions due to epilepsy in 2024/25

CYP Therapy Review.
- Improved access to universal and targeted therapy services in the community reducing demand and pressure on the specialist therapy service.

Children's Community Nursing (CCN) Review.
- Reduce unnecessary recurrent ED attendance for CYP with long-term conditions and complex health needs and disabilities.
- Reduce the number of admissions to the inpatient wards

Palliative End of Life Care for Babies, Children & Young People
- Improved care provision, access, and choice of venue of death

Integration of assessment processes and support for CYP with SEND.
- Better fulfilment of the SEND and Alternative Provision mission: Fulfil children's potential; improve parent/carer experience; support financial sustainability

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Children & Young People's mental health

KEY AREAS OF WORK

- A wholesale review and transformation programme of children and young people's emotional wellbeing and mental health support in Lincolnshire

Prevention and Community Assets
- Night Light Café pilot

Early Intervention:
- Online MH support service recommissioning
- Primary care CYP MH Practitioner pilot roll-out
- CYP counselling offer pilot
- Digital game-based therapy for anxiety pilot
- On-going delivery and expansion of Mental Health Support Teams (MHSTs)

Community Specialist Mental Health:
- Increase staffing and reduce waiting times in community specialist mental health support
- Introduce Avoidant/Restrictive Food Intake Disorder (ARFID) pathway
- Complex Needs Service review/evaluation

Urgent and Emergency Care:
- CAMHS Eating Disorders meeting demand and achieving routine/urgent waits
- CYP MH liaison in Lincoln and Boston
- Mental Health Urgent Assessment Centre all-age pathway
- Kooth digital online pilot
- Crisis respite

Transitions pathways:
- Ensuring transitions are seamless between CYP & adult MH services

TARGET OUTCOMES

Early Intervention:
- Increase access to a range of early intervention support for low/mild to moderate emotional/mental health concerns, to increase the overall access in Lincolnshire to achieve the LTP 11,829 1+ contact target
- More support in education settings to increase the number of CYP in Lincolnshire with good emotional wellbeing and MH, with at least 50% coverage of MHSTs by 2025

Community Specialist Mental Health:
- Improve waiting times so that 95% of accepted referrals are seen for assessment/support within 4 weeks by March 2025
- Reduce waiting times for specialist mental health support so that no CYP are waiting more than 12 weeks for treatment by March 2025 onwards
- Increased access to specialist mental health assessment and support for CYP presenting with ARFID
- Reduce the risk of CYP with complex needs or behaviours escalating and negatively impacting on their life chances, improving their overall outcomes

Urgent and Emergency Care:
- Achieve 95% target for routine Eating Disorder referrals (within 4 weeks) and urgent referrals (within 1 week)
- Achieve countywide coverage of 24/7 mental health crisis support and assessment for CYP and families
- Reduce hospital admissions (acute or specialist MH/LD) and shorter stays (if admission is unavoidable) for all CYP, including those with LDA
- Fewer presentations to A&E for CYP in mental health crisis
- Increased access for CYP to support during MH crisis

Transitions pathways:
- Improved patient journey and experience for 18-25-year-olds transitioning from CYP to Adult mental health services

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Adult mental health

KEY AREAS OF WORK

Prevention and Early Intervention:

- Roll out of the Mental Health Prevention Concordat Plan
- Continued development of alternative MH crisis provision. and Holistic health for the homeless expansion

Transformation of Community Services:

- Increased investment into community-based provision targeting those areas most in need around suicide prevention and adult mental health and wellbeing; development of a MH VCFSE strategy – to build resilience and generate volunteering opportunities; continued investment into primary care roles and supporting locality mental health team provision; increase workforce and improve pathways for IPS/EIP services; continued growth of CRT and PACT services countywide; further development of the adult eating disorder pathways; developing local model for SMI Health checks

Mental Health Urgent and Emergency care:

- MH UEC Pathways review and CRV provision; 111 option 2 service Provision; Boston Liaison service
- Options appraisal/business case for East Coast provision
- Right Care Right Person (RCRP) Programme

Inpatient services:

- Continuing to monitor the need for out of area provision and reviewing local inpatient services to improve quality and access for those needing it. Introducing additional roles to ensure therapeutic provision is available

Access

- Increasing the capacity/productivity of these services: NHS Talking therapies; Perinatal Services; Neuropsychology: Remote assessment pathway; Psycho-oncology; ME/CFS Pathway

TARGET OUTCOMES

Prevention and Early Intervention:

- Concordat: Inequalities are reduced; people are more responsible for their own care; disease burden is reduced. Reduction in variation of patient outcomes
- Crisis alternatives: Reduction in suicide rate. People better supported in communities. Improved self-efficacy.

Transformation of Community Services:

- SMI Physical health Checks: achieve 70.4% against 60% target
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Women Accessing Specialist Community Perinatal MH Services: 697 in line with Lincolnshire's birth rate

Mental Health Urgent and Emergency care:

- Reducing number of people with mental ill health needing to attend A&E, primary care and secondary MH services

Inpatient services:

- More people supported within Lincolnshire
- Reduced inappropriate adult acute bed days out of area.

Access

- CMH services and Talking Therapies/PMH services work collaboratively, to ensure people seeking support are provided with that support; People with a suspected first episode of psychosis start treatment within 2 weeks of referral ; All people aged 14 –65 years can access EIP services
- More people supported through Talking Therapies: reliable recovery: achieve 49% against 48% target ; reliable improvement: achieve 70% against 67% target

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Dementia

KEY AREAS OF WORK

Dementia Strategy development-

- This will have a key focus on prevention of avoidable cases of dementia; improving experience of people being diagnosed and living with dementia; championing participation, innovation and research

Prevention agenda

- Increase investment in prevention in Lincolnshire; aimed at raising awareness of the importance of good brain health across all age and reducing the risk of dementia. Ensuring we address inequalities in the risk factors for dementia & give everyone who needs it the chance to access support to be active, eat well, continue to learn, and to stay connected.

Dementia Diagnosis & Care for Lincolnshire

- Improve the dementia diagnosis rate – supporting PCNS with case finding, and coding dementia diagnosis
- Promoting use of the Diagnosis Advanced Dementia Mandate Tool as part of the primary care dementia pathway for patients with advanced/severe presentation of dementia in care homes
- Primary care support to ensure all people diagnosed having a care plan and care plan medication review in the preceding 12 months

Memory Assessment Service

- Move toward a stand-alone MAS model to improve the dementia diagnosis rate for Lincolnshire and reduce waiting time for memory assessments

Complex Dementia – managing challenging behaviour (all settings)

- Implement the role of Dementia ambassadors in care homes
- Ensure the appropriate use of antipsychotic medication
- Review & develop education and training programmes for supporting people with dementia and improve access for carers and care professionals
- Reduction of inappropriate Antipsychotic prescribing for people with dementia

Palliative and End of life Care (PEOLC)

- Explore how we can adopt elements of the Derbyshire toolkit to strengthen the PEOLC offer for people with dementia.
- Enhanced Health in Care Homes improving PEOLC for people in care homes

Young Onset Dementia

- New specialist pathway to be developed and implemented for Lincolnshire

TARGET OUTCOMES

Prevention agenda

- Support increase in Health Check 5 year (50-65) from 37% to 50%
- Reduction in people with MCI and Memory and Cognitive Problems

Dementia Diagnosis & Care

- Increase in DDR for Lincolnshire: achieve/exceed the national target of 66.7%
- Reduction in Anti-Psychotic Prescribing: maintain performance ≥ the national average
- Increase in the number of people with a Dementia Care Plans and a Medication Reviews: maintain performance ≥ the national average
- Year on year Increase in people with an advanced Care Plan & Respect form.

Memory Assessment Service

- Decrease of average time to assessment from 14 weeks to 6 weeks
- Decrease in the average time to diagnosis: year on year reduction
- Reduction in waiting list: from 1400 to 200
- Improve the outcomes, access and experience for people accessing the service

Complex Dementia – managing challenging behaviour (all settings)

- Improved offer of training and support for carers to manage challenging behaviour
- Increased number of staff accessing training to support managing challenging behaviour and a qualified upskilled workforce.

Palliative and End of life Care (PEOLC)

- Increased number of people with dementia dying at their usual place of residence. NHS digital primary care dementia data

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Learning Disability and Autism

KEY AREAS OF WORK

Service improvement

- Physical Health Liaison pathway: provide hospital and community staff with training on the support needs of patients with LD
- Develop and mobile a new ADHD pathway
- Develop and mobile the CYP Autism Diagnostic pathway
- Mobilise the Lincolnshire Virtual Autism Hub
- Service transformation review focussing on urgent care & community support
- Neurodivergent Pathways: Review Tics Tourette's and Functional Neurological Disorder and Acquired Brain Injury pathways. These are currently OATs with services commissioned on a spot purchase basis – evaluate both the CYP and Adult OATs panels in 2024/25 to determine whether this meets the needs of Lincolnshire citizens or whether cases for change are required

Accommodation Strategy:

- Develop a short-term plan and accommodation strategy to inform accommodation requirements for the LDA programme. This includes wider creative market engagement which will lead to several procurements with the market for 2024/25

Dynamic Support Register:

- Continual review of the Dynamic Support Register which informs all age admission avoidance where clinically appropriate

LDA Roadmap:

- Move to BAU: Purple light Epilepsy toolkit benchmarking; Lincolnshire LeDeR programme (Learning from Lives and Deaths - people with a learning disability and autistic people); Section 17 pilot as part of the accommodation strategy; Development of all age community support for Lincolnshire Autistic Community and family/carers; Sensory Environment work within the wards; CYP key workers.

TARGET OUTCOMES

For these two service improvement initiatives:

Physical Health Liaison Pathway

- Reduction in health inequalities for LDA citizens.
- Improved quality of annual health checks.
- Reduced (Inappropriate) demand on emergency departments and acute hospital admissions

Virtual Autism Hub

- Reduce health and societal inequalities experienced by autistic people and their families/carers
- Represent the voices and views of an underheard community in Lincolnshire and ensure this cohort of the population are fairly represented.
- Providing employment opportunities within the hub, which can have positive impact on individuals' mental health.

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Medicines Optimisation

KEY AREAS OF WORK

Primary care cost efficiencies
Identifying and addressing unwarranted variation in primary care prescribing

Community Pharmacy Integration
Including: Discharge Medicine Service; oral contraception; Blood Pressure Check Service; Smoking Cessation Advanced service; Palliative care drug stockist scheme

MO integration across the system
Engagement with practices; primary/secondary care interface

Secondary Care Procurement
Targeted list of drugs

Biosimilars
Implementation of biosimilar switch policy/protocol; addressing unwarranted variation

Antimicrobial Stewardship
Continued analysis of prescribing data; engagement of prescribers across the system

Quality and Safety
Establish Medicines Safety Network; strengthen Local Intelligence Network around the management and use of controlled drugs; Promote safe prescribing & deprescribing of opioid medication; Ensure the safe prescribing of valproates

Aseptic production
Develop a pharmacy aseptic hub to supply aseptic medicines beyond ULHT into the wider ICS and region

Antidepressant reduction
Upskilling prescribers; Identifying patients in primary care for reduction; Ensure new prescriptions in line with good practice standards and system guidelines

Pharmacy Workforce:
Focus on: marketing and attraction; recruitment; training and placements; career mapping

TARGET OUTCOMES

- **Better use of NHS resources**
- **Reduction in prescribing of targeted self-care products.**
- **More services provided to patients at their local community pharmacy**
- **Supporting patients with their medicines following discharge from hospital**
- **Improved compliance with formulary and local prescribing guidelines**
- **Reduce multi-drug resistant infections, reduction in number and length of hospital stays**
- **Reduce medicines-related harm to patients**
- **Improved patient clinical outcomes through improved availability and distribution of aseptic products**
- **More equitable access to pharmacy professionals for advice and drug supply**

Personalisation and a new relationship with the public | **Population health and Prevention** | **Integrated Community Care for major conditions** | **A happy, valued and supported workforce** | **Data and digital technology**

People & Workforce

KEY AREAS OF WORK

Value our People

- Work together across the system to deliver against the six high impact actions set out in the equality, diversity and inclusion improvement plan for the NHS
- Embed a compassionate culture built on civility, respect and equal opportunity through inclusive recruitment, Just Culture, Allyship and system level networks
- Develop and launch system-wide occupational health & wellbeing services

Grow our People

- Widen access of opportunities to people from all backgrounds and in underserved areas to join the NHS through apprenticeships.
- Engage with higher education institutions to support students, placement capacity and maximise accreditation of recognition of prior learning (RPL)
- Adopt new recruitment practices and systems in line with the national overhaul
- Embed strategic workforce planning through enhanced systems & processes

Develop our People

- Increase placement capacity & experience to support increased training places
- Develop multi-professional, system-based rotational clinical placement models
- Agree the system level Leadership Development & Talent framework
- Fully embed digital technology in training pathways

Retain our People

- Continue to embed the People Promise elements to enhance staff experience
- Agree and publish a consistent system-wide benefits offer
- Continue to focus on flexible working as a means of retaining our staff
- Work with specific staff groups/network through pilot projects
- Continue to strengthen our pastoral care for international recruits

TARGET OUTCOMES

Financial Recovery projects for 24/25

- Overall general sickness management: reduce sickness management spend by 1% across provides
- Sickness at March 2025: ULHT: 5.5%; LCHS: 4.3%; LPFT: 4.6%; ICB: 4.6%
- Turnover at March *2025:* ULHT: 9.0%; LCHS: 10.8%; LPFT: 10.1%; ICB: 9.5%
- Medical productivity increased through effective job planning: Metric to be developed
- LCHS Apprenticeship Centre embedded as a revenue generating unit: Extension to incorporate ULHT Talent Academy currently being scoped – implementation timescales to be confirmed

Bank & Agency Spend reduction schemes

- Reduce agency spend at all providers to ≤3.2% of pay bill: focussing on improving off-framework usage and cap compliance across provider organisations

Corporate Transformation Programme

- Design and implementation of new operating model

Personalisation and a new relationship with the public | Population health and Prevention | Integrated Community Care for major conditions | **A happy, valued and supported workforce** | Data and digital technology

Digital

KEY AREAS OF WORK

- Digital Social Care Records
- Development of the Lincolnshire Care Record
- Scope an online go-to resource for the population to navigate health, care and wellbeing
- Improve cybersecurity
- Improve technical infrastructure
- Integration of digital systems
- Improve technical capabilities for collaboration
- Develop framework to assess and address digital skills readiness (staff or population)
- Technology enabled care (remote monitoring, virtual wards, etc)
- Robotic Process Automation
- Support areas with digital solutions that enable business change (such as People and Workforce)
- Introduce shared system intranet
- Use operational data to provide intelligence at a system level
- Handover of maintenance and support of the reporting platform from external arrangements
- Replacement of the reporting platform
- Determine requirements for social prescribing digital solution
- Access for clinicians to LACE evidence base
- Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services

TARGET OUTCOMES

- improved decision making across pathways of care, improving patient outcomes and use of resources
- The population will be supported in keeping well, avoiding admissions, accessing health and care services only when needed making best use of resources and supporting choice and access and reducing health inequalities.
- Avoiding breaches of information including patient information, recovery costs and reputational damage.
- Provide the infrastructure that enables a modern, mobile workforce and patients to access online services.
- Reducing the need for travel and making more efficient use of resource and expertise across geographical areas in the context of rising demand
- Improve processes through speed and efficiency, freeing up staff to deal with more complexity
- Ensuring that at the end of the Optum contract, access and ongoing development of the joined intelligence dataset does not cease
- Informs a system level decision on where information needs to be captured, how it is shared to support PHM, health and care delivery, and reporting
- Putting research and evidence into practice to achieve best outcomes for patients
- Ability to manage information that supports third sector support into health and care and social prescribing

Personalisation and a new relationship with the public

Population health and Prevention

Integrated Community Care for major conditions

A happy, valued and supported workforce

Data and digital technology

Delivering on the Joint Forward Plan priorities

Priority 1: A new relationship with the public

Programme	Initiative	More information
Personalisation	**Our Shared Agreement** Working with partners and people with lived experience to 'bring to life' and demonstrate what a new personalised and proactive relationship between people and the health and care system could look like and the impact It could have. Embedding the five foundations of Our Shared Agreement' that help to describe how we should/could work together. - Being prepared to do things differently - Understanding what matters to ourselves and each other - Working together for the wellbeing of everyone - Conversations with and not about the people - Making the most of what we have available to us	65
Maternity and neonatal services	- All women will be offered personalised care and support plans.	178
Cancer	- Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028: Roll out Personalised Follow up Pathways across pathways and long-term conditions	164
Mental health: Adult	- Mental Health Prevention Concordat - Community MH transformation: whole person care – being mindful of physical, mental and social needs, assets, wishes and goals; Co-production – involving experts by experience as equal partners in the design, development and delivery of services	211
Learning Disabilities & Autism	- Physical Health Liaison pathway: provide hospital and community staff with training on the support needs of patients with LD, who will subsequently receive more personalised care - The Lincolnshire Virtual Autism Hub, which will represent the voices and views of an underheard community in Lincolnshire and ensure this cohort of the population are fairly represented, as well as providing employment opportunities	236

Delivering on the Joint Forward Plan priorities

Priority 1: A new relationship with the public

Programme	Initiative	More information
PCCSV	- Transforming the conversation between primary care and the public through a comprehensive programme of comms, engagement and co-production - Developing and commissioning a refreshed social prescribing model - Strategic partnership model with VCSE (LVET) agreed by June 2024 - 3 PCNs will be offering a High Intensity User Service by April 2024 - Implementing a case management and care co-ordination model to support delivery of PCN integrated primary and community teams - Further develop the role of integrated neighbourhood teams, in line with the Fuller recommendations, with a view to enhancing the delivery of multi-disciplinary, multi-agency personalised care and improved patient outcomes and experience for the most complex patients - Implementing the Lincolnshire Frailty Strategy and associated delivery plans - Enhanced health in care homes: ensuring 90% of people living in a care home to have a personalised care and support plan in place by 2026 - Palliative & end of life care: ensuring 70% of people in the last year of life to have a care plan by 2025, 80% by 2026 - Falls: 70% of high-risk fallers will have received a holistic falls assessment by 2025	115
UEC	- Strength-based approach to supporting flow and transfer of care	131
Dementia	- Personalised care and support planning for people with dementia	220

Delivering on the Joint Forward Plan priorities

Priority 2: Living well and staying well

Programme	Initiative	More information
Health Inequalities & Prevention	**Preconception, infancy and early years** - High-quality midwifery and children's services that support mums, babies and little ones to get the best start in life - Increase the number of babies and infants vaccinated and immunised against diseases - Encourage more people planning a pregnancy to take folic acid supplements before, during and after pregnancy. - Reduce smoking during pregnancy and increase the number of smoke-free homes - Help parents and young families to stay active, eat well and look after their health. - Support more mums to breastfeed and increase breastfeeding rates at six to eight weeks - Increase the number of people accessing mental health services and support good relationships between parents and infants. **Childhood and adolescence** - Support young people with the services they need to keep them healthy and promote physical, mental and emotional wellbeing. - Develop mental health support teams to support young people's mental health and emotional wellbeing. - Give children and young people with disabilities or long-term conditions the support they need to reach their potential and lead a full and independent life, including psychological support. - Work with schools and colleges to encourage healthy habits, identify health needs early and provide access to support. - Improve oral health especially in deprived groups.	84

Delivering on the Joint Forward Plan priorities

Priority 2: Living well and staying well

Programme	Initiative	More information
Health Inequalities & Prevention	**Working age** - Work with people to understand their skills and knowledge and give them the confidence to look after their own health and wellbeing. - Identify people who could benefit from NHS health check and screening programmes and increase take-up - Ensure regular physical health checks for people with severe mental illnesses and people with a learning disability. - Increase access to NHS talking therapies for anxiety and depression and provide additional support by expanding local services such as peer support, mental health social prescribers and community connectors. - Support more people to stop smoking and offer people in hospital who smoke, including pregnant women & high-risk mental health outpatients - Support more people who need help achieving a healthy weight by increasing uptake of our integrated lifestyle service and the NHS Digital Weight Management programme. - Improve support for people suffering from and at risk of Type 2 Diabetes to help reverse and stop the progression of the disease, - Reduce cardiovascular disease through early detection, better management of those known to be at high risk and encouraging people to manage their own health better. - Better support people waiting for treatment for musculoskeletal conditions such as back pain. Explore opportunities to improve their physical and mental health prior to any planned operations. - Improve oral health, especially in deprived groups. **Ageing well** - Find out what matters to patients and their carers for better future care planning. - Encourage more people to get vaccinated and immunised against disease, especially those in deprived groups - Improve oral health. - Provide care focused on the individual for patients and carers living with cancer. - Improve early diagnosis and detection rates for cardiovascular disease and cancer, particularly colorectal cancer. - Improve brain health and prevent people from developing dementia by understanding risk factors e.g. smoking, high alcohol intake & hearing loss - Develop a Strength and Balance programme to prevent falls	84

Delivering on the Joint Forward Plan priorities

Priority 2: Living well and staying well

Programme	Initiative	More information
Primary Care, Communities & Social Value	- Develop, embed and evaluate a Lincolnshire-wide Long-Term Condition Strategic Framework, which will include supporting prevention and management of risk factors;	115
Mental health: Adult	- Mental Health Prevention Concordat - Increased investment into community-based provision targeting those areas most in need around suicide prevention and adult mental health and wellbeing - Further development of the adult eating disorder pathways including prevention and early intervention - Developing a local model for SMI Health checks delivery including interventions to support aiming to reduce premature mortality and reduce co-occurring conditions - Review of the prevention and early intervention alternatives and acute provision of MH UEC including demand and capacity modelling to ensure seamless pathways are in place	211
Dementia	- Focused prevention programme aimed at raising awareness of the importance of good brain health across all age and reducing the risk of dementia. Utilising health inequalities data to support delivery	220

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Urgent & Emergency Care	- A focus on increasing care closer to home and reducing the requirement for patients to attend EDs in order to access services - Evolution of simplified access for both patients and professionals (including HCP SPAs and NHS 111)	131
Planned Care	**Waiting List Reduction** - Eliminate 65 week waits by March 2024 and 52 week waits by March 2025 - Increase patient choice: promoting the Patient Initiated Digital Mutual Aid System which allows us to offer patients the ability to more easily and proactively opt-in to move provider when they have been waiting over 40 weeks for care and meet the criteria; Promoting the use of the Elective Activity Coordination Hub (EACH) which offers choice to all planned care patients and increase number of specialties clinically triaged to optimise referral management; Expanding patient validation support by the EACH to out-of-area Providers with Lincolnshire patients - Increase Activity. Expanding the programme of out-patient transformation and theatre utilisation to maximise capacity and efficiencies to reduce waiting times; Maximising capacity at the recently accredited Grantham Surgical Hub using HVLC; Increase self-referral for a range of conditions to meet local and national strategies; Expanding the range of services and procedures to be delivered in the community and moved away from secondary care; Working with independent sector providers to deliver additional capacity where there are challenged specialties at our NHS providers; Expanding AQP Community Optometrist Triage Assessment and Treatment Service (COTATS) to include Independent Prescribers to support patients accessing medication at time of ophthalmology appointment rather than via a GP appointment. Incremental increase planned over next 3 years across the county - Scoping methodology for producing non-chronological waiting lists to ensure patients access services according to need - Scoping model for Women's Health Hub for Lincolnshire to meet national strategy **Outpatients** - Making the most of Virtual Consultations and Patient Initiated Follow Ups - Increasing Clinic Utilisation: Implement the 6-4-2 process for booking patient slots; Expand directly bookable functionality to all major specialties and use full digital functionalities to reduce Missed Appointments **High Volume Low Complexity & Day Case Rates** - ULHT theatre productivity programme: increasing day case rates, increasing theatre utilisation and improving pre-operative assessment. - Grantham surgical hub : the intention over the next 4 years is to increase the range of specialties and procedures that take place in the hub and to support neighbouring systems with their elective recovery; Increase day case surgery rates to ensure compliance with BADS	143

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Diagnostics	- Community Diagnostics Centres: Ongoing development and implementation of the CDC facilities across the county; Continued review and interrogation of demand and activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities and identify locations for future CDC sites. - Endoscopy: development of new endoscopy and PET CT facilities - Electronic booking: trial of the SwiftQ booking process; implementation of the Rad Cockpit software	160
Cancer	- Improving access to Targeted Lung Health checks by end of 2026 we will have provided CT scans to 100% of the total population eligible for Lung screening, Q4 24/25 rollout to First Coastal and First Coastal Rural - Breast Pain clinics are held weekly, one at Lincoln- North Hykeham Health Centre and one at Boston - Boston health clinic. Plan for further clinic at Skegness pending demand. The referral numbers are steadily increasing and 84.7% of GP practises have now made at least one referral to the pathway. - Planning to provide four Chemotherapy Chairs at the Skegness CDC - Chemotherapy Treatment Bus – providing non-complex treatment to patients across Lincs - Gynae community clinics in around Spring/Summer 2026, once the workforce is trained - 81% of endometrial patients (patients with a thickness of 10mm or below) can be seen in a community clinic which in turn would free up consultant to see first appointment 2WW patients and reduce the waiting time along with many other benefits. A new community-based clinic will be delivered to support patients that don't need consultant intervention in the hospital. Locations are yet to be confirmed, but it could potentially mirror the breast pain clinics and be located in health centres in the community. The aim of the project is very clear – to reduce unnecessary referrals into the hospital by still supporting the patients and assessing their needs. This will support earlier and faster diagnosis of cancer by reducing waiting times and ensuring that consultant time is more appropriately prioritised - Supporting 14 community cancer support groups, 7 financial support groups and 19 other cancer wellbeing groups across the county	164

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Children & Young People	- Diabetes: Reduce variation of care; Increase CYP utilising technology; access to psychological support services - Clinical Intervention in Schools Review: Providing a health offer to meet the needs of CYP with SEND in Lincolnshire's 'All Needs' special schools. - Asthma: Implementation of NHSE National Asthma Bundle; Access to diagnostic hubs, community spirometry & FeNO testing; Increased access to training for staff; Increased access to resources for CYP & families to support self-management - Epilepsy: Improved access to: Epilepsy Specialist Nurse; appropriate mental health and psychological support services; tertiary neurology - CYP Therapy Review: Develop an integrated CYP Therapy Service that provides specialist physio, SALT & OT for CYP with complex physical or speech, language & communication needs - Children's Community Nursing (CCN) Review: Develop new service model that meets best practice and offers an on-call service; direct nursing care and PEOL care to all children on the CCNS caseload - Palliative End of Life Care for Babies, Children & Young People: 24/7 out of hours specialist clinical support/advice rota for professionals - Integration of assessment processes and support for CYP with SEND: Integrating EHC SEND, Independent Placements & Continuing Care processes	185
Mental health: Children & Young People	- Investment in Community Specialist Mental Health to reduce waiting times in community CAMHS - Increased access to specialist mental health assessment and treatment for CYP presenting with Avoidant/Restrictive Food Intake Disorder - CYP mental health liaison in Lincoln and Boston: Increased access to 24/7 mental health crisis support and assessment - MHUAC all-age pathway: increased access to 24/7 mental health crisis support and assessment - Kooth digital online and crisis respite: Increased access for CYP to support during MH crisis	203

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Mental health: Adult	- Continued development of alternative MH crisis provision - Holistic health for the homeless expansion - Continued investment into primary care roles and developing a primary care strategy to support locality mental health team provision - Increase workforce and improve pathways for IPS/EIP services - Continued growth of CRT and PACT services countywide - Further development of the adult eating disorder pathways including prevention and early intervention - Review of the prevention and early intervention alternatives and acute provision of MH UEC including demand and capacity modelling to ensure seamless pathways are in place - NHS111 to be the first point of contact for anyone in a mental health crisis - Implement a Single Virtual Contact Centre for calls to 111 and 999 and a mandated Interactive Voice Response option (SPA) - Expanding the MH urgent assessment provision to the east of the county - Introduce Cloud contact centre - Working with Lincolnshire Police and wider stakeholders to implement the national Right Care Right Person programme - Continuing to monitor the need for out of area provision and reviewing local inpatient services to improve quality and access for those needing it. Introducing additional roles to ensure therapeutic provision is available - Increasing workforce within NHS Talking therapies services, including supervision and long-term condition pathways, to reduce waits for first and follow up appointments, looking at digital options. - Improving waiting times for perinatal services and ensuring provision meets need - Increase capacity to meet local population demand, reduce waiting times and improve patient experience in neuropsychology, psycho-oncology, ME/Chronic Fatigue service design and development. - Ensuring model for dual diagnosis meets the needs of the Lincolnshire population.	211

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Learning Disabilities & Autism	- Physical Health Liaison pathway: provide hospital and community staff with training on the support needs of patients with LD - The Lincolnshire Virtual Autism Hub, which will provide easily accessible community support, signposting and a level of advocacy - Development of a Children & Young People's Autism Diagnostic Pathway	236
Primary Care, Communities & Social Value	- Improve access to community pharmacy services in line with Pharmacy First - Improve access to urgent same day primary appointments and planned appointments in line with national guidance and Lincolnshire ambitions	115

Delivering on the Joint Forward Plan priorities

Priority 4: Delivering integrated community care

Programme	Initiative	More information
Primary Care, Communities & Social Value	Entire portfolio which is comprised of these three programmes: - Integrating primary care: Integrating primary care and delivering access; Developing Partnerships to Support Primary Care Integration; Vaccinations - Integrating community partnerships: PCN Development; Integrating Care - Integrating Specialist Care: Ageing well – Older age; Long Term Conditions – Working age	115
Children & Young People	- An integrated care pathway for CYP Asthma - Develop suitable clinical intervention within schools for CYP with complex health needs in an education setting closest to a CYP's home. - Develop an integrated CYP Therapy Service that provides specialist physio, SALT & OT for CYP with complex physical or speech, language & communication needs - Integration of assessment processes and support for CYP with SEND: Integrating EHC SEND, Independent Placements & Continuing Care processes	185
Mental health: Children & Young People	- Complex Needs Service review: Better integrated care available in the community for Lincolnshire CYP with complex presentations, who may be engaging in risk taking behaviours	203
Mental health: Adult	- Continued investment into primary care roles and developing a primary care strategy to support locality mental health team provision	211
Dementia	- Move towards a stand-alone MAS model in order to improve the dementia diagnosis rate for Lincolnshire and reduce memory assessments waits	220
Medicines optimisation	- Community Pharmacy Integration including: Discharge Medicine Service; oral contraception; Blood Pressure Check Service; Smoking Cessation Advanced service; Palliative care drug stockist scheme - MO integration across the system : Engagement with practices; primary/secondary care interface	247

Delivering on the Joint Forward Plan priorities

Priority 5: A happy and valued workforce

Programme	Initiative	More information
People & Workforce	• Work together across the system to deliver against the six high impact actions set out in the equality, diversity and inclusion improvement plan for the NHS • Embed a compassionate culture built on civility, respect and equal opportunity through inclusive recruitment, Just Culture, Allyship and system level networks • Develop and launch system-wide occupational health & wellbeing services • Widen access of opportunities to people from all backgrounds and in underserved areas to join the NHS through apprenticeships • Engage with higher education institutions to support students, placement capacity and maximise accreditation of recognition of prior learning (RPL) • Adopt new recruitment practices and systems in line with the national overhaul • Embed strategic workforce planning through enhanced systems & processes • Increase placement capacity & experience to support increased training places • Develop multi-professional, system-based rotational clinical placement models • Agree the system level Leadership Development & Talent framework • Fully embed digital technology in training pathways • Continue to embed the People Promise elements to enhance staff experience • Agree and publish a consistent system-wide benefits offer • Continue to focus on flexible working as a means of retaining our staff • Work with specific staff groups/network through pilot projects • Continue to strengthen our pastoral care for international recruits	278

Delivering on the Joint Forward Plan priorities

Priority 5: A happy and valued workforce

Programme	Initiative	More information
Personalisation	• By April 2026, All relevant staff working on the agreed pathway development have completed appropriate personalisation training as part of their induction/mandatory training • By April 2028 Personalisation is included in the values-based recruitment policy for all statutory organisations and is a key part of the selection process as well as appraisal process/supervision processes • By April 2028 there is a clear strategy in place to embed personalisation in workforce development at every level (training, degree, post grad, CPD etc) • By April 2028 all local policies and procedures reflect how personalisation and strength-based approaches are embedded in service delivery and the organisations core values.	65
Primary Care Communities & Social Value	• Deliver the Primary Care People Plan	115
Maternity	• Supporting our workforce to develop their skills & capacity to provide high-quality care	178
Medicines Optimisation	• Pharmacy workforce development – focus on: marketing and attraction; recruitment; training and placements; career mapping	247

Section 1: Introduction

- The national requirement and the Lincolnshire approach
- How it was developed – key drivers
- Where it fits with our strategic vision for health and care

NHS Lincolnshire Joint Forward Plan 2023-28

The national requirement

- The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and their partner trusts to prepare their Joint Forward Plan (JFP) before the start of each financial year.
- Systems have significant flexibility to determine their scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements

The Lincolnshire approach

Rather than cover all the national requirements in as single document, the Lincolnshire NHS agreed to develop separate documents, which are tailored to the target audiences:

- **NHS Lincolnshire Joint Forward Plan 2023 – 2028** [published June 2023]
  - a relatively concise public-facing document, which is easy to read and understand
  - articulating our new strategy for the NHS in Lincolnshire, co-produced with people and communities

This is underpinned by a number of more technical documents which are primarily targeting health and care staff but will still be publicly available:

- **Allocation of Duties and Responsibilities** [first published June 2023]
  - outlining how the legal duties and responsibilities of the ICB and NHS partner Trusts in Lincolnshire are exercised. This will be updated annually.

- **JFP Delivery Plan [this document]**
  - collating the delivery plans for the system service transformation and enabler programmes; the development of these will also be informed by further engagement with people and communities
  - Providing further details on how the five JFP priorities will be delivered

- **Activity, Workforce and Finance Plans**
  - Rolling, five-year projections (detail for Years 1 & 2; estimates for Years 3-5) that reflect the programme delivery plans as far as possible

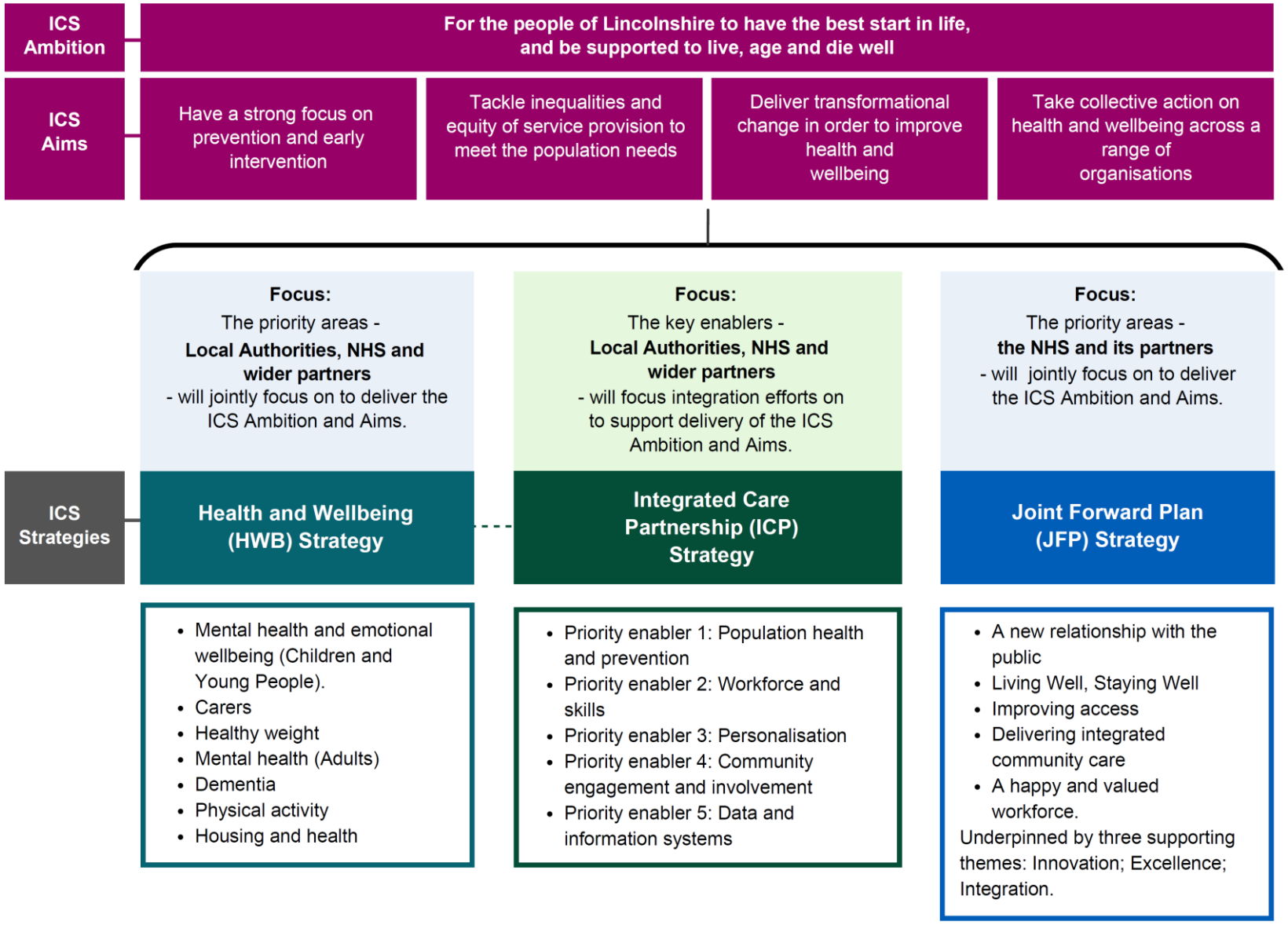
Key drivers

The key drivers informing the development of this plan have been

- Population insight: understanding the needs, causes, outcomes and disparities of our populations through analysis of population and public health data, along with patient and citizen feedback
- Current status of local services: service sustainability, efficacy and efficiency, including analysis of performance and benchmarking data
- System strategy: Health & Wellbeing Strategy, Integrated Care Strategy and the NHS Lincolnshire strategy
- National priorities, objectives & targets e.g. urgent and emergency care, primary care access, and elective and cancer care recovery plans

These programme delivery plans will continue to be evolved in response to national policy (e.g. Major Conditions Strategy) and local developments (e.g. development of Community Primary Partnerships).

Where the JFP fits with our strategic vision for health and care



Five themes across the three strategies

- **Personalisation and a new relationship with the public**
- **Population health and Prevention**
- **Integrating community care for major conditions**
- **A happy, valued and supported workforce**
- **Maximising the use of data and digital technology**

Our five cross-cutting strategic themes

Personalisation and a new relationship with the public

At the heart of the Better Lives Lincolnshire strategy is the recognition that we need to establish a new relationship with the public.

Together with the people of Lincolnshire, we want to build a shared view and agreement on what the best wellbeing, care and health for Lincolnshire looks like.

This strategic theme has five key elements:

- Creating a shared agreement.
- Supporting shared decision making
- Developing and designing services together
- Working with people and their families to manage their own health and wellbeing
- Supporting people to feel connected and engaged in their local communities

Population health and Prevention

Population health and prevention is the 'golden thread' that runs through our strategies and underpins its focus on improving health and wellbeing and tackling inequity.

Addressing the wider determinants of health will help improve overall health by helping to improve the conditions into which people are born, live and work. Addressing these determinants throughout the life course allows us to consider the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

People have different needs at different points in their lives and we have specific ambitions relating to each life stage: Preconception, infancy and early years (0-5); Childhood and adolescence (5-19); Working age (16-64); Ageing well

Integrating community care for major conditions

Integrating primary care: delivering timely access to primary care – general practice, pharmacy, dental, optometry – today, while designing a sustainable future.

Integrating Specialist Care: delivering improved health outcomes, reduced health inequalities and reduced disease progression, enabling people to live well and die well. Implementing new models of care, via a one team approach, transcending organisational boundaries; adopting a more proactive and holistic approach informed by individual wishes and need; Focussing on prevention, early identification and diagnosis; Delivering both timely, urgent care & long-term ongoing care

Integrating community partnerships, developed around PCN footprints; supporting their ongoing evolution to provide person-centred care, delivered by multi-disciplinary & multi -agency teams, for local communities, reflecting population need

A happy, valued and supported workforce

We truly appreciate our people and everything they do. We also appreciate the link between an engaged, happy workforce who feel valued and the quality and efficiency of the care they are able to deliver.

Having the right workforce in the right place at the right time allows our services to meet the healthcare needs of people locally.

To continue to do this we need a constant flow of talented people from our communities into the organisations. We also need to provide good opportunities for training and development to encourage them to stay in Lincolnshire rather than move elsewhere.

To develop our workforce in Lincolnshire we will:

- Value our people
- Grow our people
- Develop our people
- Retain our people.

Maximising data and digital technology

As health and social care services face unprecedented challenges, data, digital technology will be at the heart of how we transform health services for the benefit of citizens, patients and staff.

There is significant potential for the transformation of health and social care through better widespread use of digital technologies. This includes a growing role for technology in supporting people to monitor and manage their own health and wellbeing and also enhancing people's experience of accessing services.

New and more integrated ways of providing care will require local health and care professionals to act and behave in different ways. This will include closer working with local people, carers and their families so they are more empowered to set their own care goals and manage their own wellbeing, being part of a multi-disciplinary team and delivering more responsive and proactive care.

Our planning aims, approach, principles & priorities

Our Planning Aims

Maximising the use of our collective resources

Better Care
Improving patient outcomes: patient experience; patient safety; clinical effectiveness

Better Health
Improving the health of the Lincolnshire population – tackling the burden of disease & health inequalities

Better Value
Reducing the per capita cost of healthcare: reducing avoidable activity; eliminating waste

Our Planning Approach

Expert-led; intelligence-driven; year-round

Diagnosing & Prioritising
Analysing citizen feedback, public health, PHM & performance data

Defining & designing
Exploring and testing desirability, viability & feasibility

Planning the change
Developing the blueprint for implementation

Managing implementation
Executing plans to move to future state

Evaluating & Refining
Change is refined/embedded/ spread/stopped

Our Improvement Priorities

Integration; Excellence; Innovation

Stop
avoidable illness & intervene early

Shift
to digital and community

Share
the best

Strengthen
the hands of the people we serve

Support
our partners

Section 2: Our population

a) An overview of the health and wellbeing of Lincolnshire's population: headlines from the Joint Strategic Needs Assessment (March 2023)
b) Our target populations from a health inequalities perspective
c) Getting a deeper understanding of: the population's differing health needs, preferences and risks; the inequalities that exist within the county

POPULATION

Size

Lincolnshire's population is

768, 364

(Census 2021)

129
people per km²
(Census, 2021)

9.5%
Population projection by 2040
(ONS, 2018)

6,559
Births recorded
(ONS, 2021)

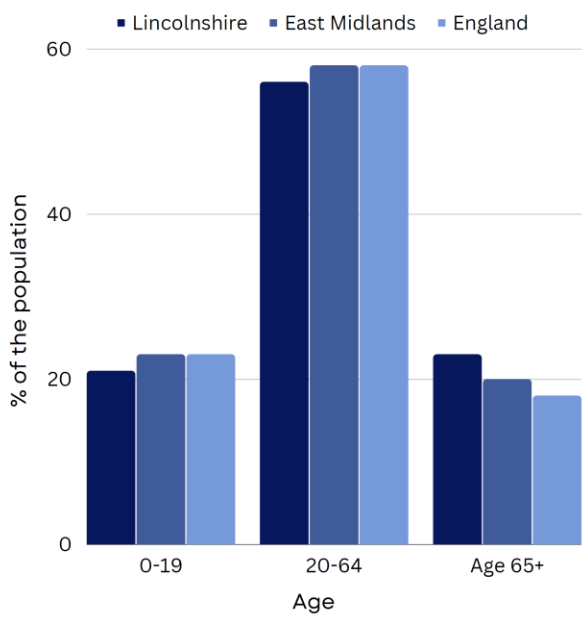
9,128
Deaths recorded
(ONS, 2021)

813, 119
Patients are registered with a GP practice in Lincolnshire
(NHS England, Feb 2023)

Demographics

Age

(Census 2021)

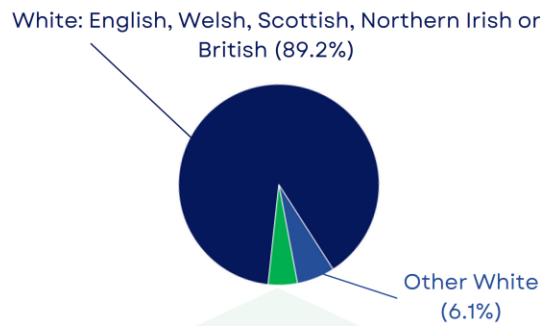


Sex

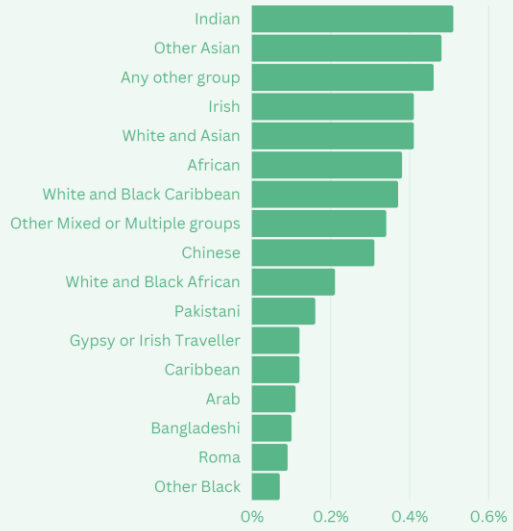
(Census 2021)

Ethnicity

(Census 2021)



Other Ethnic Groups (4.7%)



Characteristics

19.1% have a disability (26.8% of households)

304, 863 people are married or in a civil partnership

2.7% identify as lesbian, gay, bisexual, pansexual or queer

14, 921 (1.9%) follow a religion other than Christianity

8.71% use a main language which is not English

(Census 2021)

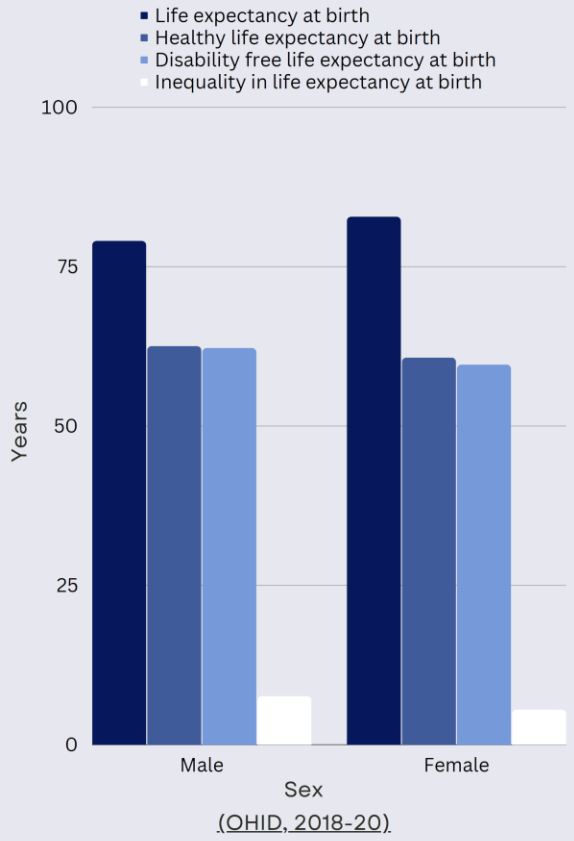
Last updated March 2023

HEALTH & WELLBEING

Life Expectancy

Females live
4.5 years
longer than males (ONS, 2021)

Males live
2.6 more years
disability free than females (ONS, 2018-20)



(OHID, 2018-20)

Health Outcomes

79.3%
of residents report being in good or very good health


(Census, 2021)

The top 5 conditions amongst patients registered with GP practices in Lincolnshire are:

(QOF, 2021-22)

Of 9,128 deaths in Lincolnshire in 2021;

31.3% were before their 75th birthday

10.7% involved Covid-19

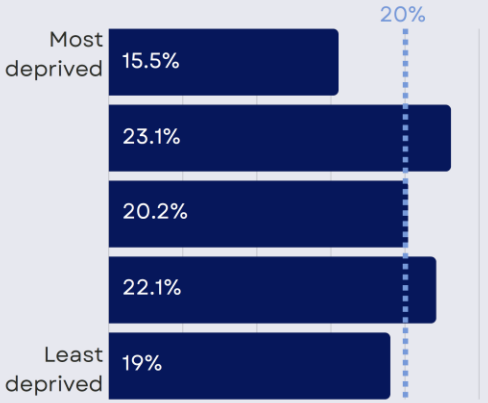
25.2% had underlying cancer

3.8% had underlying COPD

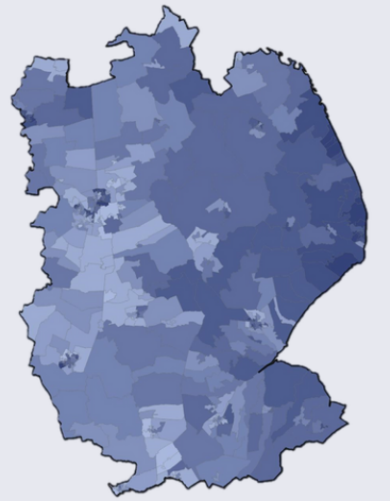
25.9% had underlying cardiovascular disease

(OHID, 2021)

Deprivation



(IMD, 2019)



Last updated March 2023

START WELL

Population

21%
of Lincolnshire's population are aged 0-19 years (161,200 people) (Census 2021)

2%
Population projection by 2040 (ONS, 2018)

6,559
Births recorded (ONS, 2021)

18.1%
of mothers smoke in early pregnancy (MSDA, 2018-19)

66.4%
of babies' first feed was breastmilk (MSDS, 2020-21)

3.2 per 1,000
rate of deaths in infants aged under 1 year (ONS, 2019-21)

15.4%
of children live in income deprived families (OHID, 2020-21)

0-5 years

3.1%
of school pupils have a social, emotional or mental health need (DfE, 2021-22)

38.3%
of year 6 pupils are overweight or obese (NCMP, 2021-22)

64.1%
of children achieve a good level of development at the end of reception (DfE, 2021-22)

5-11 years

23.9%
of reception aged pupils are overweight or obese (NCMP, 2021-22)

25.5%
of 5 year olds have visible dental decay (OHID, 2018-19)

11-18 years

78.5 per 10,000
hospital admissions for unintentional and deliberate injury amongst 0-14 year olds (OHID, 2021-22)

47
is the average achievement across 8 qualifications (Attainment 8 score) (DfE, 2021-22)

5.4%
of 16-17 year olds are not in education, employment or training (DfE, 2021)

14.1 per 1,000
young women under 18 became pregnant (ONS, 2020)

Disease burden

The top causes of years lived with disability for children & young people in Lincolnshire are:

1. Dermatitis
2. Headache disorder
3. Anxiety
4. Asthma
5. Depressive disorders

(GBD, 2019)

JSNA

Last updated March 2023

LIVE WELL

Population

56%
of Lincolnshire's population are aged 20-64 years (426, 800 people) (Census 2021)

-0.67%
Population projection by 2040 (ONS, 2018)

Health behaviours

15.4%
of adults currently smoke (GPPS, 2020-21)

67.6%
of adults are overweight or obese (OHID, 2020-21)

62.9%
of adults are physically active (OHID, 2020-21)

20.4%
of adults drink over 14 units of alcohol a week (Health Survey for Eng, 2015-18)

Health outcomes

179.1 per 100,000
mortality rate from causes considered preventable amongst under 75s (ONS, 2021)

15.8%
of adults have a common mental health disorder (APMS, 2017)

Wider determinants

23.9%
of 16-64 year olds are economically inactive (ONS, 2021-22)

25.6%
have a level 4 qualification or above (Census, 2021)

14.2%
of households are experiencing fuel poverty (BEIS, 2020)

13.3%
of residents live in social rented properties (Census, 2021)

Disease burden

The top causes of years lived with disability for adults in Lincolnshire are:

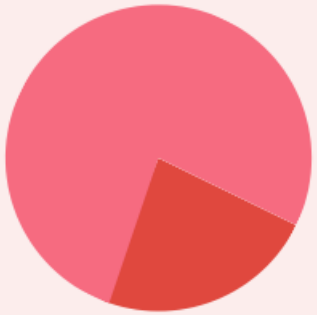
1. Low back pain
2. Depressive disorders
3. Headache disorders
4. Diabetes
5. Neck pain

(GBD, 2019)

JSNA
Last updated March 2023

AGE WELL

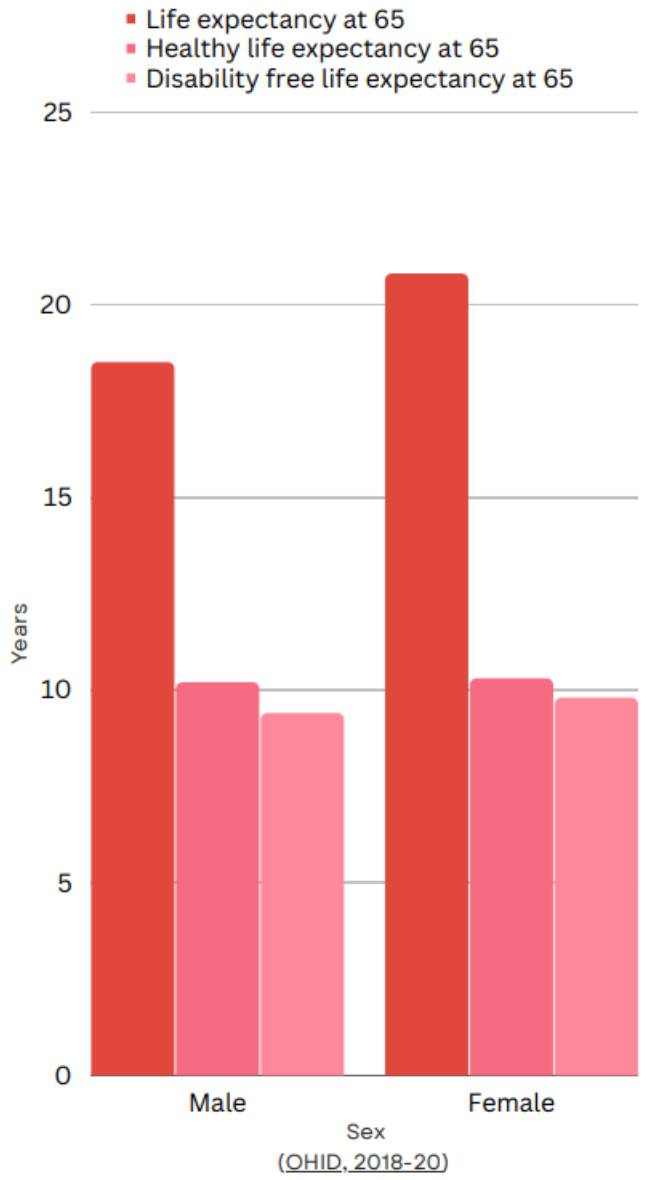
Population



23%
of Lincolnshire's population are aged 65 years or over (179, 805 people) (Census 2021)

40%
Population projection by 2040
(ONS, 2018)

Life expectancy



(OHID, 2018-20)

19.1%
of people are disabled under the Equality Act 2010
(Census, 2021)

14.4%
of those aged 66+ live alone
(Census, 2021)

3.2%
of people provide 50+ hours of unpaid care
(Census, 2021)

15.5%
extra deaths from all causes occur in the winter
(ONS, Aug 2019-Jul 2020)

1,712 per 100,000
hospital admissions due to falls in people aged 65+
(HES, 2021-22)

3.95%
of patients aged 65+ have dementia
(NHS Digital, 2020)

46.2%
of social care users, aged 65+, have as much social contact as they would like
(ASCOF, 2021-22)

526 per 100,000
adults aged 65+ are permanently admitted to residential and nursing homes
(ASCOF, 2021-22)

Disease burden

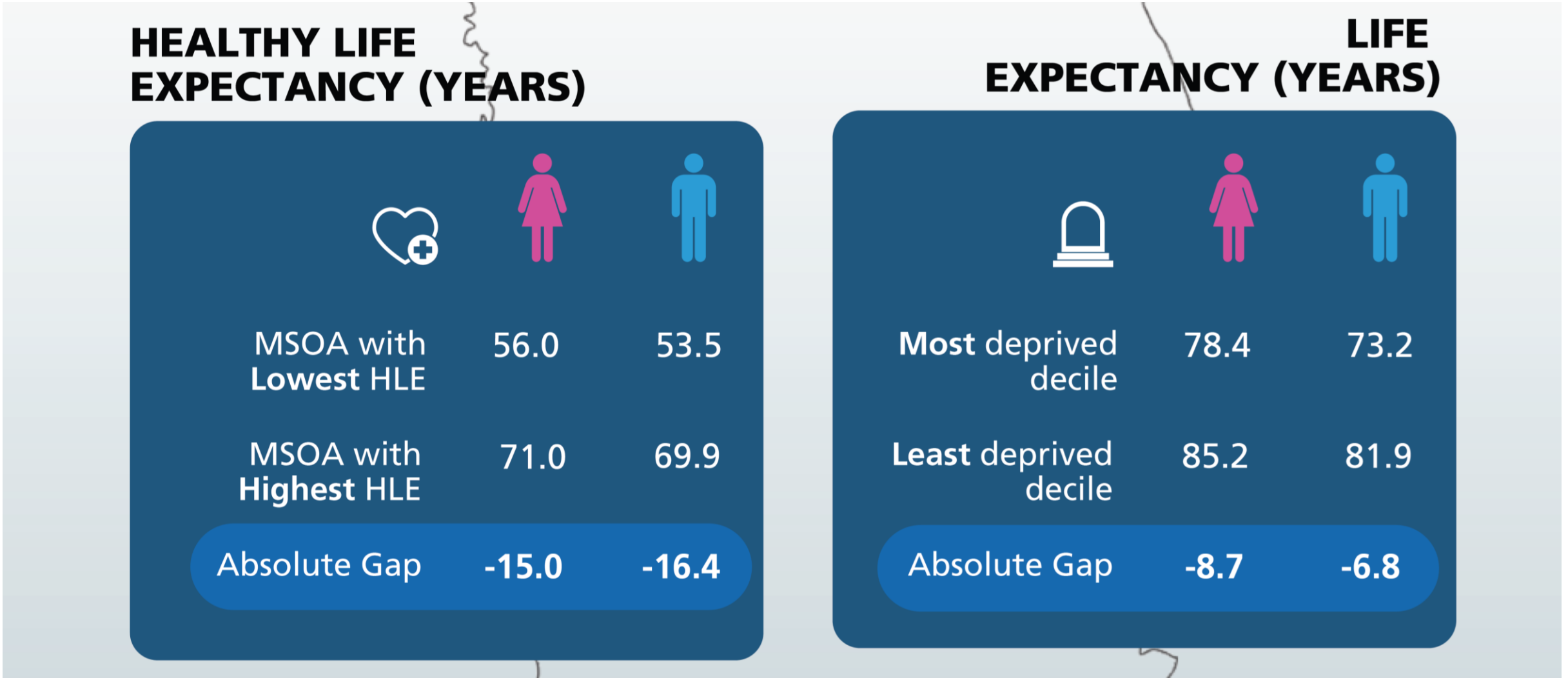
The top causes of years lived with disability for older adults in Lincolnshire are:

1. Low back pain
2. Diabetes
3. Age related hearing loss
4. COPD
5. Osteoarthritis

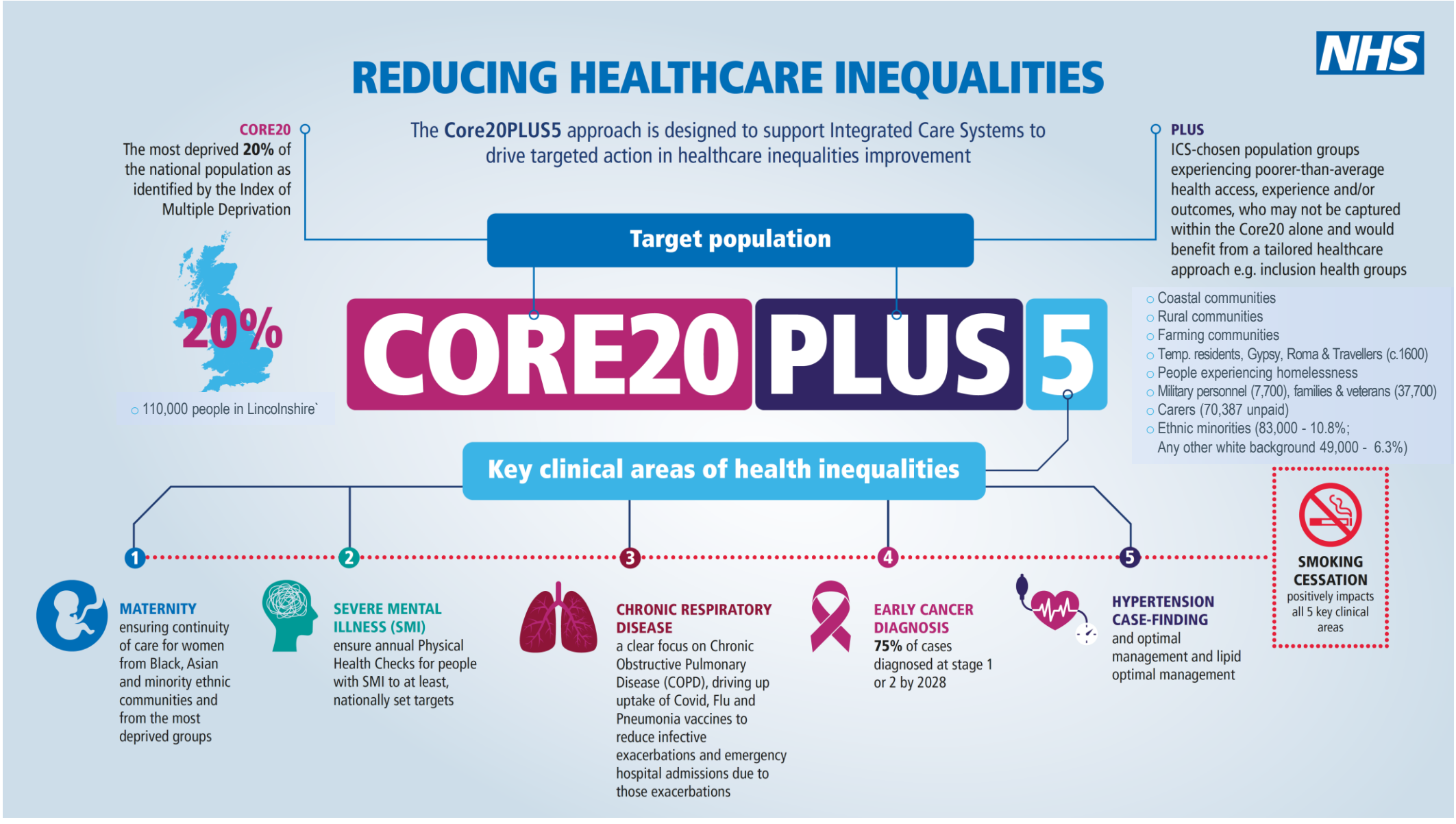
(GBD, 2019)

JSNA
Last updated March 2023

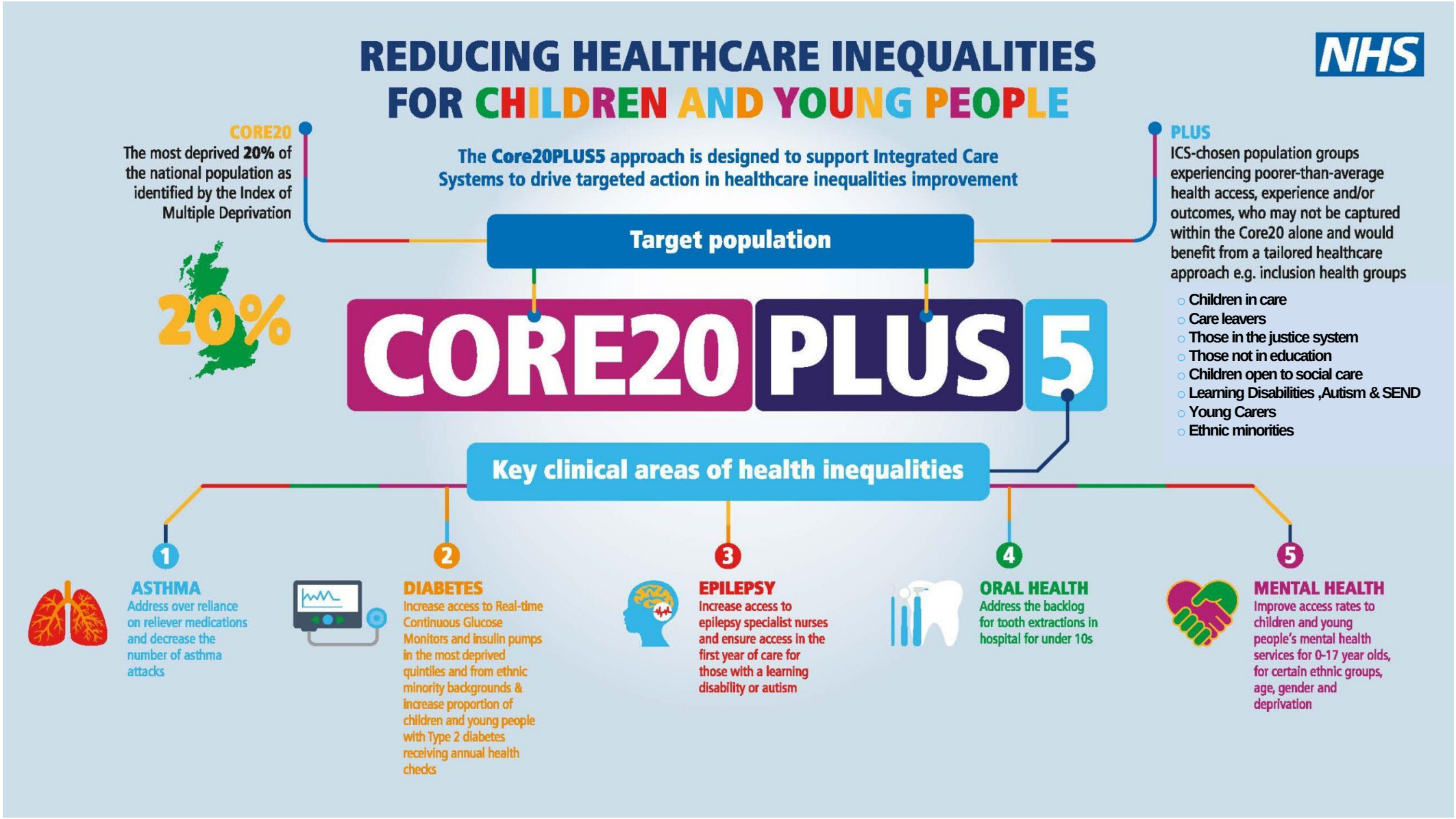
Health Inequalities: Life & healthy life expectancy gaps in Lincolnshire



Health Inequalities: Target Populations - Adults



Health Inequalities: Target Populations - Children & Young People



Lincolnshire Population Segmentation Model | Introduction

In population health management, a population segmentation model is used to categorise a large population into distinct groups or segments based on specific shared characteristics or health-related factors. The purpose of using a population segmentation model is to gain a deeper understanding of the population's health needs, preferences, and risks, and to tailor interventions and strategies accordingly. Critical purposes of using a population segmentation model in population health management include:

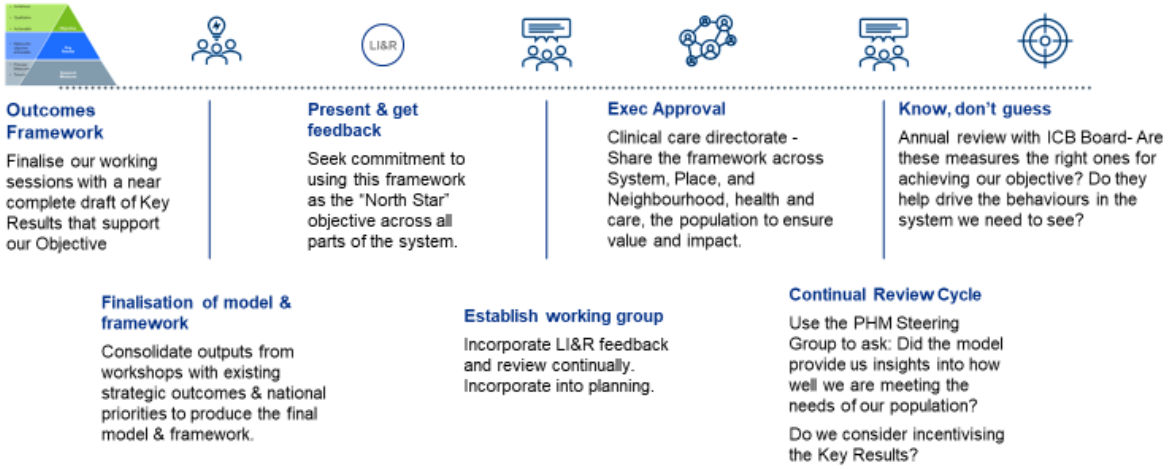
1. **Targeted Interventions**: Population segmentation helps identify subgroups within the population that have similar health characteristics or needs. By understanding the unique characteristics of each segment, organizations can design targeted interventions and programs to address specific health issues faced by each group. This approach increases the effectiveness of interventions by focusing on the needs of each segment.
2. **Resource Allocation:** With limited resources available, population segmentation helps prioritise resource allocation based on the identified health needs of different segments. By understanding the prevalence and severity of health conditions within each segment, healthcare systems can allocate resources strategically to provide optimal care and support where it is most needed.
3. **Risk Stratification:** Population segmentation enables risk stratification, which involves identifying individuals or subgroups at higher risk of developing certain health conditions or experiencing poor health outcomes. By categorising the population into risk tiers, healthcare organizations can proactively intervene and provide preventive care to individuals at higher risk, potentially reducing future healthcare costs and improving overall health outcomes**.**
4. **Health and Care Planning:** Population segmentation models inform healthcare planning by providing valuable insights into the health status, utilisation patterns, and needs of different population segments. This information helps in forecasting future healthcare demands, designing appropriate healthcare delivery models, and developing targeted health promotion campaigns
5. **Evaluation and Monitoring:** Population segmentation allows for better evaluation and monitoring of improvement initiatives. By comparing outcomes and health indicators across different segments, the system can assess the effectiveness of interventions and make data-driven decisions to refine and improve their population health management strategies.

Overall, the purpose of using a population segmentation model is to identify and understand the diverse needs of different population segments, enabling healthcare organisations to deliver targeted, efficient, and effective interventions and ultimately improving health outcomes for the entire population.

Design of The Lincolnshire SSM

The Lincolnshire SSM has been co-designed by a cross-system group of subject matter experts over a number of months, working to a directive and ambition from a system-wide Executive Leadership group.

The Lincolnshire SSM is an MECE model, this is a Mutually Exclusive Collectively Exhaustive model used to group data into categories that follow two specific rules: Mutually Exclusive – An item (or individual) can only be in one category at a time; and Collectively Exhaustive – All items (or individuals) must be included in one category. The MECE method is an analytics standard and makes it easier to analyse and derive useful conclusions, in this case on the focus of attention and resources across population need in relation to health and care.



Lincolnshire Population Segmentation Model | Application

The Lincolnshire Strategic Segmentation Model & the Joint Forward Plan

Currently in Lincolnshire we predominantly arrange ourselves around those parts of the system that are under pressure, and which require specific attention, such as UEC, or planned care, with a few notable exceptions such as the recent Frailty initiative. A system focus can be incredibly useful for making short term or rapid change to efficiency, productivity or quality of processes or pathways.

However, it is very difficult for direct care or clinical pathway stakeholders to make meaningful upstream change outside of their area of accountability or remit. Without upstream impact - prevention, early intervention, system transformation across organisations, workforces, contracts and resources – we cannot make any longer-term improvement to the cause of our pressures. Taking this traditional approach, we cannot switch from an organisation, system or disease pathway focus to a population health outcomes focus; or from a system designed to treat ill-health to one also designed to proactively prevent ill-health and intervene in the wider determinants of health.

Together the system planning approach and SSM present a huge opportunity for the Lincolnshire ICS to think differently about how we meet the challenges within our system whilst, and by, concentrating on the outcomes for our population.

We need to consider whether the current governance structures that we have in place meet the needs of each of our population segments and whether accountability for the outcomes for those segments is sitting with the right groups or individuals (or in some cases, with anyone at all). It is likely that we will need to rearrange some of our governance structures across the ICS to be able to respond effectively and make longer term improvements which focus proactively on population outcomes and the causes of ill health and system pressures, rather than reactively on the implications of that ill-health.

Adoption and Use

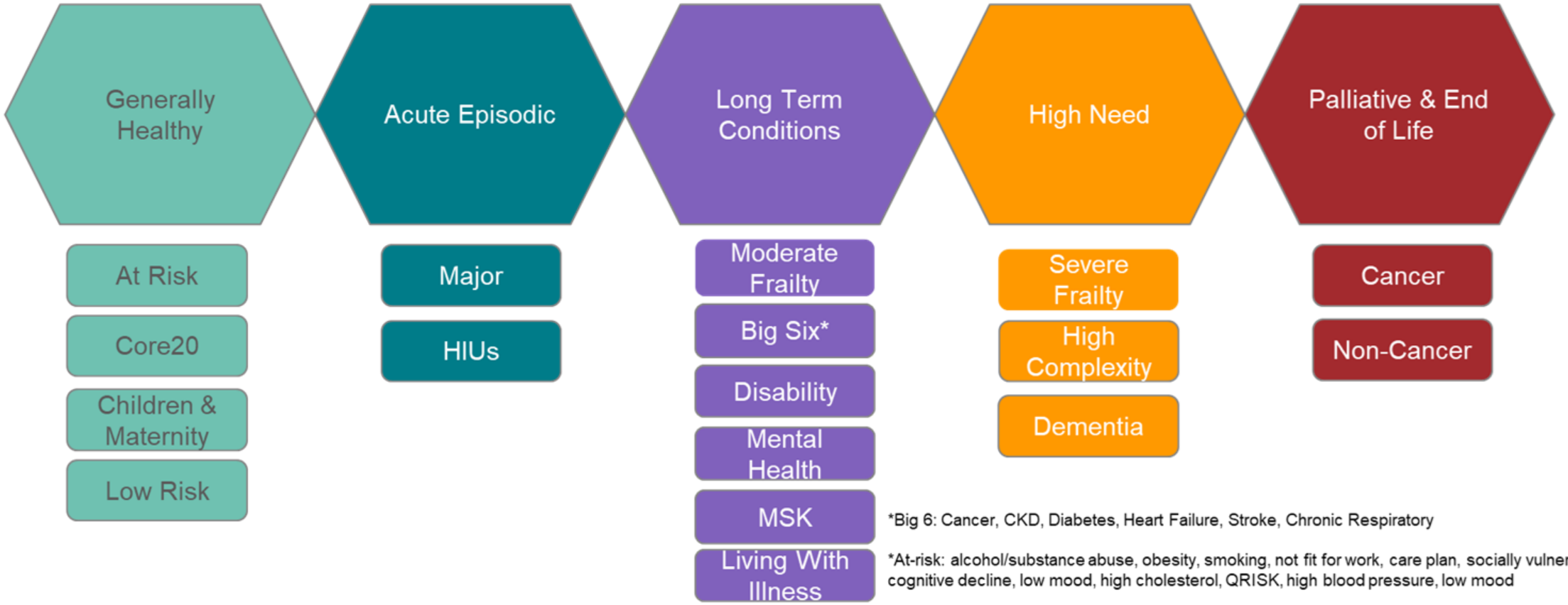
To gain maximum benefit for our local people from taking a consistent PHM approach in Lincolnshire and utilising a segmentation model to identify opportunity for improvement and monitor impact, it is recognised that an incremental approach to adoption will be required.

This model will not be able to be successful in isolation and therefore requires recognition and adoption by all partner organisations and to form part of the core infrastructure of the ICS. The plan for this will need to be codesigned throughout 23/24 with key partners such as the Clinical & Care Directorate, Strategy & Planning Directorates and other system stakeholders.

Approval of the *concept* of this segmentation model has been sought and received from all organisational boards and the ICS Clinical & Care Directorate. Detailed planning for implementation and adoption will continue into 2024/25, This is complex and needs to take account of: NHS England's operating model, regulatory factors/requirements and evolving system discussions regarding functions, roles and accountability.

In the meantime, we will continue to signal our system intent to use this approach, with specific areas of work e.g. framing the stocktake of population healthcare needs with the five segments; mapping service lines and system transformation programmes to the segmentation model; starting to analyse and report against these segments.

Lincolnshire Segmentation Model | Summary View



*Big 6: Cancer, CKD, Diabetes, Heart Failure, Stroke, Chronic Respiratory

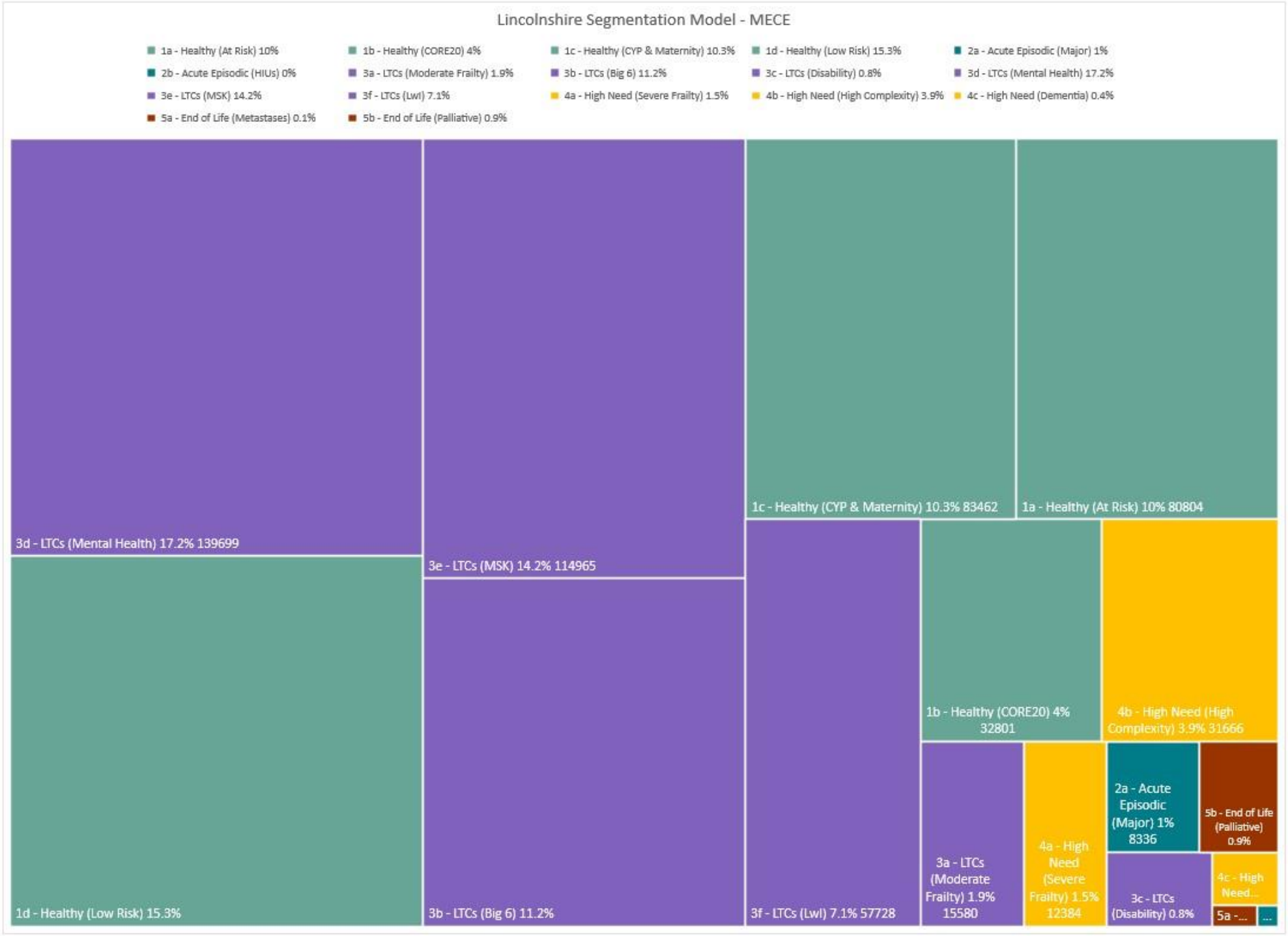
*At-risk: alcohol/substance abuse, obesity, smoking, not fit for work, care plan, socially vulnerable, cognitive decline, low mood, high cholesterol, QRISK, high blood pressure, low mood

*MSK: admission, outpatient attendance, or is on a waiting list, for one of the following specialties - Trauma and Orthopaedics, Rheumatology, Physiotherapy Service. We have also looked in the primary care dataset to look for any complaints of musculoskeletal pain, history of MSK issues or and referrals to a MSK Service.

*Mental Health: depression, anxiety, serious mental illness (e.g. bipolar & schizophrenia)

*Frailty: as defined by Electronic Frailty Index (eFI), these segments are defined by a high number of frailty deficits

Lincolnshire Segmentation Model – Cohort sizes



Segments by Spend and decile of multiple deprivation

Bringing together the population segmentation model and health inequalities

- The charts over the next five pages focus on each headline population segment and show the total population in the segment, and the Spend Per Person Per Year, split by the national decile of multiple deprivation within which those people live.

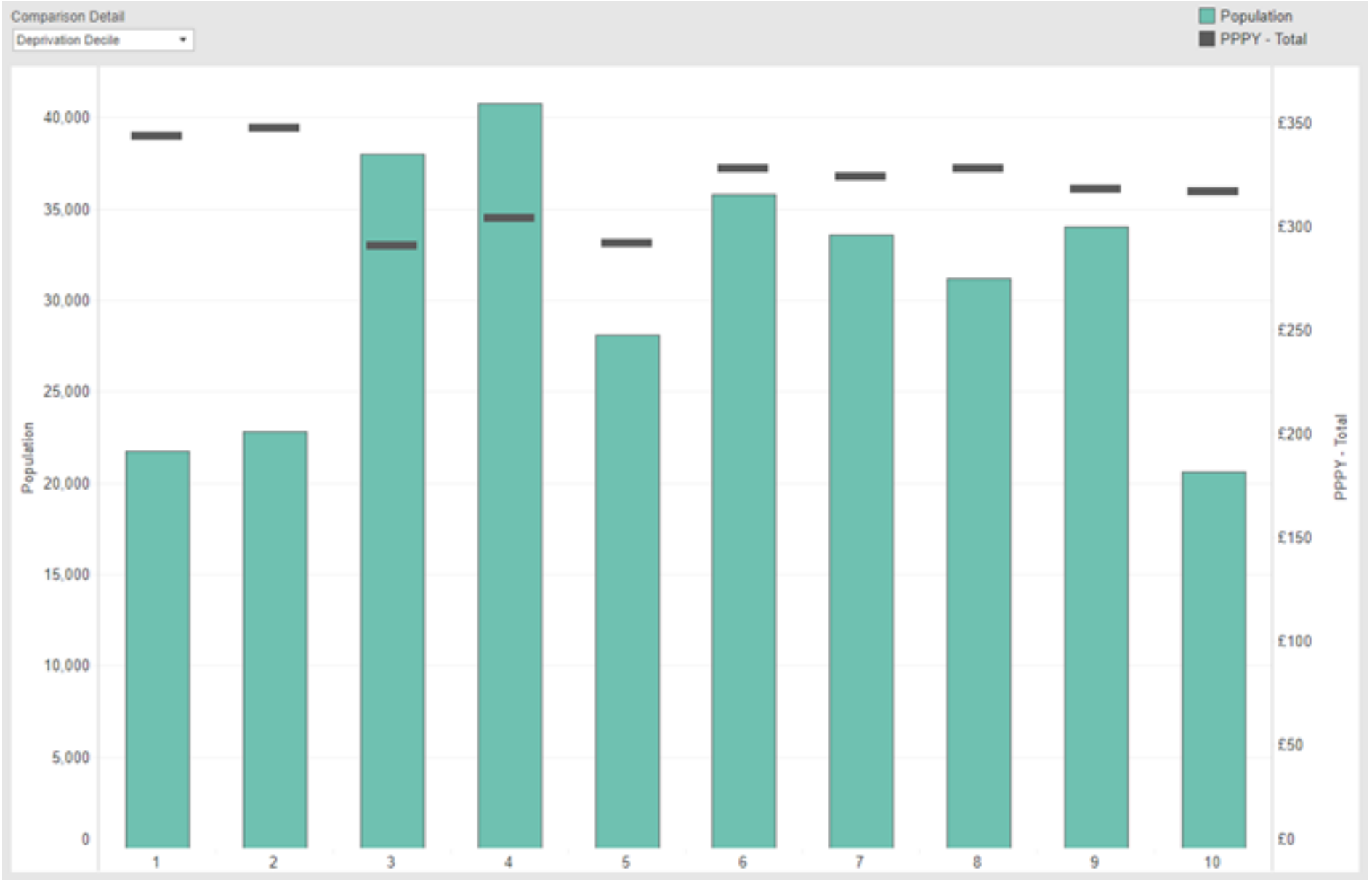
- IMD Deciles are national ones, reflecting where Lincolnshire's communities feature in the national scale of deprivation. This means that the number of people in each IMD decile in Lincolnshire is different depending on how relatively deprived they are.

- Therefore, population numbers are incredibly useful for understanding the *scale* of need.

- Spend Per Person Per Year (PPPY) is comparative and useful for understanding differences in the indicative cost of care for individuals in any given decile of a segment.

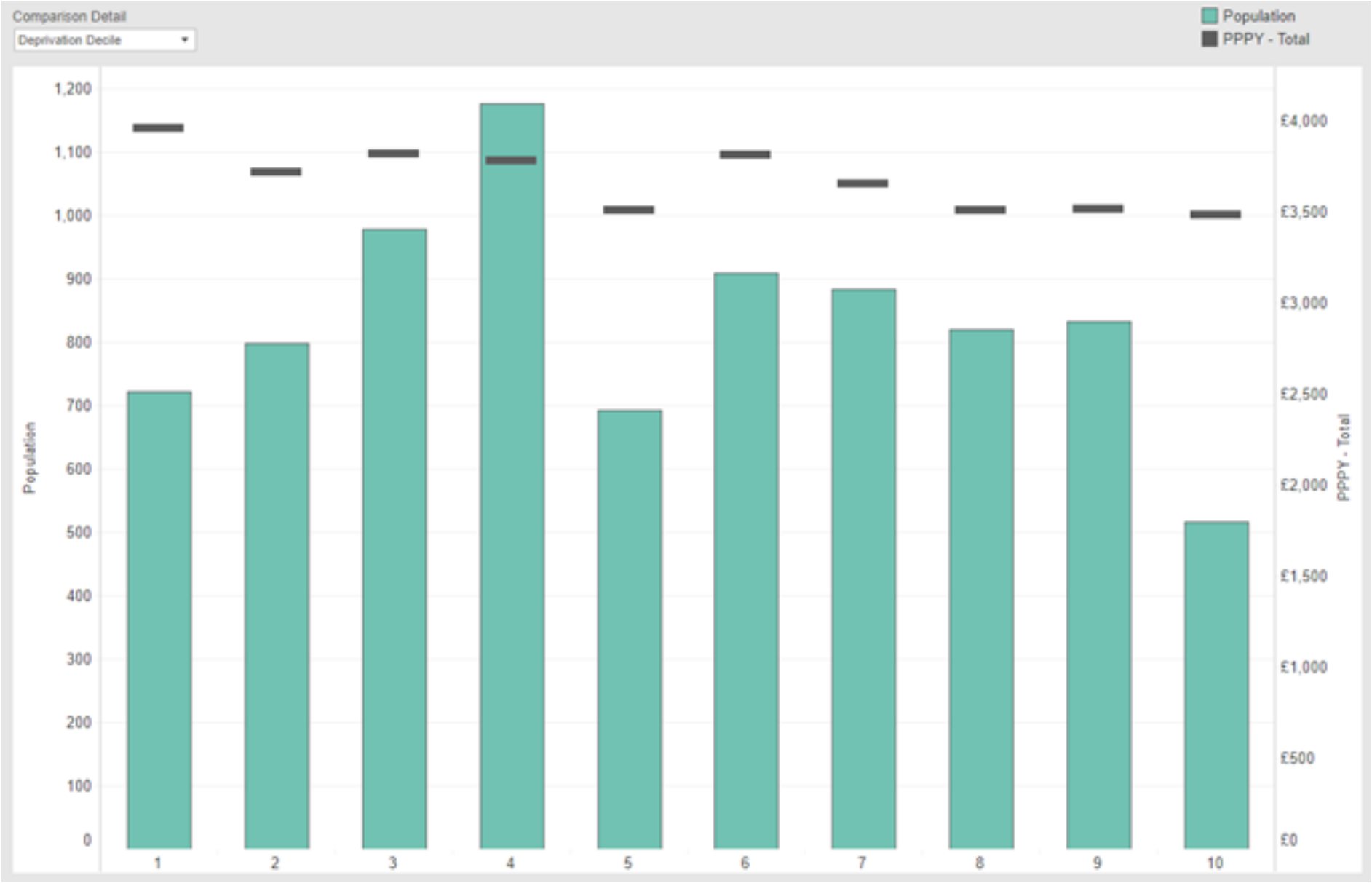
- This is why Lincolnshire has higher numbers of people in the middle deciles of any segment, as we have higher populations generally in the moderate range of deprivation deciles. However, there are clear gradients in the individual indicative cost of care for people in almost any segment when you look from the most deprived deciles (1 and 2) to the least deprived (9 and 10).

Segments by Spend PPPY and IMD Decile: 1. Generally Healthy



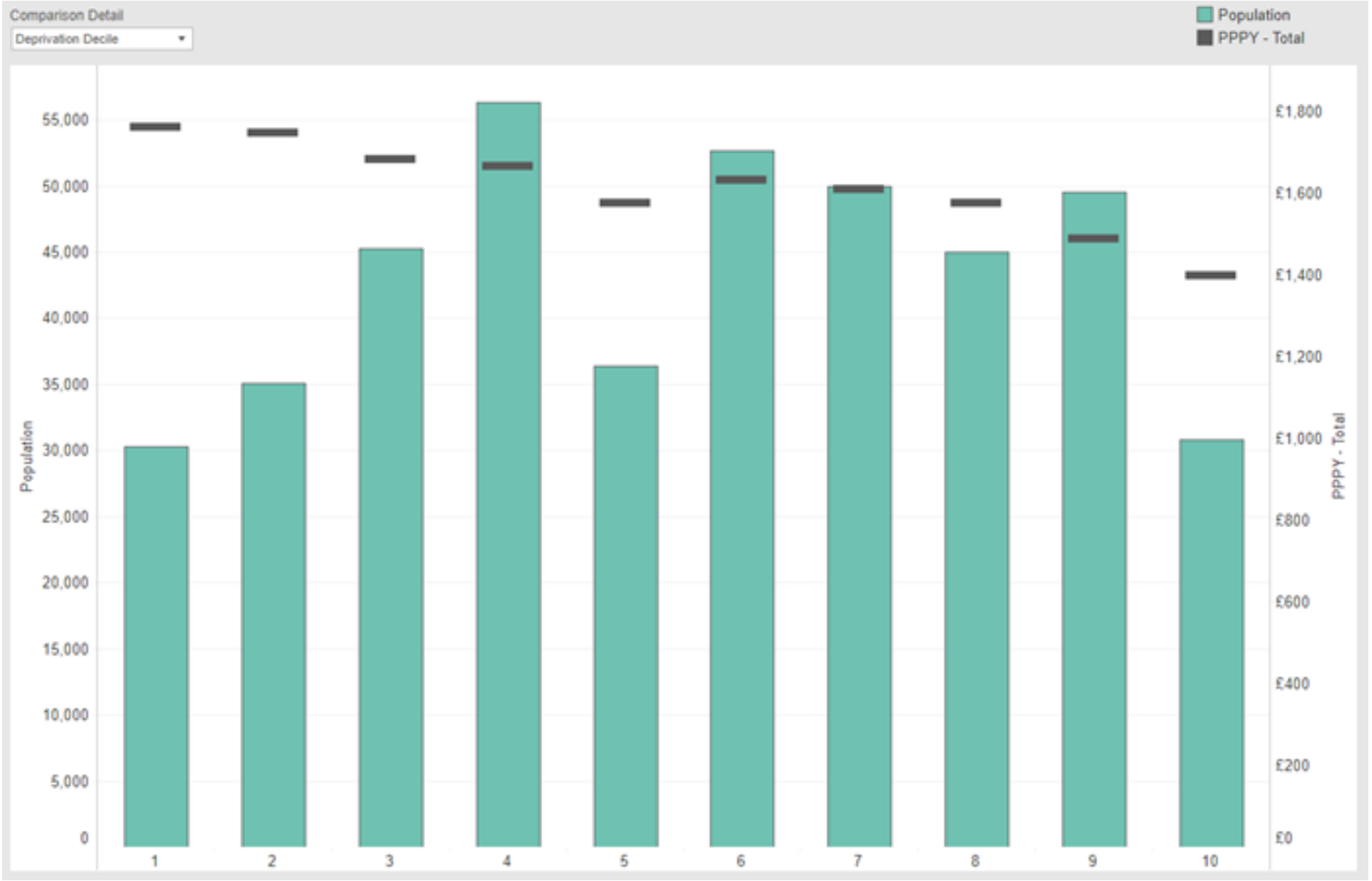
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY and IMD Decile: 2. Acute Episodic



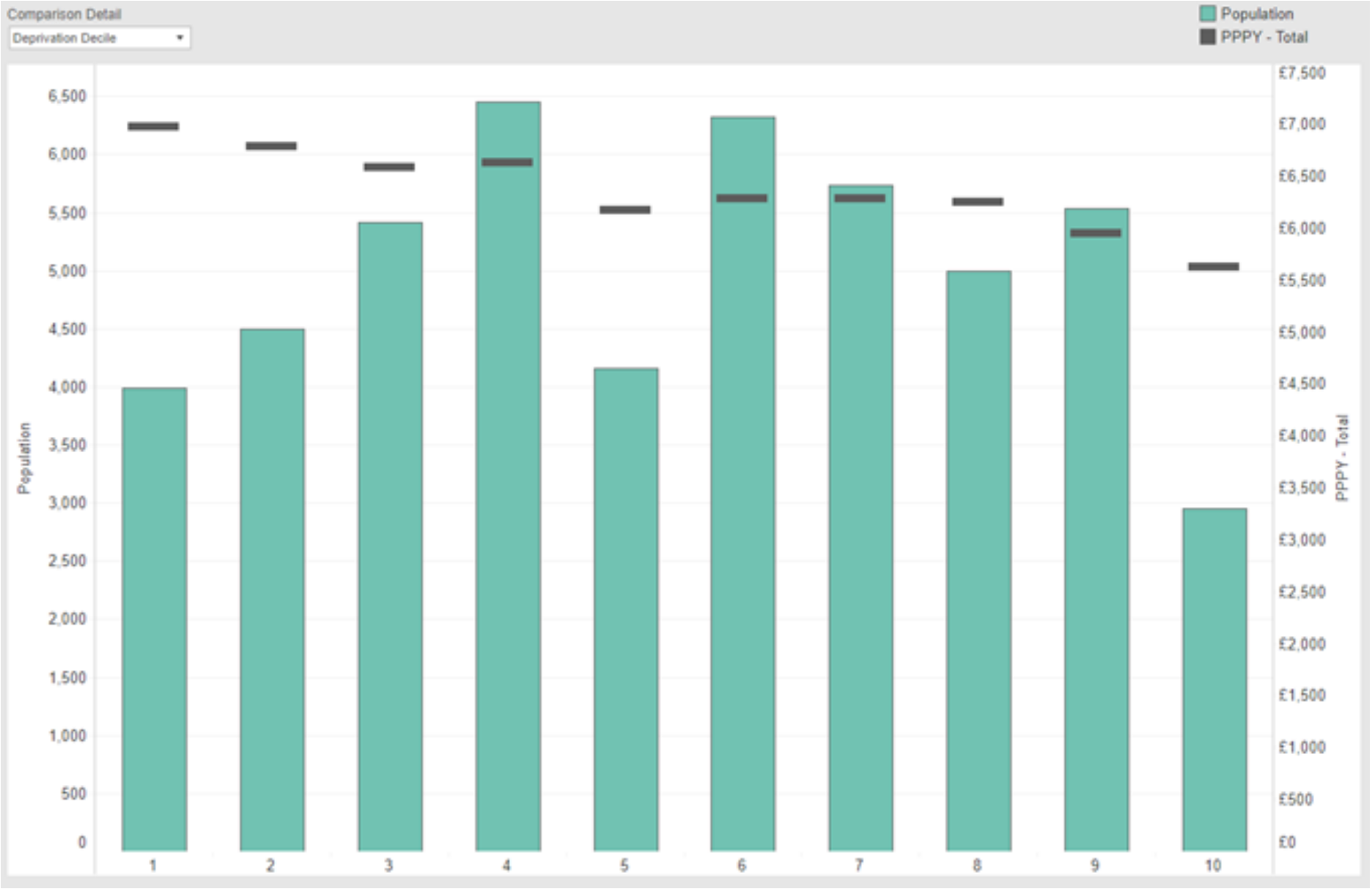
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY & IMD Decile: 3. Long Term Conditions



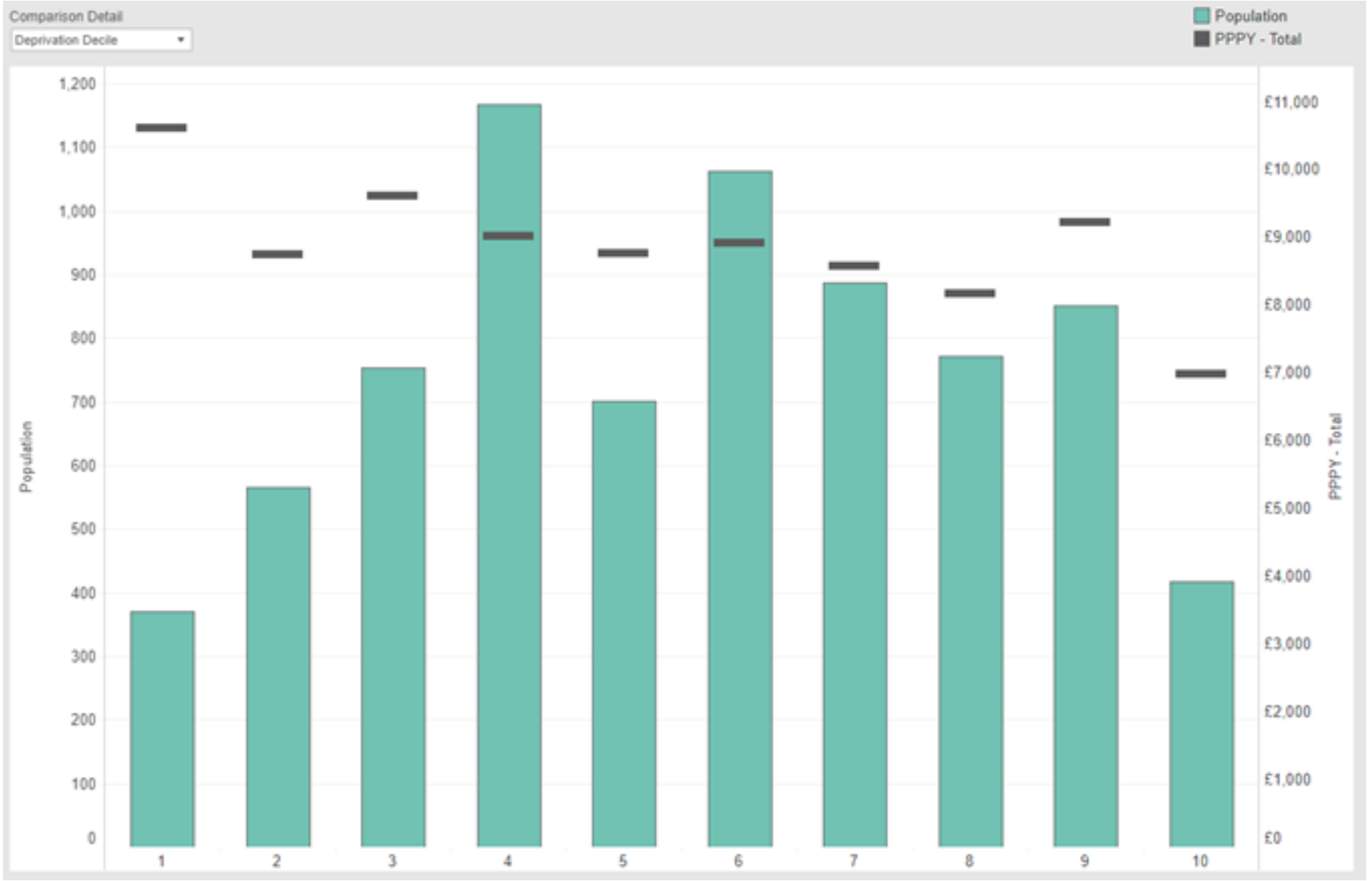
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY and IMD Decile: 4. High Need



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY and IMD Decile: 5. Palliative & End of Life



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Section 3: Our 2023-28 priorities

a) Cross-cutting methodologies
   - Personalisation | Health inequalities

b) Service transformation & improvement programmes
   - Primary Care, Communities & Social Value | Urgent & Emergency Care | Planned care, cancer & diagnostics | Local Maternity & Neonates System | Children & Young People | Mental health & Dementia | Learning Disabilities & Autism | Medicines optimisation

c) Enabler programmes
   - People & Workforce | Digital, Date & technology | Estates | A Greener NHS

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

1. Future state

- Personalisation is rooted in the belief that we all want the best life for ourselves and those we care for, whatever our age or stage of life. It's a way of working that changes the conversation from 'what's the matter **with you**?' to 'what matters to you?' and should be seen as a **significant cultural and behavioural transformation for Lincolnshire's health and care system and population**.

- Collectively our aim is to evolve the relationship and conversations between people, professionals and the health and care system to one which focuses on people's strengths and assets and 'what matters to them' - providing a positive shift in power and decision making that enables people and those who are important to them to have more choice and control to be able to live their best life.

- **Personalisation** is a critical enabler and a **generational behaviour change**, that will help to transform the way we work with and improve outcomes for people and carers of all ages in Lincolnshire.

Our Shared Agreement

Being prepared to do things differently

Together we will:
- Be open to change and acknowledge it will take time
- Have patience and learn by doing
- Have and give permission to do things differently

Understanding what matters to ourselves and each other

Together we will:
- Offer a safe non-judgemental environment for you to be open and honest and to be ourselves
- Embrace and value differences and implement this in a person-centred way
- Make no decisions about you without you

Working together for the wellbeing of everyone

Together we will:
- Walk alongside you instead of leading you by asking the service users, carers and all involved in their care, what their goals are and how we will achieve them together
- See the wellbeing of staff as equally important

Conversations with and not about people

Together we will:
- Recognise the importance of active listening and having time to make choices
- Do what we say we will do, in an environment of openness and honesty
- Offer information, knowledge and skills

Making the most of what we have available to us

Together we will:
- Be honest about what is and isn't available
- Recognise our own strengths and opportunities
- Recognise support starts with the individual, family and community
- Actively support communities to best manage their health and wellbeing

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Working with people with lived experience and colleagues from across the health and care system have come together to help describe what a better relationship should and could feel like. The work is being developed under the term ‘Our Shared Agreement’ and through co production we have developed a set of 5 foundations that help to describe how we will and shall work together, recognising that this will change and evolve over time. More information about the Our Shared Agreement can be found here.

Collaboration with Population Health Management intelligence will enable us to identify where we can have the biggest impact on improving Health Inequalities for the population using personalised and strength-based approaches.

Embedding proactive strengths- based personalised ways of working together with people and carers should be considered an integral way to how we deliver services. Such as,

- Including people in any service redesign through Co - Production.
- Through exploring and understanding what’s important to people and their carers through ‘what Matters to You’ conversations
- Proactively planning for now and into the future through personalised care and support and advanced care planning which are owned by the person and shareable to all relevant parties.
- Ensuring that people and carers have meaningful information that enables them to make a shared decision with health and care professionals about their treatment, care, health, and wellbeing.
- Working together to understand people’s knowledge and skills and confidence to look after their own health and wellbeing, through coaching and strength-based conversations and tailoring the intervention accordingly.
- Supporting people to feel connected and engaged in their local communities.

National Guidance/Requirements

- NHS Long term Plan and NHS Universal Personalised Care
- NHSE Guidance Proactive care: providing care and support for people living at home with moderate or severe frailty (published Dec 23)
- Support for 2023/24 system planning for Community Health Services (CHS) including Personalised Care LTP commitments.
- NHSE Major Conditions Strategy (out for consultation)
- Fuller Stocktake (Primary Care)
- People at the Heart of Care: Adult Social Care Reform White Paper
- Think Local Act Personal (TLAP) Making it real, how to do personalised care and support.

Local Strategies

- Integrated Care Partnership Strategy (ICP) – Key Enabler 3 Personalisation
- Joint Forward Plan (JFP) – Priority 1 – A better relationship with the people of Lincolnshire
- VCSE Alliance Community Strategy
- Community and Primary Partnerships (CPP)

Evidence Base

The Long-Term Plan mandates that personalised care will become business as usual across the health and care system and Personalisation will contribute to national priorities (reducing occupancy rates, unnecessary appointments, AARS roles delivery, proactive support and enhanced community response).

Personalisation is explicit in the Fuller stocktake recommendations and implicit in the recent Hewitt report. Personalisation contributes to delivery of Network Contract Directed Enhanced Services and Quality and Outcomes Framework and will be a key element of the anticipated NHSE ‘Proactive Care’ framework.

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

The Adult social Care white paper, People at the Heart of Care, sets out an ambitious 10-year vision for how support and care will be transformed in England. The vision puts people at its heart and revolves around 3 objectives:

1. People have choice, control, and support to live independent lives.
2. People can access outstanding quality and tailored care and support.
3. People find adult social care fair and accessible.

Emerging evidence base is demonstrating the impact personalised approaches can have on reducing demand

1. What Matters to you conversations, supported Self-Care and Self-Management

- Only 55% of adults living with long-term conditions feel they have the knowledge, skills and confidence to manage their health and wellbeing on a daily basis
- If people and carers are more informed, better activated, and have a clear plan they are likely to have: 18% fewer GP contacts; 38% fewer emergency admissions; 32% fewer attendances to A&E
- People most able to manage a mental health condition, as well as any physical health conditions, experienced 49% fewer emergency admissions than those who were least able
- Providing better personalised support to those least able to manage, can reduce A&E attendances by 6% & emergency admissions by 7% (Health Foundation, 2018)

2. Shared Decision Making / Strength Based Approaches

- People have long been saying that they want to be more involved than they currently are in making decisions about their own health and health care (Care Quality Commission Inpatient Survey 2020; GP Patient Survey 2022; Community Mental Health Survey 2021).
- In all three surveys on average 50% of people state they are not as involved in the decision making about their care and treatment as they would like to be.
- Cochrane Review 2017 states; optimal shared decision-making improved communication, information sharing and risk assessment, thereby helping patients feel more satisfied with their choices, knowledge base, and decisions. Optimal shared decision making also helps to reduce repeat appointments, therefore, saving time in the long run.

3. Non-medical interventions such as Social Prescribing and Health Coaching

- Reduced the need for a GP appointment by 28%
- Reduced the need for A&E by 24%
- 20% GP consultations are for non-medical interventions such as psycho, social, and economic issues.
- 4% of GP appointments could be dealt with by Social Prescribing link worker
- NHS Alliance & Primary Care Foundation (2015)

4. Social isolation and loneliness is harmful.

- It can shorten people lives – risk of dying prematurely by 30%
- It damages peoples physical and mental health
- It reduces their quality of life
- Worse for us than obesity and lack of physical activity
- 16 – 24-year-olds the loneliness in society (UK)
- People are more likely to survive cancer than loneliness – 3.8 million people living with chronic loneliness compared to 3 million people with cancer

Scope

- In Scope:
  - Adults, all organisations,
  - PHB's – cultural and behaviour change
- Out of scope:
  - Children and Young people – until more resource and capacity is made available.
  - PHB's operational delivery – sits with the CHC & PHB team

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

2. What's being done to get there | Overview

- The approach: Continuing to co-produce and develop the building blocks around personalised and strengths-based approaches
- Areas of focus: working with stakeholders to understand the programme interdependencies around service redesign work and agreeing the implementation and delivery timescales.

Culture and behaviour change • Our Shared Agreement • Co – Production	- Working with partners and people with lived experience to 'bring to life' and demonstrate what a better personalised and proactive relationship between people and the health and care system could look like and the impact it could have. - Exploring the use of language across the health and care system to support a shift from deficit based – what's wrong with you, the team, organisation, system to strengths based – what's strong in you, team, organisation, system. - Feeling comfortable having open and honest conversations as part of the evolving relationship between people and the system. - Working together better with people and professionals to develop and improve services.
Workforce and People	- Focus on people's strengths and assets, and 'what matters' to them, enabling shared decision making that prepares and encourages people to have more choice and control and to live their best and healthiest life.
Workforce Development	- Training teams in new tools and techniques, coaching and motivational interviewing, strengths-based approaches and analysing impact.
Toolkit / Resource Development	- Ease and simplify ways of embedding strengths - based and personalised approaches into new pathways and service redesign.
Social Prescribing and community-based development	- Supporting the procurement of Lincolnshire's social prescribing link worker model. Working with partners to develop a shared vision and plan for the wider social prescribing model that considers the two procurement exercises that are underway – ICB Social Prescribing link workers and LCC Wellbeing Lincs
Social Movement	- Developing a network of champions, advocates, and voices of personalised care in Lincolnshire

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Area of work (2024 – 2026)	Programme Lead	Stage	Proposed Implementation dates
1. Frailty	ICB / Group	Scoping	Jan 24 – 26
2. Serious Mental Illness – Physical Health Checks	ICB	Scoping	Jan 24 – 26
3. Muscle Skeletal pathways – Hip and knee -Embedding personalised approaches	Personalisation	Consultation/ Implementation	Jan 24 – 26
4. Roll out of High Intensity Use of secondary care	ICB – PCCSV	Delivery	Spring 24 onwards
6. Social Prescribing & Community Based Development	LVET & Personalisation	Scoping	Sept 24 – March 25
7. Improving Access – Framework for Lincolnshire's Hubs	Personalisation	Planning	June 24 – March 25
7. Transfer of Care hubs (reflective learning and development)	Home First Partnership / UEC	Scoping	Sept 24 – March 25
8. Direct Payments / Personal Budgets	LCC	Scoping	TBC

Response to potential improvement opportunities

- Reduction in people on MSK waiting lists
- Improving access to health and care services

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

3. What's being done to get there | Detail

Initiative	Deliverables	24/25				25/26	
		Q1	Q2	Q3	Q4	Q1	Q2
Culture and Behaviour Our Shared Agreement (OSA) and Co-production	1. Co-producing with people with lived experience and staff a way of describing, illustrating and demonstrating the shift in relationships between people, staff and the Health and Care System.	■	■	■	■	■	■
	2. Funded 12-month implementation plan to be developed		■				
	3. Embedding into the Community Primary Partnership programme	■	■	■	■	■	■
	4. Extending the reach of the OSA	■	■	■	■	■	■
	5. Creation of OSA assets / bringing it to life for people		■	■	■	■	■
	6. IAAP champions have access to a co-produced OSA awareness raising toolkit and know how to use it effectively.		■	■			
	7. IAAP champions are strong advocates for the OSA.				■		
	8. An agreed number of the public are trained in community reporting				■		
	9. Call out for personal stories/experience that illustrate one or more of the foundations (Story Matrix)	■	■	■	■	■	■
	10. Embed the OSA agreement in areas of service redesign (LACE, Hospital Discharge, MSK hip and knee pathway)	■	■	■	■	■	■
	11. Personalisation evaluation and impact framework is launched on the website		■				
	12. Supporting ICP Board Development sessions re: Priority one: Personalisation		■				
	13. Launch of the Our Shared Agreement		■				
	14. BLLLT and the ICP Board have committed to a shared Co – Production Strategy.					■	
	15. Increase the number of Co – Production Champions	■					■
	16. Co-production with people with lived experience are part of service redesign in 5 programmes: frailty, MSK, SMI physical health checks, Social Prescribing, ACCW (LCC)	■	■	■	■	■	■
	17. Lincolnshire ICS Co - Production strategy forms part of organisations planning cycle.						■
	18. Encouraging ways of working that are based on collaboration, information sharing and a holistic approach to health and wellbeing.	■	■	■	■	■	■
	19. Supporting a workforce culture of feeling comfortable and confident having strength-based person-centred conversations with people through learning and development opportunities (Dr Ollie Hart & Tommy Whitelaw)	■	■	■	■	■	■
	20. 12 stories / case studies will be used to showcase how the better relationship is improving across the ICS.				■		

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

3. What's being done to get there | Detail

Initiative	Deliverables	24/25				25/26	
		Q1	Q2	Q3	Q4	Q1	Q2
Workforce Development	1. Co production of a Personalisation and Strength based curriculum that is included in statutory sector induction and mandatory training.						
	2. Co-Produced Train the Trainer programme (Personalisation, Shared Decision Making, Personalised care and support planning, Strengths based approaches, motivational interviewing, our shared agreement)						
	3. Working with partners to commission a L&D programme for Strength based personalised approaches for 24/25						
	4. Map trusted assessor models and share best practice (LCC)						
	5. Baselining and TNA for target groups of staff (frailty / transfer of care hubs hospital discharge)						
	6. Co – Production and roll out of a learning and development programme that covers PCA, SBA, OSA, PCSP, PAM etc, to agreed cohorts of staff						
Communication and marketing campaign – creating a social movement	1. Develop, deliver and promote a range of Personalisation communication assets and events. (Podcasts, newsletters, blogs, social media activity, roadshows) plus OSA see above.						
	2. Review and redesign of the IAAP website to be the home of the 'how' to embed strength based and personalised approaches.						
	3. IAAP Conference 24 – Our Shared Agreement and Co - Production						
	4. Co-producing material that promotes shared decision making and preparing People to have confidence to ask questions about their treatment, their health and wellbeing. (MSK hip and knee Pathway)						
	5. Working with Primary care to develop Social Prescribing and personalised care roles assets that educate and promote the value and importance of Social Prescribing and the wider roles that support Personalised Care						
	6. Recruitment campaign for It's all about People Champions						
	7. Developing a space on the website for the IAAP champions						
Social Prescribing (part of service redesign work on JFP)	Working with partners to develop a shared vision and plan of social prescribing that considers the two procurement exercises that are underway – ICB Social Prescribing link workers and LCC Wellbeing Lincs.						
	Paper to SMODG re: Options appraisal for the future funding of Social RX						
	Supporting the re-commissioning of Social Prescribing Link Workers (ICB led procurement)						
	Working with the ICB and primary care to develop and deliver a comprehensive engagement and comms plan for social prescribing and the wider personalised care roles.						

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Initiative	Deliverables	23/24		24/25			
		Q3	Q4	Q1	Q2	Q3	Q4
Toolkit / Resource Development / Including Impact and Evaluation framework	1. Co - creation of an interactive 'how to' guide and options to embedding personalised and strengths-based approaches (web based), which will include a range of tools, techniques and evaluation options, including the Our Shared Agreement and co – production.						
	2. Information Standard for PCSP and Social Prescribing to be implemented (Mandated for NHS providers including Primary Care)						
	3. Standard operating procedure for Personalised Care and Support planning						
	4. Testing the patient activation measure (PAM) in service redesign as a way of understanding peoples skills, knowledge and confidence to be able to look after their own health and wellbeing, thus tailoring the response or intervention required.						
	5. Developing an option appraisal for Flourish the online PAM tool re: ongoing funding.						
	6. Promoting the use of digital technology and Technology Enabled Care (TEC), to encourage personal independence and support the embedding of strengths based and personalised approaches, with staff and people.						
	7. The IAAP evaluation and impact framework is updated with the OSA and embedded into service redesign work such as Community Primary Partnership and frailty.						
	8. Working with the LWC team to develop evaluated and quantifiable case studies and people's stories ready for use from April 25						
	9. Continuing to build personalisation and strengths-based approaches into the LACE processes for deep reviews.						
Service redesign	1. Working with engagement colleagues to facilitate co-production groups to support service redesign through the co-production champion network						
	2. Supporting the Frailty early adopter PCN's in embedding personalisation and strengths-based ways of working, alongside health inequalities and PHM.						
	3. Impact and evaluation framework to be tested out through the frailty work						
	4. Implementing decision support tools across the MSK pathway						
	5. Using the learning from the MSK work to explore the use of decision support tools across a range of pathways						
	6. Through a CPP lens, developing a Lincolnshire framework for 'hub's that support personalised ways of accessing health and community services, using the learning and evaluation from the Grantham Aches and pains hub, wellbeing hubs and PCN pop up events.						
	7. Scoping and baseline setting for personalised approaches in 2 service redesign areas SMI physical health checks and transfer of care hubs. (case for change, TNA, IAAP maturity assessment, outcomes)						
	8. PDSA methodology : embedding strengths-based personalisation approaches (transfer of care hubs & SMI Physical health checks)						
	9. Exploring new ways to contract and commission Personalised Care through outcomes measures						
	10. Processes and procedures are reviewed and amended to support working in a Personalised and strengths-based way						
	11. Increasing the personalised use of direct payments across adult social care (LCC) , and sharing the learning across the ICS.						
	12. Supporting early adopters of the CPP model with understanding their level of maturity to deliver personalised and strengths-based approaches						

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	L,S A	2023/24 Q1	Q2	Q3	Q4	2024/25 Q1	Q2	Q3	Q4	2025/26 Q1	Q2	Q3	Q4	2026/27 Q1	Q2	Q3	Q4	2027/28 Q1	Q2	Q3	Q4
Culture and Behaviour Our Shared Agreement and Co – Production	Working with partners and people with lived experience to 'bring to life' and demonstrate what a new personalised and proactive relationship between people and the health and care system could look like and the impact It could have	L	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro
	Working with partners and people with lived experience to develop, implement and deliver and evaluate a Co-production framework for ICS	S		Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro				
Workforce Development	Developing a Personalisation and Strength based curriculum that is included in statutory sector induction and mandatory training	L					Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro								
	Recruitment to the IAAP Train the Trainer programme.	L																				
	Co-Produced learning and development programme (Personalisation, SDM, PCSP, SBA, MI, OSA) – Test and learn in Frailty								Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro								
	Creating a space for reflective practice and action learning (Person centred learning network, personalisation Huddles, Personalised Roles society)	L																				
Communication and marketing campaign – creating a social movement	Development and implementation of a communication and marketing plan	L																				
	Development of a suite of Personalisation and OSA communication assets (Co – Produced)	L					Co- Pro	Co- Pro						Co- Pro	Co- Pro						Co- Pro	Co- Pro
	Holding Personalisation conference & roadshows which can be specifically tailored depending on audience i.e.: PCN's / Maternity	L			Co- Pro	Co- Pro	Co- Pro	Co- Pro		Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro		Co- Pro	Co- Pro	Co- Pro
	Launch and roll out of It's all about People Champions	L																				
	Co-producing material that promotes shared decision making and preparing People to have confidence to ask questions about their treatment, their health and wellbeing.	L				Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro
Impact and Evaluation Work	Implementation of the impact and evaluation framework in the IAAP programme plus further opportunities to explore where it could be used						Co- Pro	Co- Pro														
	Co – design of a qualitative, quantitative approach to using peoples stories / case studies to demonstrate impact.						Co- Pro	Co- Pro	Co- Pro	Co- Pro												

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	L,S, A	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tools and Resources	Co - creation of an interactive 'how to' guide and options to embedding personalised and strengths-based approaches (web based)	L			Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro												
	Embedding Personalised Care and Support Planning across the ICS – including a digital solution	L					Co- Pro	Co- Pro	Co- Pro	Co- Pro												
	Extending the use of Patient Activation Measure and decision support tools to understand impact and evaluation	PAM									Funding decision needed											
		DST																				
	Ongoing roll out of Strengths based approaches and Technology Enabled Care (LCC) – extending the reach into health	L																				
Service redesign: Embedding personalised and strengths-based approaches	Embedding strength based personalised approaches in service redesign programmes (phased over next 5 years)	S	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro		Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro		Co- Pro	Co- Pro
	Exploring new ways to contract and commission Personalised Care through outcomes measures	S																				
	Processes and procedures are reviewed and amended to support working in a Personalised and strength-based way	S								Co- Pro	Co- Pro	Co- Pro		Co- Pro	Co- Pro	Co- Pro		Co- Pro	Co- Pro	Co- Pro	Co- Pro	Co- Pro
	Increasing the personalised use of direct payments across adult social care (LCC) and sharing the learning across the ICS.	S				Co- Pro	Co- Pro	Co- Pro	Co- Pro													
Social Prescribing	Influencing and supporting the strategic development of social prescribing and community-based support in Lincolnshire	S						Co- Pro														
	Supporting a promotional campaign of personalised care roles in Primary Care. (social prescribing link workers, care coordinators and health and wellbeing coaches)	S						Co- Pro	Co- Pro	Co- Pro												

Personalisation

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4. Projected impact on patients and system partners

Please click on the link below to the It's all about people impact and evaluation framework. This is a developing piece of work that has been co – produced with people with lived experience and partners.

The framework has been developed around the 5 foundations of the Our Shared Agreement and has several longer-term outcomes identified plus more detailed KPI's and measures against each foundation. It also includes the benefits that can be attributed to people, workforce, and the system.

The sections highlighted in yellow are specifically relevant to the work the personalisation programme are leading on, the rest are system KPI's / measures that are relevant to all or some partners across the ICS.

The KPIs for 24/25 will be captured through the following methods;

- Peoples' stories and case studies
- Use of PHM data such as Theographs.
- ICB engagement surveys with the public.
- Personalisation Awareness Survey (Workforce)
- IAAP Maturity Assessment
- Personalised Care Institute Dashboard and the IAAP dataset– Workforce training data
- NHSE personalisation dashboard – PHB, Social Prescribing, PCSP and Shared Decision Making data
- Clinical Systems and Social RX– to corroborate NHSE data
- Flourish – Online Patient Activation Measure dashboard
- External research support for the MSK work which will support the wider programme

Extending the reach of the programme through

- Videos hits
- Attendance at the conference
- Podcast hits
- Website activity
- Attendance at Personalisation Huddles, webinars and the Person-centred learning network

Work is underway to develop a dashboard for the programme from September 2024 onwards which will bring together all the information, intelligence and data into one place

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

OSA Foundation	Outputs	Outcomes	
		Patients & Population	System Partners
Foundation 1 Being prepared to do things differently	Personalisation and Our Shared Agreement are included in the NHS Joint Forward Plan and the Integrated Care Partnership strategies OSA social change campaign Co – Production Strategy for ICS Co – Production groups are recruited to for all service redesign work Shared Plan for Social Prescribing and community - based support NHS Contracts and schedules include Personalisation outcomes Learning and development curriculum for Personalisation & Strength based approaches Review of HR processes to include personalisation and strength-based approaches.	People with lived experience and experts by experience are integral to the design, governance, delivery and review of care and health services. There is strong evidence the public have an awareness and understanding of Our Shared Agreement and there are examples where this is being brought to life. People who are accessing a newly redesigned service are reporting that the relationship is improving between themselves and those who provide services	Lincolnshire's ICS has fully adopted a personalisation and strength-based framework, which includes the Our Shared Agreement. The framework Includes business planning, contract & commissioning, decision making, workforce development & HR procedures. Lincolnshire's ICS will have committed to and adopted a shared Co-Production Strategy. Personalisation and strength-based approaches are recognised across all parts of the health and care system, including infrastructure services. Co production methodologies are embedded and integral to the process of service redesign across the integrated care system The Integrated Care System has a dedicated workforce who have time to be able to work with people to focus on the behaviour changes they need to make to improve their health and wellbeing A shared vision for the future of social prescribing and community-based support Personalisation and our shared agreement is included in the values-based recruitment policy for all statutory organisations and is a key part of the selection process as well as appraisal process/supervision processes Recognition of the importance of the voluntary, community, faith and social enterprise sector (VCFSE) and engaging them in discussions about system change and transformation from the beginning. Contracting, commissioning and procurement policies / processes considers / includes co– production and Personalisation as a core requirement

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

OSA Foundation	Outputs	Outcomes	
		Patients & Population	System Partners
Foundation 2 Understanding what matters to ourselves and each other	Evaluated and quantifiable case studies and people's stories . Standardised operating procedure for PCSP. Agreed digital solution for PCSP. Patient portal – access to PCSP Staff access the local PCSP offer. Patient Activation Measures Extensive learning and development offer Use of podcasts and other communication techniques to demonstrate the uniqueness of people Annual personalisation / OSA survey for public Personalisation awareness survey for workforce	People in Lincolnshire feel valued whether that is as a carer, person accessing services or family member, and is considered an expert in themselves/their own care and experience. We see people as individuals with unique strengths, abilities, aspirations and requirements and value people's unique backgrounds and cultures People are reporting that they are having what matters to you conversations and have been central to developing their PCSP along with those people who are important to them People feel more knowledgeable and confident about looking after their health and wellbeing.	We have 'what matters to me' conversations with people, find out their strengths and what they want to achieve and build these into their Personalised Care and Support Plans All relevant staff working on the agreed pathway development have completed appropriate personalisation and strength based approaches learning and development. We have a 'can do' approach which focuses on what matters to people and we think and act creatively to make things happen for them

Personalisation

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OSA Foundation	Outputs	Outcomes	
		Patients & Population	System Partners
Foundation 3 Working together for the wellbeing of everyone	Engagement plan for OSA which uses a range of techniques and methodologies to connect with people we don't normally connect with. Business case for additional resource to extend the remit of the programme to include children and young people. Personalisation and strength-based approaches is unincluded in induction and mandatory training. Collaboration with Lincoln Uni and other higher education providers to ensure personalisation is included in the local curriculums. Personalisation and strength-based approaches are included in • Organisational operational plans. • LACE deep dive processes • Service redesign process mapping. Partnership and collaborative working with other transformation programmes . IAAP Hub framework	**We are creative in how we engage with people including workforce . It is built on going to people and not expecting them to come to us .** People are able to access what they need, when they needs it, as organisations work seamlessly together for person centred outcomes.	We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services Personalised care and strengths -based approaches are expanded to services for children and young people by 2027/8 Workstreams are aligned and shared priorities identified (including across Health Inequalities, Population Health Management, Personalisation, Public Health, Social Care, PHBs etc) Staff report feeling their work environment enables them to work effectively with colleagues across the system There is a clear strategy in place to embed personalisation in workforce development at every level (training, degree, post grad, CPD etc) Staff training in care and health includes personalisation and the work of the personalisation programme is part of induction for all new staff

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

OSA Foundation	Outputs	Outcomes	
		Patients & Population	System Partners
Foundation 4 Conversations with and not about people	Use of decision support tools across a range of pathways Evaluated and quantifiable case studies and people's stories . Staff access the local SDM training. People Reported Outcome measures Annual personalisation / OSA survey for public Public information and leaflets are reviewed and co – produced (where possible) Public 'just ask' campaign Shared Decision Making is included in clinical pathway reviews. Reflective Practice opportunities - Personalisation Huddles (6 weekly) & Person Centred learning network (4 weekly)	People understand their own wellbeing needs and how to support themselves where possible People tell us they feel more actively involved and in control of their health and wellbeing People feel listened to and heard, and do not need to repeat their story unnecessarily. People tell us they have access to the information they need and understand to manage their condition/circumstances and know who to turn to for support People are supported through a range of approaches to feel more confident to ask questions about their health, care and wellbeing options.	Shared Decision -Making conversations are recognised and endorsed as best practice across the ICS, enabling more people to understand the benefits, harms and possible options available to them. Honest conversations and active dialogue between people and professionals are at the heart of everything we do Shared decision making is embedded in agreed pathways, processes and Standard Operating Procedures and learning is shared

Personalisation

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OSA Foundation	Outputs	Outcomes	
		Patients & Population	System Partners
Foundation 5 Making the most of what we have available to us	IAAP Hub Framework Collation and publication of People's and workforce stories Bespoke and commissioned learning and development offers Toolkit for services / practitioners to use to support the embedding of Strength based personalised approaches inc evaluation and impact framework in service redesign work Contract and commissioning guidance for outcome based, personalised and strength based ways of working. Personalisation maturity assessment to be completed as part of service redesign baselining.	People including workforce recognise and understand the value of connecting into their local communities People feel able to take responsibility for their own care/health as much as they can, and are able to self - serve/self-assess where appropriate People feel more involved in their treatment plan and are more knowledgeable about their options More people use technology to stay independent or improve quality of life People are better able to look after themselves in a place they call home, retaining independence and living the life they choose	A personalised, strength based, and collaborative approach is recognised as best practice and is the norm across Lincolnshire The workforce tell us they are equipped with tools to be able to implement personalised approaches A personalised approach is recognised as best practice and is the norm across Lincolnshire Contracting and finance teams take a holistic approach which considers Social Value and personalised ways of working and enables recognition/adoption of personalised/strengths -based approaches. We keep up to date with local activities, events, groups and learning opportunities and share this knowledge so that people have the chance to be part of the local community

Personalisation

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5. What's needed to make this happen

Input from providers

- On the 13/03/24 the Better Lives Lincolnshire Leadership Team (BLLLT) fully endorsed and committed to the Our Shared Agreement and the new relationship, this included personal, organisational and system commitments. The Personalisation team will work with identified leads across the ICS to agree and develop a costed implementation plan and will help to lead, facilitate, influence, and deliver against the agreed plan.
- However, the success of this programme and the 'our shared agreement' will be through providers and commissioners of health, care and VCSE services working with people to change the relationship to one that focuses on people's strengths and assets and what matters to them.
- This will require leadership and commitment from our workforce to transform the way they work through;
  - Co-production and co-design
  - Embedding our shared agreement and the 5 foundations
  - Learning and development opportunities
  - Use of behavioural science
  - Changing HR processes
  - Operational procedures and processes
  - Commissioning and contracting arrangements.

Requirements from enablers (e.g. digital, estates, workforce, PHM, personalisation and health inequalities)

- Digital: Use of technology to promote people's independence, commitment to the development of the patient portal to enable people to be able to access their PCSP, use of digital system that interface with each other to improve how information is communicated and shared.
- Currently working with PHM and HI to confirm how the 3 key enablers support one another.
- Workforce: To work together to consider how strength based and personalised approaches is built into all appropriate HR processes, including induction and mandatory training. Exploring opportunities to build the approaches into local curriculums within higher education.

Other support requirements

- Communication, engagement, and marketing – this is a key part of the programme of work, with both professionals and the public. The programme is hoping to bring in some additional capacity to support this piece of work, however there is a requirement for all organisations and partners to understand what the programme's ambition is and how they can support some of the messaging, marketing and engagement that will be required.
- Business intelligence: important to have BI expertise aligned to the programme to supported with being able to demonstrate impact and outcomes and how we might be able to do those through less traditional methods.

Resource requirements: investment and non-financial

- Substantive investment in the personalisation programme beyond March 2025 – see risks and mitigation below

Personalisation

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6. What could make or break progress

Interdependencies with other programmes/organisations

- Specific interdependency with HI and PHM
- All transformation programmes and in particular Primary Care, Community and Social Value (frailty & HIU), Community Mental Health (SMI Physical Health Checks), Maternity, Living with Cancer, Adult Social care, Personal Health Budgets,

Challenges & Risks

	Risks / Challenges	Mitigation
1	System executive and leadership teams have identified and agreed that personalisation is one of the key enablers to transform the health and care system in Lincolnshire, with it featuring in two strategies, however the risk is that this is just rhetoric and managing expectations and reality means this becomes too hard to do.	Managing expectations will be key to transforming the way we work. This is generational change and will therefore take courage, time, commitment and dedication that it is the right thing to do.
2	Contracting and commissioning needs to focus on person centred outcomes	Working with commissioners to enhance the Schedule 2 to include more specific personalised care outcomes.
3	Processes/ procedures / systems need to change to enable staff to work in a person-centred way – we need to move away from transactional ways of working.	Learning from LCC Adult Care who have fundamentally changed their processes to support staff to work in a strength-based way.
4	Our workforce has change fatigue and personalised care can be seen as ‘a nice’ to have, takes more time and has little impact on the wider system challenges.	Using the network of champions, advocates, and voices of personalised care in Lincolnshire to demonstrate the impact personalised care can have on people / workforce
5	Recognising the value and importance of the community and VCSE sector by certain parts of the health and care system is still challenging, with a lack of understanding and awareness.	Part of the LCC Community Strategy which is focusing on addressing the opportunities and barriers to working with the VCSE sector in and ICS.
6	There is a lack of system commitment and engagement with some of the key enablers such as a digital solution for personalised care and support planning, creating a scatter gun approach and a lack of consistency for people and staff.	Working with colleagues to agree the escalation route for the Personalisation programme board for system decision making
7	The Personalisation team is only funded until March 2025. There is a risk that all the progress that has been made will be lost if there isn’t a dedicated resource of expertise, knowledge, and skills from April 2025 to be able to continue to drive forward this key enabler across the Lincolnshire ICS.	A business plan will be co – produced with people with lived experience and key partners for ICS consideration by October 2024.

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

7. Stakeholders

Stakeholders

- People with lived experience
- Lincolnshire County Council – Public Health and Adult Care
- Lincolnshire Voluntary Engagement team
- District Councils
- Lincolnshire Partnership Foundation Trust
- Lincolnshire Community Health Services
- United Lincolnshire Hospital
- Primary Care Network Alliance
- Primary Care Networks
- Integrated Care Board
- NHS England
- VCSE (St Barnabas, Age UK Lincoln and south Lincolnshire, Active Lincolnshire, Voluntary Centre services, Lincolnshire community and voluntary service)
- Lincolnshire Care Association

Project team

- People with lived experience
- Kirsteen Redmile (NHS) – Lead Change Manager (NHS)
- Chris Erskine (LCC) Principal social worker (LCC)
- Matt Evans – Project Manager (NHS)
- Caty Collier – Social Prescribing development lead (VCSE)
- Alison Smith- Workforce development lead (LCC)
- Shibina Mathews – project support officer (NHS)
- Jenny Brereton – Lead for Personalisation (LCC)
- Mary Nel – Lead Professional (LCC)
- Vicky Thomson – Co-Production Partner (VCSE)

Health Inequalities & Prevention

Programme: Health Inequalities & Prevention	SRO: Sandra Williamson	Programme lead: Ann Johnson-Brown	Clinical/Technical Lead: John Parkin (Prevention – Smoking Dependency) Andy Fox (Public Health Lead)

1. Future state

Vision: 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.

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 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 shift more of our resources to **focus on prevention**, making it easier for people to be able to make healthier choices and reduce the risk of developing ill health, disease and premature death.

We will achieve our ambitions via 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:**. *Primary* - working with partners to prevent disease or injury before it occurs, making it easier for people to make healthier choices and reduce the risk of ill health and disease; *Secondary* - detecting the early stages of disease and intervening before full symptoms develop , providing treatment to support changes in lifestyle and behaviours to improve a person's healthy life expectancy; *Tertiary* - helping people manage long-term conditions and injuries to improve their quality of life and life expectancy.
- **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

The plan supports delivery of the following national requirements:

- Five strategic priorities for Health Inequalities
- Core20plus5 (Adults) and Core20plus5 (Children and Young People)
- LTP priorities and High Impact Interventions for Prevention (Modifiable Risk Factors, CVD, Respiratory, Diabetes)

The programme also leads on Lincolnshire NHS **Joint Forward Plan Priority 2: Living well, staying well.**

In scope:

- Health Inequalities and Prevention initiatives directly led/delivered by the Health Inequalities Programme
- Joint Forward Plan Priority 2: Living well, staying well oversight.

Out of scope:

- Health Inequalities and Prevention improvement initiatives directly led/delivered by other transformation programmes – these are not detailed within this section of the plan, as they are included within the relevant transformation programmes' section.

System level assurance for these initiatives in respect of Health Inequalities & Prevention requirements (including reporting to NHS Midlands HI & Prevention Teams) will be provided by the Health Inequalities Programme.

Health Inequalities & Prevention

Programme: Health Inequalities & Prevention	SRO: Sandra Williamson	Programme lead: Ann Johnson-Brown	Clinical/Technical Lead: John Parkin (Prevention – Smoking Dependency) Andy Fox (Public Health Lead)

2. What's being done to get there | Overview

Health Inequalities and Prevention Programme workstreams:

Embedding a system approach to health inequalities (HI)
Implementing HI tools and embedding HI approaches within governance arrangements; providing a regular programme of HI Training & Development; developing awareness and workforce leads /champions within NHS Trusts and PCNs, developing supporting strategies and embedding within financial and resource strategies and contract arrangements.

HI performance and intelligence
Developing intelligence and insights to support understanding of Health Inequalities and Prevention priorities, supporting programmes with access to and understanding of HI data, research and intelligence; developing system HI metrics, KPIs & dashboards; improving data collection to support understanding and performance; develop and collate insights on core20plus population groups such as inclusion health groups , use of HI metrics within internal and public performance reports; utilise PHM approaches to address HI and work with system Intelligence colleagues to develop HI elements of the joined data set reporting suite

HI in clinical areas and cross cutting themes:
Work with programmes to deliver against 5 national HI priorities and 5 clinical priority areas within Core20plus5 for Adults and CYP. Lead on local cross cutting HI themes, 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 LACE and Quality team to integrate Health inequalities within improvement approaches.

Communication and engagement
Collecting and using insights from Core20plus groups to reduce the gap in access, experience and outcomes service access; improve understanding of barriers for core20plus groups; co-production and engagement as golden thread through HI programme workstreams and initiatives and JFP priority2

Prevention
Improving the population's health and preventing illness and disease, catching the causes of ill health as early as possible to prevent or reduce the chances of them leading to more serious conditions, accelerating preventative programmes and supporting people to live well and stay well

Digital Inclusion
System lead. Addressing digital exclusion and ensuring alternatives are available for those within our population who are unable to utilise digital access channels and service delivery; adopting and implementing national guidance on digital inclusion through development of system Digital Inclusion Strategy and plan in partnership with digital programme colleagues

Inclusion Health
System lead. Improving access, experience, and outcomes for people in inclusion health groups by understanding the characteristics and needs of people in inclusion health groups; developing the workforce for inclusion health; delivering integrated and accessible services for inclusion health; demonstrating impact and improvement through action on inclusion health. Developing Strategy and plan as per new National Health Inclusion Framework .

Health Inequalities & Prevention

Programme: Health Inequalities & Prevention	SRO: Sandra Williamson	Programme lead: Ann Johnson-Brown	Clinical/Technical Lead: John Parkin (Prevention – Smoking Dependency) Andy Fox (Public Health Lead)

JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Preconception, infancy and early years		
Provide high-quality midwifery and children's services that support mums, babies and little ones to get the best start in life possible.	Maternity and Neonatal Programme – Transformation Plan and Quality Plan, Assurance Dashboard.	• The Local Maternity and Neonatal System (LMNS) works with stakeholders across the system to deliver the Maternity and Neonatal Three-Year Delivery Plan, Long Term Plan requirements and address the needs of our local population to reduce health inequalities. • The LMNS Transformation group brings together stakeholders involved in providing and organising maternity and neonatal care to provide a means of systematically managing the transformation agenda within this arena. • The LMNS Quality and Safety group provides system assurance that maternity and neonatal services are delivered in a high-quality safe manner, utilising dashboards to review relevant indicators.
Increase the number of babies and infants vaccinated and immunised against diseases, especially those from deprived groups or ethnic minority communities.	Midlands Antenatal and Newborn Screening Programme Board plan	• Once communities with lower vaccination uptake have been identified, the team will work with service providers, community leaders and other stakeholders to put in place a bespoke solution to compliment the core offers currently in place. • Booking a vaccination for yourself or a dependant should be a straightforward process. There needs to be a variety of methods to book a vaccination. • Explain to people the benefits of vaccinations and how they can access them, through clear and consistent communication from trusted sources. Building on increased awareness of vaccination and targeting vaccine mis-and-dis-information • There are several well-established national campaigns that run throughout the year, the Lincolnshire system will map these so that local materials can be used to supplement those used as part of the national campaign. All system partners should be a part of local initiatives and take steps to actively promote vaccination programme.

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Preconception, infancy and early years cont…		
Encourage more people planning a pregnancy to take folic acid supplements and stay fit and well before and after pregnancy.	Maternity and Neonatal Programme – Transformation Plan, including staying fit and well project in partnership with Active Lincolnshire	• Identified as an LMNS Transformation priority – initial scoping and planning commenced with a system wide Action Plan to be agreed.
Reduce smoking during pregnancy and increase the number of smoke-free homes	Tobacco Dependency Service (Maternity Pathway)	• NHS Maternity Tobacco Dependency Service now embedded within ULHT and delivered to 100% of women. • Next steps - implement vapes and monetary incentives into the pathway to improve outcomes, and to develop a wider system strategy for smoke-free pregnancy and smoke-free homes
Help parents and young families to stay active, eat well and look after their health.	Family Hub project (partnership approach, LCC lead organisation) LCC Public Health - Glojii Project	• Identified as an LMNS Transformation priority – initial conversations to review the whole pathway pre-conception, antenatal and postnatal into Early Years / Family Hubs agenda and Children and Young People.
Support more mums to breastfeed and increase breastfeeding rates at six to eight weeks	Breast Feeding Strategy and plan (completed by March 2024 Family Hub Project (partnership approach, LCC lead organisation) Relaunch Latch on Lincs campaign (LCC funded)	• System Breast Feeding and Infant Feeding Strategy in development as part of the Family Hub Project. • Maternity and Neonatal Programme to relaunch Latch on Lincs campaign in line with the launch of the system strategy (LCC funded). • ULHT Maternity Baby Friendly Accreditation level 2 achieved.
Increase the number of people accessing mental health services, and support good relationships between parents and infants.	Expansion of LPFT Perinatal MH Team (completed) Establishment of Trauma and Loss Service within Perinatal MH Team (completed) Family and Baby Support (Fab) Project Family Hub project (LCC lead organisation)	MH & Dementia – Community • Perinatal – increased access • Family and Baby Support (Fab) Project – initially funded by the Maternity and Neonatal Programme, role taken on and expanded as part of the family hubs agenda (LCC lead organisation).

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Childhood and adolescence		
Support young people with the services they need to keep them healthy and promote physical, mental and emotional wellbeing.	CYP Transformation Programme MHLDA - CYP MH Transformation Programme	*CYP* • Child Intervention in Schools review – activity & deliverables aligned to the 7 KLOE *CYP – Early Intervention* • Online MH support service recommissioning • Primary care – CYP MH practitioner pilot roll out • Mental Health support in schools – 50% of pupils in county will have access by 2025 • CYP counselling offer pilot *CYP – Prevention* • Night Light café pilot
Encourage more parents and guardians to vaccinate and immunise their children against disease – especially those in deprived groups or ethnic minority communities.	Lincolnshire Immunisation Board and CYP Immunisation Group	• Once communities with lower vaccination uptake have been identified, the team will work with service providers, community leaders and other stakeholders to put in place a bespoke solution to compliment the core offers currently in place. • Booking a vaccination for yourself or a dependant should be a straightforward process. There needs to be a variety of methods to book a vaccination. • There are several well-established national campaigns that run throughout the year, the Lincolnshire system will map these so that local materials can be used to supplement those used as part of the national campaign.
Develop mental health support teams to support young people's mental health and emotional wellbeing.	CYP Transformation Programme MHLDA - CYP MH Transformation Programme	CYP – Community Specialist Mental Health • Review waiting times and increased support • Introduce ARFID pathway/ Eating Disorders • Complex needs service review

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Childhood and adolescence cont...		
Give children and young people with disabilities or long-term conditions the support they need to reach their potential and lead a full and independent life, including psychological support.	CYP Transformation programme (includes Core 20 plus5 CYP) MHLDA - CYP MH Transformation Programme	*CYP - Asthma* • Integrated care pathway for CYP Asthma • Access to diagnostic hubs • Implementation of NICE asthma bundle *CYP – Diabetes* Implementation of Core20Plus Health Inequality Community Connectors to look at the following: • Reduce variation of care • Increase CYP utilising technology to manage & control their diabetes • CYP with diabetes having access to psychological support *CYP – Epilepsy* • Reduce variation of care – with access to specialist support • Access to appropriate mental health and psychological support • Timely access to tertiary specialist support for those that meet the criteria for management of complex epilepsy. • Improve transition between CYP and adult services • Epilepsy LDA pathway *CYP – Mental health* • Review of MH services *CYP and all age – LDA* • Expansion of Dynamic Support Register

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Childhood and adolescence cont…		
Work with schools and colleges to encourage healthy habits, identify health needs early and provide access to support.	CYP Transformation Programme Healthy Weight Partnership LCC Public Health	• TBC – current work in progress
Improve oral health especially in deprived groups.	PCCSV – Dental Strategy LCC Public Health	• TBC – current work in progress

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Working age		
Work with people to understand their skills and knowledge and give them the confidence to look after their own health and wellbeing.	Personalisation Programme – embedding use of patient Activation Measure (PAM) Work Well Partnership Programme	• Embedding use of patient Activation Measure (PAM). Patient Activation Measure is a tailoring tool and encourages the use of tailored interventions to improve activation for those who would most benefit. • Personalisation Programme is looking to roll out PAM across clinical teams. It is currently being piloted in specialist services in LCHS, LWC, selected PCNs. • Work Well Partnership Programme is an early-intervention work and health support and assessment service, providing holistic support to overcome health-related barriers to employment, and a single, joined-up gateway to other support services.
Identify people who could benefit from NHS health check and screening programmes and encourage more people to take up the opportunity	NHS Health Checks programme (LCC Public Health) Making Every Contact Count (MECC (delivery by C19 Vaccination team)	*Cancer* • Targeted Lung Health Checks national priority (to improve early diagnosis and survival for those diagnosed with cancer) *MECC* • The team undertook a Health Improvement project with several PCNs which included MECC • Engaged 20% of patients who attend for vaccination in MECC conversations and offered support and signposting. Conversations took place at events such as 'What matters to you' and through vaccinations to specific health inclusion groups. • MECC posters displayed along with vaccination information in areas of high deprivation
Ensure regular physical health checks for people with severe mental illnesses and people with a learning disability.	MHLDA Programme - SMI Health Checks Plan MHLDA Programme – LD Physical Health Checks	*MH & Dementia – Community* • Increase uptake for Physical health checks for those with SMI and LD Personalisation – strength-based approach for people with SMI - Physical health checks

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Working age cont...		
Increase access to NHS talking therapies for anxiety and depression and provide additional support by expanding local services such as peer support, mental health social prescribers and community connectors.	MHLDA - Community Mental Health Transformation Programme	*MH & Dementia – Community* • NHS Talking therapies.
Support more people to stop smoking and offer people in hospital who smoke, including pregnant women and high-risk mental health outpatients, NHS-funded tobacco dependency services.	Maternity and Neonatal Transformation Programme – Tobacco Dependency Service	*Health Inequalities & Prevention* • Implementation of Tobacco Dependency Service across all settings & expansion to community
Support more people who need help achieving a healthy weight by increasing uptake of our integrated lifestyle service and the NHS Digital Weight Management programme.	PCCSV - PCN DES delivery	• Primary Care Team to work with low referring practices and PCN's (if appropriate) to increase referrals – PCN in East of Lincolnshire agreed to make yearly weight management plan with support of local services • Pilot lessons learned - Blueprint successfully tested in the East of the county (The Sidings) • Co-producing flow chart with Birchwood Medical Practice to show templates on Ardens • Arranging practice education sessions with Arden to ensure clear understanding of all weight management options

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Working age cont…		
Improve support for people suffering from and at risk of Type 2 Diabetes to help reverse and stop the progression of the disease, for example through our NHS Diabetes Prevention programme.	PCCSV LTCs Programme - Diabetes review & improvement plan; Diabetes: primary & secondary prevention	*Major conditions – Diabetes:* • Primary & Secondary Initiatives • Clinical pathway review with prioritised improvement plans • The National Diabetes Prevention Programme (NDPP), we appointed Xyla our provider from a framework contracted by NHSE to continue running our programme from November. The programme will accept 5,200 referrals this financial year. • The Type 2 remission programme went live on the 1st April, and aims to promote rapid weight loss, and reverse type 2 diabetes for those diagnosed within 6 years not on insulin. We have 250 spaces on the programme this year, and 250 next year. • The Type 2 DAY programme is for patients under 40 and makes provision for general practice to recall them for an additional care process that might have been missed, or support with pregnancy planning, or lifestyle support to reduce the gap in younger people's outcomes. • We are recommissioning our Type 2 structured education and implementing a new model to try and make the most of this capacity. We are also currently reviewing the T1 Education offer
Reduce cardiovascular disease through early detection, better management of those known to be at high risk and encouraging people to manage their own health better.	PCCSV LTCs Programme - CVD - primary & secondary prevention plan	*Major conditions – CVD:* • Primary & Secondary Initiatives • Integrated Cardiology • Integrated Lipid Specialist Nurse Pilot – We are targeting secondary prevention patients with high cholesterol through this work.

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Working age cont…		
Better support people waiting for treatment for musculoskeletal (MSK) conditions such as back pain. Explore opportunities to improve their physical and mental health prior to any planned operations.	Personalisation Programme – MSK waiting list – Different conversations; decision support tools; prototype one stop shop model for waiting well; strength based language	*Personalisation* • MSK wellbeing Hub (early adopter Grantham Joint Aches and Pains hub) held 11th Jan which enabled people with aches and pains to come and talk to physios, clinicians, One You, VCSE, pre hab clinics. Currently pulling together early findings report. • Decision Support Tools rolling out in hip and knee pathway in ULHT and Primary Care and community.
Improve oral health, especially in deprived groups.	PCCSV – Dental Strategy	• TBC – current work in progress

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Ageing well		
Find out what matters to patients and their carers for better future care planning.	Personalisation Programme – embedding 'what matters to you' and strength based conversations approaches across system	*Personalisation - Embedding strength-based approach in service redesign* • Scoping and baseline setting with 4 early adopter PCN's with a focus on frailty • Personalised Care and Support Planning continues to be rolled out across Lincs and focussing in LCHS and PCNs. Use of Care portal and Shared Care Record remains priority for this work.
Encourage more people to get vaccinated and immunised against disease, especially those in deprived groups	Lincolnshire Immunisation Programme Board	• Once communities with lower vaccination uptake have been identified, the team will work with service providers, community leaders and other stakeholders to put in place a bespoke solution to compliment the core offers currently in place. • Booking a vaccination for yourself or a dependant should be a straightforward process. There needs to be a variety of methods to book a vaccination. • There are several well-established national campaigns that run throughout the year, the Lincolnshire system will map these so that local materials can be used to supplement those used as part of the national campaign. All system partners should be a part of local initiatives and take steps to actively promote vaccination programmes
Improve oral health.	PCCSV – Dental Strategy	• TBC – current work in progress

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Ageing well cont...		
Provide care focused on the individual for patients and carers living with cancer.	Cancer: Living with Cancer programme	*Cancer* • Implement NHS model of personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028 • The Programme's strategic priorities are addressing fragmented pathways, information governance, integration, communications, the cancer workforce, access to information advice and support, support services and inequity in the county. • The Programme is using enablers including co-production and community development to identify gaps in service provision and increase wellbeing and support for people Living with Cancer.

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Ageing well cont…		
Improve early diagnosis and detection rates for cardiovascular disease and cancer, particularly colorectal cancer.	Health Inequalities Programme – HI within Colorectal screening project Cancer Programme – early Diagnosis and Screening PCCSV LTCs Programme - CVD - primary & secondary prevention plan PCCSV Frailty Programme	*Health Inequalities & Cancer Programme joint initiative* • Scope, review & implement HI programme of work focusing on the colorectal pathway *Cancer* • Scope & commence transition of personalised care models of working to support people living with other LTCs in Lincolnshire • Scope, develop and commence transition of PFUP protocols and models of working to support other LTC specialities aligning with PIFU • Scope the economic modelling (actuarial modelling) – proactive preventative care for colorectal screening • Cervical Screening - researching numbers of people with LD in 3 practices (Gainsborough/Lincoln/East Coast) who have not attended cervical screening, aiming to increase uptake. *Frailty* • All partners will work together to deliver multidisciplinary care, with additional support where our population heath needs and inequalities indicate it is required such as in care homes, in some geographical locations and for specific population segments • Four early adopter PCNs have been selected - IMP, K2, South Lincoln Healthcare and Trent. The PCNs have attended a Personalisation and Health Inequalities Workshop.

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery	What's being done to get there
Ageing well cont…		
Improve brain health and prevent people from developing dementia by understanding risk factors such as smoking, high alcohol intake and hearing loss.	MHLDA Programme – Lincolnshire Dementia Strategy; Dementia Prevention	*MH & Dementia – Prevention offer for Dementia* • TFG – Prevention programme focus on raising awareness of the importance of good brain health across all age & reducing risk of Dementia • Increase and improve access to health checks – inclusive of risks of Dementia • Patients to be better informed on modifiable risk factors and self-care to reduce risk of Dementia and promotion of physical activity and exercise interventions.
Develop a Strength and Balance programme to prevent falls.	PCCSV Ageing Well – Falls review & improvement plan; Improved community-based falls response	*Ageing Well – Falls (Proactive)* • Clinical review of and prioritised improvement plan *Ageing Well – Falls (Responsive)* • Improving community- based falls response service • A number of PCNs have identified falls prevention as one of their key objectives. For example, Meridian, Four Counties and IMP PCNs are undertaking proactive fall prevention clinics both in the community and care homes.

Health Inequalities & Prevention

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3. What's being done to get there | Detail

Health Inequalities & Prevention Programme Deliverables & Milestones:

Embedding a system approach to health inequalities:

- HI Strategy (alignment with review of ICP Strategy) Q4 24/25 sign off by ICB Board
- Annual HI Training Plan – developed Q4 each year; delivery Q1 - Q4 annually
- Develop network of Health Inequalities Champions - Scoping Q1 24/25; Implementation Q2 24/25; live Q3 24/25
- Roll out HEAT to provider trusts – Scoping Q2 24/25; Implementation Q4 24/25
- Embedding HI within provider trusts – Scoping Q1 - Q2 24/25
- Scoping with Population Health Management next steps to support Health Inequalities lens to resource allocation – Scoping Q3 - Q4 24/25; Implementation Q1 25/26

HI in clinical areas and cross cutting themes:

- HI within Elective Care CYP missed appointments project with ULHT - Scoping Q3 24/25; Solutions implemented Q1 - Q4 25/26
- HI within Bowel cancer pathway project - solutions co-produced Q2 24/25; Solutions implemented Q4 24/25 – Q1 25/26
- Investigate whether specific HI issue within uptake and outcomes for LD Health checks – Scoping and proposal Q3 24/25; Implementation Q4 24/25 – Q1 25/26
- Investigate whether specific HI issue within uptake and outcomes of SMI Health checks - Scoping and proposal Q3 24/25; Implementation Q4 24/25 – Q1 25/26
- Jointly evaluate HIU service for further rollout Q4 24/25

Prevention:

- Support early adopter PCNs to embed HI and Prevention lens in delivery of frailty plans working with PHM and Personalisation Q1 - Q4 24/25
- HI & Transport for Targeted Lung Health check - Scoping Q2 24/25
- Work with Primary Care and Communities Programme to scope and complete needs assessment for provision of Tier 3 Weight Management Services within Lincolnshire – Scope/needs assessment Q2 24/25
- LTP Tobacco Dependency Services:
  - move to BAU (MH and Maternity) following evaluation Q3 24/25
  - Implement workforce service through alignment to support ILS recommissioning Q2 24/25 – Q1 25/26
- HI Grant fund for VCSE - Evaluation Q3 24/25; Expansion Q1 – Q4 25/26
- Wider determinants project with District Council - Scoping & proposal/brief developed Q3 24/25
- Inclusion Health project with LCC/ District Council – Scoping Q4 24/25; Implementation Q1 - Q4 25/26
- Work with Primary Care and Communities Programme to support age related HI in relation to BP reading of age-appropriate treatment threshold - Scoping Q2 - Q3 24/25
- MMR vaccination increased uptake project – Implementation Q2 24/25
- Work with Primary Care and Communities Programme to increase the number of people with Type 1 and Type 2 diabetes receiving all 8 care processes in areas of greatest deprivation and targeted population groups by 2028 - (access/experience/outcomes) Q2 25/26

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3. What's being done to get there | Detail

Health Inequalities & Prevention Programme Deliverables & Milestones (cont.):

HI performance and intelligence:

- Joint development of Virtual Health Inequalities Hub with Lincs County Council – Implementation Q3 24/25; Evaluation of initial phase Q4 25/26
- Evaluate the use of Lincolnshire Core20PLUS5 HI Dashboard (Adults) – Initial review Q2 24/25; Deep Dive Q3 24/25; Scoping of Phase 2 Q1 25/26
- Scope Lincolnshire Core20PLUS5 HI Dashboard (CYP) Q3 24/25
- Improve data quality, capture and insights of protected and Health Inequalities characteristics – Implementation Q1 - Q4 24/25
- Further develop PHM RS HI elements and HI reporting suite Q1 25/26
- Quarterly update of the Health Inequalities Legal Duties performance report for regular ICB committees / programme boards Q1 - Q4 24/25

Communication and Engagement:

- HI Community Connectors – Role out to further Core20PLUS5 clinical areas - Scoping Q2 24/25
- Work with communications team to develop a HI lens to future public facing comms – Scoping Q3 - Q4 24/25; Implement Q1 - Q4 25/26
- Joint work with Performance & Intelligence to create insight repository for inclusion and population plus groups in Lincolnshire – Scoping Q2 - Q3 24/25; Implementation Q4 24/25

Digital Inclusion:

- Develop and implement Digital Inclusion Strategy and Action Plan – development by Q2 24/25; Engagement Q3 24/25; Implement Plan Q4 24/25; Delivery (Year 1 of 3) Q1 - Q4 25/26

Inclusion Health:

- Develop and deliver Inclusion Health Strategy and Plan – scoping of draft strategy and plan Q3 24/25; development of draft strategy and plan Q4 24/25; Engagement Q1 - Q2 25/26; Implementation plan Q3 25/26; Delivery (Year 1 of 3) Q4 25/26 – Q1 26/27
- Inclusion Health workshops (part of annual HI training plan) – delivery Q3 23/24 to Q4 24/25
- Inclusion health guides Q1 - Q4 24/25
- Safe Surgeries scheme increased engagement within General Practice (with HI lens) Q1 - Q4 24/25

Health Inequalities & Prevention

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Embedding a system approach to health inequalities	HI Strategy (alignment with review of ICP Strategy)																					
Embedding a system approach to health inequalities	Annual HI Training Plan																					
Embedding a system approach to health inequalities	Develop network of Health Inequalities Champions																					
Embedding a system approach to health inequalities	Roll out HEAT to provider Trusts																					
Embedding a system approach to health inequalities	Embedding HI within Provider Trusts																					
Embedding a system approach to health inequalities	Scoping with Population Health Management next steps to support HI lens to resource allocation																					
HI in clinical areas & cross cutting themes	HI within Elective Care CYP missed appointments project with ULHT																					
HI in clinical areas & cross cutting themes	HI within Bowel cancer pathway project																					
HI in clinical areas & cross cutting themes	Investigate whether specific HI issue within uptake and outcomes for LD Health checks																					
HI in clinical areas & cross cutting themes	Investigate whether specific HI issue within uptake and outcomes of SMI Health checks																					
HI in clinical areas & cross cutting themes	Jointly evaluate HIU service for further rollout																					

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Prevention	Support early adopter PCNs to embed HI and Prevention lens in delivery of frailty plans working with PHM and Personalisation																					
Prevention	HI & Transport for Targeted Lung Health check																					
Prevention	Work with Primary Care and Communities Programme to scope and complete needs assessment for provision of Tier 3 Weight Management Services within Lincolnshire																					
Prevention	LTP Tobacco Dependency Services - move to BAU (MH and Maternity) following evaluation																					
	LTP Tobacco Dependency Services - Implement workforce service through alignment to support ILS recommissioning																					
Prevention	HI Grant fund for VCSE																					
Prevention	Wider determinants project with District Council																					
Prevention	Inclusion Health project with LCC/ District Council																					
Prevention	Work with Primary Care and Communities Programme to support age related HI in relation to BP reading of age-appropriate treatment threshold																					
Prevention	MMR vaccination increased uptake project																					
Prevention	Work with Primary Care and Communities Programme to increase the number of people with Type 1 and Type 2 diabetes receiving all 8 care processes in areas of greatest deprivation and targeted population groups by 2028																					

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
HI performance and intelligence	Joint development of Virtual Health Inequalities Hub with Lincs County Council																					
HI performance and intelligence	Evaluate the use of Lincolnshire Core20PLUS5 HI Dashboard (Adults)																					
HI performance and intelligence	Scope Lincolnshire Core20PLUS5 HI Dashboard (CYP)																					
HI performance and intelligence	Improve data quality, capture and insights of protected and Health Inequalities characteristics																					
HI performance and intelligence	Further develop PHM RS HI elements and HI reporting suite																					
HI performance and intelligence	Quarterly update of the Health Inequalities Legal Duties performance report for regular ICB committees / programme boards																					
Communication and Engagement	HI Community Connectors – Role out to further Core20PLUS5 clinical areas																					
Communication and Engagement	Work with communications team to develop a HI lens to future public facing comms																					
Communication and Engagement	Joint work with Performance & Intelligence to create insight repository for inclusion and population plus groups in Lincolnshire																					

Health Inequalities & Prevention

Programme: Health Inequalities & Prevention	SRO: Sandra Williamson	Programme lead: Ann Johnson-Brown	Clinical/Technical Lead: John Parkin (Prevention – Smoking Dependency) Andy Fox (Public Health Lead)

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Digital Inclusion	Develop and implement Digital Inclusion Strategy and Action Plan																					
Inclusion Health	Develop and deliver Inclusion Health Strategy and Plan																					
Inclusion Health	Inclusion Health workshops (part of annual HI training plan)																					
Inclusion Health	Inclusion health guides																					
Inclusion Health	Safe Surgeries scheme increased engagement within General Practice (with HI lens)																					

Health Inequalities & Prevention

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4. Projected impact on patients and system partners

Benefits - Health inequalities & Prevention Programme workstreams:

- Increased equity of access, experience and outcomes for people from:
  - 20% most deprived areas
  - Black, Asian and ethnic minority backgrounds
  - health inclusion groups
  - other Lincolnshire population segments experiencing worse access, experience and outcomes

  (Measured through service / clinical data on service access, experience and outcomes)
- Prevention of ill health
- Earlier detection of conditions and modifiable risk factors to reduce impact and enable people to better manage their health conditions and live in good health as long as possible
- Understand barriers to service access and take-up

System outcome measures for Health Inequalities:

Reduction in Variance between Core20Plus populations and whole population against March 2022 baseline for:

- Life Expectancy
- Healthy Life Expectancy
- Disability-adjusted life years (DALYs)
- Obesity – CYP and adults
- Smoking prevalence
- Infant Mortality

Measures below – working in partnership with Programmes to deliver with HI focus on Core20Plus population:

- Ensuring annual health checks to 60% of those living with SMI (completion of the 6 Health Checks)
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65%
- HIU service for 3 PCNS – working with targeted population group. Outcomes include reducing health inequalities and a reduction in avoidable emergency department attendances and non-elective admissions.
- Equitable vaccination take up for children and young people in areas of greatest deprivation and ethnic groups
- Reduction in smoking among people with a severe mental illness from 40% to 35%
- Increase of patients aged 40-59 years whose last BP reading is age-appropriate treatment threshold from 58% to 63%
- Increase the patients with hypertension treated according to NICE guidance from the most deprived population currently 65.2% to the least deprived 71.6%
- Increase % of adults on obesity register accessing healthy lifestyle offer(s) from 11% to 13% ; 5% increase in uptake to the Digital Weight Management offer and Diabetes Prevention Programme in areas of greatest deprivation and targeted groups. Reduction in the gap in people with Type 1 and Type 2 diabetes receiving all 8 care processes in areas of greatest deprivation and targeted population groups by 2028
- Increase in uptake of faecal immunochemical tests by 3% for 4 selected G.P Practices – most deprived
- Increase achievement of reliable improvement for Talking Therapies in areas of greatest deprivation from 63% to 70% (to the level experienced in the least deprived) and increase access to NHS Talking Therapies for ethnic groups by 2028

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Specific measures and targets for initiatives within HI Programme direct delivery:

Initiative	Outputs and Outcomes	
	Patients and Population	System Partners
HI within Bowel cancer pathway project	• Increase in uptake of FIT by 3 percentage points for 4 selected G.P Practices by 25/26 against 23/24 baseline	• Contributes to reduction in later stage cancer diagnosis
HI within Elective Care CYP missed appointments project with ULHT	• Reduction in missed appoints of people living in 20% most deprived to align with overall population rates	• Contributes to inclusive elective recovery
Improve ethnicity data quality /collection rates	• TBC	• Reduce the proportion of invalid ethnicity records to ≤ 10% by no later than September 2024
Smoking Dependency Service (workforce/community /acute/ MH outpatients)	• Number of referrals/self-referrals; • Number of quits at 4 weeks; • Number of quits at 12 weeks; • Timescales TBC	• Supporting NHS staff to quit results in reducing absenteeism, ill-health treatment and loss of productivity • Reduction in smoking is related to reduction in LTCs, A&E attendances and hospital admissions
Health Inclusion Group workshops	• Improved patient experience	• 18 workshop sessions delivered in 23/24 to 24/25 • Target 20 staff per session (360 staff places) • Increased awareness and understanding by workforce of the barriers faced by health inclusion groups; application of learning to service provision/design
Scoping of provision of Tier 3 Weight Management Services within Lincolnshire	• Increase in number of patients receiving treatment within Lincolnshire. • Reduction in patients required to travel outside of county for support	• Reduction in obesity related hospital admissions and LTCs
Wider determinants Project	• TBC following scoping of project in 2024	• TBC following scoping of project in 2024
Inclusion Health Project	• TBC following scoping of project in 2024	• TBC following scoping of project in 2024

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***I*nitiatives funded by HI Programme, delivered by other programmes**

Initiative	Outputs and Outcomes	
	Patients and Population	**System Partners**
HI and Transport Project (Targeted Lung Health Checks)	• Patients feedback on what is considered 'reasonable travel' to a Targeted Lung Health Check captured and used to inform service development	• Equitable access to a Targeted Lung Health Check service commissioned
High Intensity user project (delivery by Primary Care Community & Social Values Programme)	• 3 PCNs will be offering a High Intensity User Service by March 25 (Trent, Boston and First Coastal PCN) • By Q3 2024/25 to tie in with evaluation of 1 PCN	• Contributes to reduction in emergency admissions and A&E attendances
MMR Vaccination Project (led by Primary Care Community & Social Values Programme)	• Focus on 3 key geographical areas of Lincolnshire (Boston, Lincoln and Spalding) to increase uptake of MMR vaccine in children	• MMR vaccination uptake in selected PCNs to reach WHO recommended target of 95%
HI and LD project	• TBC following scoping of project	• TBC following scoping of project
HI and Diabetes	• TBC following scoping of project in 2024	• TBC following scoping of project in 2024
HI and SMI	• TBC following scoping of project	• TBC following scoping of project

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Benefits - JFP Priority 2: Living well, staying well:

Community

- People will live independently for longer, free from illness and disease.
- Those with long-term conditions will be supported to live the best life they can, and we will treat the person, not the condition.
- Detecting diseases, such as cancer, early on means we'll be able to slow down their progression, or in some cases even reverse them.
- Everyone will have equal access to excellent health and care services provided in a way that best suits them, particularly those from our most disadvantaged groups.
- All children will have the opportunity to reach their full potential and those with disabilities and long-term conditions will be able to lead a full and independent life.
- We will ensure our older population can live the life they want in older age, with the right support at home, in the community and through our services to stay well and manage health conditions proactively.

Workforce

- Preventing people from getting ill will be a high priority and approaches to achieve this will be a key part of the person's journey, preventing or reducing the impact of illness and promoting healthy ageing. This will especially benefit those people at high risk of developing long-term physical and mental health conditions.
- Best practice and quality of care will be embedded in the person's journey.
- Using innovative models of service delivery, we will ensure that one size does not fit all; our approach to intervention will be appropriate to meet the needs of the most at-risk members of the population.
- We will work with people from across our population who have used services and can best help shape how they should look and feel.
- We will support staff to work alongside people, patients and communities to ensure that self-care is part of their everyday life, improving their health and wellbeing and helping them to manage long-term conditions.
- Staff will have access to information and resources so they can support people effectively, and the workplace culture will give them the confidence to have honest conversations with people that put them first.

Health Inequalities & Prevention

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5. What's needed to make this happen

Input from providers

- Support staff to participate in workforce related initiatives e.g. HI Training events, HI Champions
- Commitment and support to roll out tools and approaches within processes and governance arrangements e.g. Health Equity Assessments

Requirements from enablers (e.g. digital, estates, workforce, PHM, personalisation and health inequalities)

- Participation in relevant steering groups, workstream groups and project teams
- Embrace opportunities to embed within enabler approaches

Resource requirements: investment and non-financial

- Plan can be delivered with the continuation of the ringfenced Health Inequalities recurrent resource allocation and the SDF allocation to support the implementation of Tobacco Dependency Service
- Additional funding to support increase investment in prevention (primary, secondary, and tertiary prevention) which will support the JFP priority – living well, staying well – commitment 1% of ICB allocation.
- Development of differential / allocative resourcing methodology and incentives to address health inequalities - targeting resources to support transforming care models and pathways to improve access, experience and outcomes

Health Inequalities & Prevention

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5. What's needed to make this happen

Scheme	Provider contributors	Requirements from enablers	Other support requirements	Resource requirements
Workstream: Embedding a system approach to health inequalities	LCHS/ LPFT/ ULHT/ LCC Public Health - Support staff to participate in workforce related initiatives e.g. HI Training events, HI Champions - Commitment and support to roll out tools and approaches within processes and governance arrangements e.g. Health Equity Assessments and take action to address inequalities identified in service access or outcomes - Continue to have named Health Inequalities Executive and operational leads (clinical leads where appropriate) and attend regular network meetings	Workforce – support to raise awareness and engage with staff Finance – development of resource allocation approach PHM & Personalisation – work in partnership e.g. support LACE and the quality improvement approach	ICS Transformation programmes & providers to provide monthly assurance reports on progress to HI Programme ICS Transformation programmes & providers – identifying How new services or redesign of services/ pathways will reduce health inequalities rather than just thinking about how a new service doesn't increase health inequalities.	Meeting rooms and facilitators for briefings, workshops and training
Workstream: Prevention	LCHS/ LPFT/ ULHT/ LCC Public Health/VCSE sector – LVET and other VCSE partners/District Councils - Membership of project teams - Staff resource to scope and implement	Finance business partner support with NHSE bidding process	ICS Transformation programmes & providers to provide monthly assurance reports on progress to HI Programme	NHSE funding (Tier 3 Weight Management; Workforce Tobacco Dependency Service)

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5. What's needed to make this happen

Scheme	Provider contributors	Requirements from enablers	Other support requirements	Resource requirements
HI performance and intelligence:	LCHS/LPFT/ULHT/AGEM - HI Performance reporting embedded within provider organisations, ICB & system governance arrangements - Take action to improve HI data quality	PHM – PHM Reporting/ Data Suite – work in partnership to improve HI elements to ensure meets national and local HI requirements		
HI in clinical areas & cross cutting themes	LCHS/LPFT/ULHT/ LCC Public Health Provide staff input to project teams and scoping		Comms and engagement support	
Digital Inclusion	LCHS/LPFT/ULHT/ LCC Public Health/VCSE sector – LVET and other VCSE partners/District Councils - Staff resource -membership of strategic Group, Collaboration Group and any task and finish groups/project teams - Provide regular data on digital provision/take-up	AGEM/PHM - data	Comms and engagement support	
Inclusion Health	LCHS/LPFT/ULHT/ LCC Public Health/VCSE sector – LVET and other VCSE partners/District Councils - Staff resource -membership of strategic Group, Collaboration Group and any task and finish groups/project teams		Comms and engagement support	Additional Programme/Project management to support development of Inclusion Health Strategy

Health Inequalities & Prevention

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6. What could make or break progress

Issues & blockers

- None at this time

Interdependencies with other programmes/organisations

- Dependent on all ICS transformation programmes, in particular CMHT Programme, CYP Transformation Programme, CYP MH Transformation Programme, Maternity and Neonatal Programme, Cancer Programme, Planned Care Programme, Primary Care, Community & Social Value (e.g. LTC (CVD, Diabetes, Respiratory), Frailty, HIU), provider trusts and partners for delivery of some elements of Core20plus5 (Adults and CYP), Five National Strategic Priorities for Health Inequalities, LTP Prevention High Impact Interventions and Joint Forward Plan Priority 2: Living well, staying well
- Specific interdependency with HI, Personalisation and PHM – including the development of working model with LACE

Health Inequalities & Prevention

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Risk/ Challenges	Mitigation
Access to relevant data and intelligence – e.g. local sub county level /small area data ; health inclusion groups and other local plus groups	- Development of ICS joined data set and specific initiatives within plans for HI & Prevention Programme and Communication and Engagement Enabler Programme - Performance reporting to include HI metrics including measuring the slope index and relative index of inequalities in health service utilisation
Capacity within other transformation programmes, provider trusts and other partners to engage with, support and contribute to initiatives	- Early stage stakeholder engagement
Digital exclusion – national requirement to have digital inclusion strategy and implement action plan - strategy not currently in place ,therefore not currently at stage to implement action plan.	- System group has been established (Autumn 2023) to develop digital inclusion strategy and action plan – membership and active engagement of key system organisations.
Health Inclusion – national requirement to develop strategy and action plan	- System group will be established to develop strategy and plan with membership of key system partners
Operational pressures – capacity of providers to engage with work to reduce health inequalities; achievement of national programme targets prioritised difficult for providers to balance this requirement alongside addressing inequalities gap and finding solutions	- Early engagement with partners - Identify opportunities to align with other work within their plans so that HI is an integral part of this and embedded within this - Involve partners at early stage of scoping/project development - Provide project management support from within HI Team for priority pieces of work where capacity allows - Prioritise work programme to align with provider capacity where feasible/possible
Resource /allocation approach – challenge of balancing the need to meet population need/ address inequalities against current financial context	- Development of Health Inequalities Resource Allocation strategy and approach – targeted to addressing health inequalities (access, outcomes and experience - Implementation of resource allocation approach for 2024/25 planning – phasing to consider new investment and/ or additional allocations received in year with a plan developed for full implementation from 2025/26 - Embracing the principle of proportionate universalism where actions taken are universal, but with a scale and intensity that is proportionate to the level of disadvantage i.e., with more resource and effort (intensive support) into supporting the most deprived communities; vulnerable groups targeted to improve equity of access, excellent experience, and optimal outcomes.
Vacancies– currently carrying 1 vacancy - 1 x Health Inequalities Improvement Facilitator	- Vacancy recruitment is in progress

Health Inequalities & Prevention

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7. Planning assumptions

Demand drivers

System-driven:

- That there are no significant changes in national policy/ask in relation to Health Inequalities and Prevention
- That there are no changes to LTP Prevention High Impact Interventions (CVD/Diabetes/Respiratory/modifiable Risk Factors)

Productivity, capacity & resource enablers and constraints

Finance

- That Health Inequalities SDF continues to be available and ringfenced for Health Inequalities
- Additional funding to support increase investment in prevention (primary, secondary and tertiary prevention) which will support the JFP priority – living well, staying well – commitment 1% of ICB allocation.
- Assumption we can recruit to vacancies in the future to support the developing work programme and expansion in 25/26

Capacity

- That system transformation programmes and providers have capacity to engage with initiatives
- Clinical Care Directorate identifies clinical leads for Health Inclusion (new requirement) and Health Inequalities and Prevention (under review) and that lead/s have capacity to support the programme.

8. Stakeholders

Key Stakeholders

- NHS Trusts: LCHS, ULHT, LPFT – key named Health Inequalities leads
- Primary Care
- Health Inequalities PCN Leads identified in 12/14 PCNs
- VCSE – LCVS, VCS, LVET key partners on selected projects
- Public Health (PH) - The deputy chair for the HI Programme is from PH. Some of the HI programme's workstreams and projects are led in partnership with PH
- Local Authorities – South and East Lincolnshire partnership (Emily Spicer), North Kesteven District Council (Yvonne Rogers)
- Healthwatch
- System Transformation Programmes and Programme leads – with specific links to the Adult Core20PLUS 5 programme and projects; CYP Integrated Transformation Board – with specific links to the CYP Core20PLUS 5 programme and projects; MHLDA Alliance: specific links to the Adult Core20PLUS 5 programme and projects
- Clinical and Care Directorate and LACE
- Patients & carers: specific focus on identified 'Plus' & inclusion health population groups
- Other Enabler programmes – for example Digital, PHM, Personalisation,

HI Programme/ Project Team:

- Health Inequalities Programme team is made up of; Assistant Director Health Inequalities x 1 FTE, Health Inequalities Improvement Manager x 2 FTE, Health Inequalities, Improvement Facilitators x 3 FTE, Health Inequalities Programme Support Officer x 1 FTE, Principal Analyst in Health Inequalities x 1 FTE, Health Inequalities Engagement Manager 1 x FTE. In addition to this the following posts will be recruited to in Q3; Health Inequalities Improvement Facilitator x 1 FTE.
- Finance lead – ICB Finance Business Partner (Lauren Washington)
- Engagement lead – ICB Strategic Communications and Engagement Lead Manager (Steph King)
- Communications lead – ICB Marketing and Communications Manager (Tony Crowden)
- Business Intelligence – AGEM, ICB Director of Intelligence & Analytics (Katy Hardwick) and ICB Head of Performance (Martin Bambro)

Primary Care, Communities & Social Value

SRO: Sarah-Jane Mills	Programme leads: Nick Blake - Primary Care; Sarah Button - Integrating Community Partnerships; Lisa Foyster – Ageing well and Long Term Conditions	Clinical/Technical Lead: Sunil Hindocha

1. Future state

Our vision

Enabling the people of Lincolnshire to live well, stay well, age well and die well by

- Proactively addressing health inequalities and focusing upon prevention
- Early identification and treatment of disease
- Creating integrated community-based multi –disciplinary teams who proactively manage long term conditions

Key ambitions

- Improve access to integrated primary care, by creating new and innovative models of care which will deliver the ambitions for improved access detailed within the 'Delivery plan for recovering access to primary care', improve quality of patient experience and outcome and create enhanced resilience of services and workforce. Transforming for tomorrow whilst delivering today.
- In partnership with PCNs develop integrated community-based, multi-professional and multi -agency teams with a view to delivering person-centred care, targeted to meet the identified need of local communities.
- To implement integrated pathways of care for patients with long term conditions including children and young people, people with mental health conditions and those with long term conditions including frailty and people at the end of their lives to support proactive identification, early intervention, personalised care planning and seamless management of deterioration

The case for change

Our overall aim is to create sustainable models/pathways of care outside of the hospital setting, which will improve patient outcomes and experience, in line with our ambitions and reduce year on year growth in demand for and therefore investment in, Urgent and Emergency Care.

General practice is the foundation of all our transformed pathways of care. It is the universal health offer to all our patients, from birth to death, for those that are healthy and those that are unwell. It represents a rich source of data and intelligence about the majority of our population allowing us to

- identify people who would benefit from our support before they become unwell,
- to target our care to prevent deterioration and loss of independence and
- to identify and address inequalities of outcome and experience.

Without sustainable primary care we will be unable to deliver our ambitions. However, across Lincolnshire, we are struggling to sustain the current model of delivery due to a combination of demographic changes, shortages of general practitioners and demand inflation. We will, therefore, whilst continuing to deliver access to appointments in line with nationally agreed performance targets, aim to create, in partnership with our key stakeholders, including patients and public, innovative, new models of care which deliver the right care, at the right time, in the right place.

The Primary Care Networks (PCNs) are central to supporting the design and delivery of this new landscape. Working with PCNs will enable us not only to improve access to care for those who are acutely unwell but also to build integrated care, in partnership with key stakeholders, for those with longer term health and care needs.

Our systemwide priorities detailed in 'integrating specialist services' have been driven by Population health management and inequalities data and intelligence, workforce data, performance data, local knowledge from our teams and partner agencies, patient and public feedback and the Care and Clinical Directorate's view of what will have the greatest impact locally.

Primary Care, Communities & Social Value

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1. Future state

The Case for change (cont.)

Our ambitions are driven by national and local guidance and frameworks including

- The major conditions framework, NHS England (2023)
- Delivery plan for recovering access to primary care, NHS England (2023)
- Next steps for integrating primary care, Fuller stocktake report, NHS England (2022)
- Providing proactive care for people living in care homes – Enhanced health in care homes framework, NHS England (2023)
- Joint forward plan – Lincolnshire Integrated Care Board (2023)
- NHS vaccination strategy, NHS England (2023)
- Proactive care: providing care and support for people living at home with moderate or severe frailty, NHS England (2023)
- Planning Guidance 24/25 NHS England (2024)
- Faster, simpler and fairer: our plan to recover and reform NHS dentistry, Department of Health and Social Care (2024)

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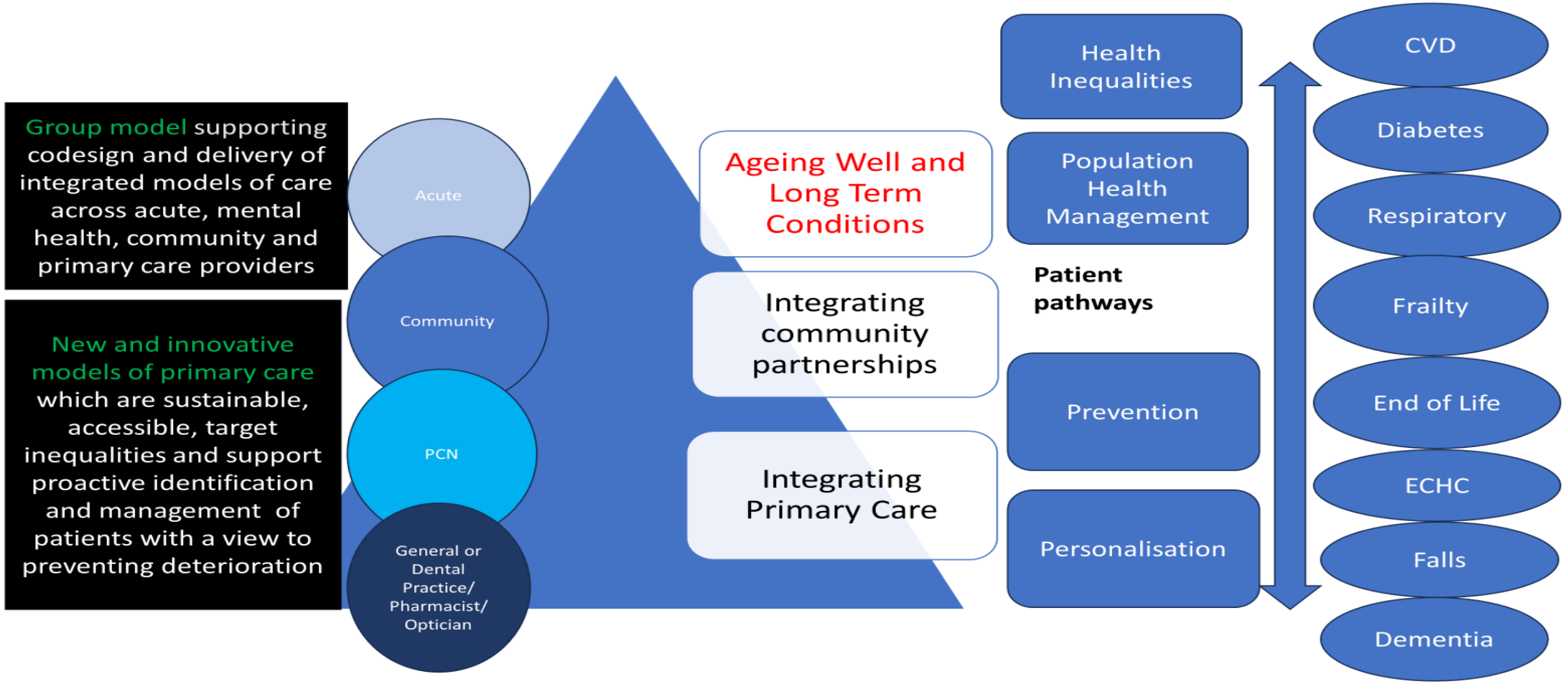
2. What's being done to get there | Overview

Our delivery model



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3. What's being done to get there | Detail

Our key delivery objectives 2024-2029 are as follows

Integrating primary care delivering timely access to primary care – general practice, pharmacy, dental, optometry, today whilst designing and delivering new models of integrated primary care, with a view to creating a sustainable future.

Integrating primary care and delivering access

- Maintain and develop delivery of the business-as-usual elements of primary care commissioning – for general practice, dental, pharmacy and optometry to ensure services continue to deliver safe and timely access to care.
- Foster and develop Leadership across and communication between the LMC, LPC, LDC and LOC with a view to ensuring they are proactively represented in system wide fora and shared learning across the people they represent
- Improve access to community pharmacy services in line with Pharmacy First ambitions
- Empower patients to manage their own health by providing them with technology and information including innovative digital monitoring systems, access to online information, advice/guidance and consultations and access to their digital records via the NHS app
- Improve access to urgent same day primary appointments and planned appointments in line with national guidance and Lincolnshire ambitions.
- Improve productivity and reduce time wasting activities across primary care
- Improve collection, accuracy and utilisation of primary care data as a mechanism for enhancing quality of care, evidencing change and informing business cases.

Developing Partnerships to Support Primary Care Integration

- In partnership with providers (including General practices and pharmacy practices), PCNs, LMC, LPC, the public and our patients - design and implement new sustainable model/s of integrated primary care with a view to improving access, addressing inequalities and unwarranted variation, and enhancing proactive identification and management of long-term health conditions
- Deliver the Primary Care People Plan ensuring alignment to both the system workforce strategy and other national initiatives, with a view to creating a sustainable and resilient Integrated primary care workforce
- Develop a Lincolnshire framework for enhanced services which supports delivery of improved outcomes for patients, with a focus upon reducing growth in demand for acute based services
- Enhance our primary care estate to ensure it is fit for purpose and facilitates delivery of our vision
- Develop our digital capabilities across primary care with a view to enhancing patient experience and outcomes and being able to evidence change
- Improve quality of care in line with locally and nationally agreed best practice and initiatives
- Transform the conversation between primary care and the public by implementing a comprehensive programme of communication, engagement and co-production with a view to empowering our patients to be leaders in enhancing their own health and well-being.

Vaccinations

- Develop in partnership with key stakeholders, implement and evaluate a Lincolnshire-wide Vaccine Strategy to deliver the ambitions detailed within of the newly published National Strategy (December 2023)
- Undertake the required planning and actions to enable the ICB to assume delegated commissioning responsibility from NHS England
- Support providers to develop an integrated multi-disciplinary, multi-agency vaccination staffing model in line with ambitions detailed within the Strategy to enable delivery of agreed Key Performance Indicators

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3. What's being done to get there | Detail

Integrating community partnerships developed around the PCN footprints to support their ongoing evolution to provide access to person centred care, delivered by multi-disciplinary and multi-agency teams, for local communities, reflecting population need.

PCN Development

- Develop different ways of working at PCN level to enable demand to be managed and/or capacity to be released, to support improved access to integrated primary care.
- Fully implement the PCN DES with a view to supporting improvements to population health via proactive identification, care coordination and case load management of patients with longer-term health and social care needs, evaluate impact with a view to enabling continuous improvement
- Further enhance leadership capability and capacity across the PCNs in line with the agreed Lincolnshire maturity framework.
- Continue to implement ARRS roles in line with national agreement and local priorities.
- Develop and implement integrated pathways of care across primary and community care for therapy and nursing services to meet the specific needs of PCN populations
- Implement delivery plans for High Intensity Users and Social prescribing, in line with national best practice and evaluate impact.
- Build, implement and evaluate a Lincolnshire wide Quality Framework which supports learning, continuous improvement and transparency across stakeholders.
- Further develop the role of integrated neighbourhood teams, in line with the Fuller recommendations, with a view to enhancing the delivery of multi-disciplinary, multi-agency personalised care and improved patient outcomes and experience for the most complex patients
- Deliver Integrated community teams (community nursing and community therapy)
- Develop and implement the Integrated Communities Strategy (Strategic partnerships, link to Community Primary Partnerships)
- Codesign and implement a framework for working in partnership with the voluntary sector.

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Ageing well and Long Term Conditions delivers improved health outcomes, reduced health inequalities and reduced disease progression, enabling people to live well and die well. Implementing new integrated models of care, via a one team approach, transcending organisational boundaries, whilst adopting a more proactive and holistic approach informed by individual wishes and need. These new models are informed by our population health management intelligence, focus on prevention, early identification and diagnosis. They will deliver both timely, urgent care and long-term ongoing care and treatment for working age and older adults.

Ageing well – Older age

- Implement the Lincolnshire Frailty Strategy and associated delivery plans to reduce the onset and progression of frailty.
- Fully delivery the local Lincolnshire and national aspirations for the Enhanced Health in Care Homes (EHCH) programme, as outlined in the DES and the updated National EHCH framework (updated November 2023) to all care homes in Lincolnshire and evaluate the impact.
- Fully implement the Lincolnshire-wide Palliative and End of Life integrated care model supported by strategic commissioning arrangements for specialist palliative care.
- Deliver the proactive/primary care elements of the Lincolnshire Dementia strategy including the recovery of the dementia diagnosis rates. This work is led by LPFT.
- Implement the Lincolnshire Falls pathway such that people with the potential of falling are proactively identified and are proactive managed by timely and effective multi-disciplinary interventions including an effective falls response.
- Develop, embed and evaluate a Lincolnshire-wide Long-Term Condition Strategic Framework with a view to supporting:
  - Prevention and management of risk factors
  - Early and accurate complete diagnosis
  - Proactive care
  - Clinical Pathway Review
  - Integrated pathways of care
  - Other targeted improvement initiatives
- Deliver Transformation, Targeted and Transactional programmes of change in line with national "must do's" & guidance, best practice and local clinical priorities (effectiveness and impact) directed by our Lincolnshire Care and Clinical Directorate for:
  - Major conditions identified in the NHS LTP – Cardiovascular disease including Stroke, Diabetes and Respiratory
  - Other long-term conditions where opportunities are identified
- Review all commissioning arrangements to support and underpin service redesign

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Integrating Primary Care

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating Primary Care and delivering access	Access recovery and improvement																					
	Integrating urgent care																					
	Resilience framework																					
Developing partnerships	Contracting and Commissioning framework																					
	GP Strategy																					
	Pharmacy Strategy																					
	Dental Strategy																					
	Primary Care People Plan																					
	Estates Plan																					
	Digital implementation																					
	Vaccinations and immunisations																					

Primary Care, Communities & Social Value

SRO: Sarah-Jane Mills	Programme leads: Nick Blake - Primary Care; Sarah Button - Integrating Community Partnerships; Lisa Foyster – Ageing well and Long Term Conditions	Clinical/Technical Lead: Sunil Hindocha

3. What's being done to get there | Detail

Integrating Community Partnerships

Programme	Project	2023/24				2024/25				2025/26				2026/27				2027/28			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating Community Partnerships																					
Integrating Care	Care co-ordination and case management framework																				
	Community Integration																				
	Integrated community nursing & therapies																				
	Strategic Partnerships (will become absorbed as part of CPP development)																				
PCN Development	PCN DES Delivery																				
	PCN Manager Development																				
	ARRS Utilisation																				
	Social Prescribing Procurement																				
	High Intensity Users																				

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Programme	Project	2023/24				2024/25				2025/26				2026/27				2027/28			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating Specialist Care																					
Long Term Conditions	Long Term conditions - Prioritised Targeted Action Plans																				
Major Conditions - Respiratory	Clinical Pathway Review with prioritised improvement plans																				
Major Conditions - Diabetes	Clinical Pathway Review with prioritised improvement plans																				
Major Conditions - Diabetes	Primary and Secondary Prevention initiatives																				
Major Conditions - CVD	Integrated Cardiology																				
Major Conditions - CVD	Primary and Secondary Prevention initiatives																				

Programme	Project	2023/24				2024/25				2025/26				2026/27				2027/28			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Frailty	Ensure delivery of frailty strategy & plans, benefits realisation, comms and engagementand personalisation programme														Implement continuous improvement, learning and refinement						
	Frailty - Integrated Care																				
														Implement continuous improvement, learning and refinement							
	Frailty -Primary Care Phase 1 (Early Adopter PCNs)									Implement continuous improvement, learning and refinement											
	Frailty -Primary Care Phase 2 (PCN)																				
	Frailty - Proactive Care														Implement continuous improvement, learning and refinement						
Ageing Well - EHCH	Delivery of EHCH DES and implementation of EHCH Framework																				
Ageing Well - Falls - Proactive	Clinical review of and prioritised improvement plan																				
Ageing Well - Falls - Responsive	Improving community-based falls response services																				
Ageing Well - PEOL	Delivery of the new PEOL integrated operating model of care supported by a strategic commissioning framework																				

Primary Care, Communities & Social Value

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4. Projected impact on patients and system partners

Further work will be required to ensure mechanisms are in place to capture and share the assurance detailed below. Dashboards are either in development or are already in place and will be reviewed via the agreed governance infrastructure for PCC and CV.

The KPIs detailed below have been shared with the Clinical and Care Directorate for challenge and critical appraisal

Integrating Primary Care

Access

- 85% of patients, with an identified clinical need for an appointment, to receive one within 2 weeks of their contacting their practice by March 2025
- All patients will be able to communicate with someone within their practice, either virtually or via telephone, on the day they contact them and know how their enquiry has been dealt with by March 2025
- 100% of practices have enabled online patient appointment booking and cancelling, repeat prescriptions and access to care records by March 2025
- 100% of GP practices using CBT or system with the same functionality by April 2024
- 100% of practices using high quality online consultation tools by April 2025
- Pharmacy First will be in place by March 2024
- Lincolnshire Enhanced service framework co-designed and implementation mechanisms in place, with a view to enhanced services being a key enabler of our local priorities by July 2024
- Deliver 1,070,025 units of dental activity over 2024/25
- Lincolnshire Dental strategy implemented, with associated improvements to access by March 2027
- Design and implement Lincolnshire Pharmacy strategy by March 2028

Transformation Integrating primary care

- Facilitate a big conversation between General Practice and its key stakeholders, including the public to gain a shared understanding of the future of General Practice to support development of the GP strategy
- Implement national General Practice pilot programme by 2026
- Integrated Primary Care Strategy including both digital and estates as enablers completed by June 2025

Vaccinations

- Resilience
  - Retain and expand a central workforce which can offer support into Primary Care where needed to deliver seasonal and life-course vaccinations and be sufficiently flexible to provide a response to any outbreaks by March 2024
- Access
  - Develop a delivery model that meets the needs of the population and establish delivery points at the point of need by April 2025.
  - Co-administration of vaccines will be the default model by April 2025.
- Uptake
  - Agree system-wide uptake targets for all vaccination programmes by March 2024
  - Meet all vaccination uptake targets by March 2027
  - Identify variation in uptake between PCNs and develop and implement mechanisms to close the uptake gap, focusing on continuous improvement and learning by March 2027

Primary Care, Communities & Social Value

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4. Projected impact on patients and system partners

Integrating Community Partnerships

Additional Roles Reimbursement Schemes (ARRS)

- Lincolnshire will have 392.50 WTE ARRS roles in place (this is Lincolnshire share of the 26,000 WTE manifesto commitment) by March 2024. At Month 8 Lincolnshire has 496.64 WTE, well above the end of year target.

High intensity Users

- 3 PCNs will be offering a High Intensity User Service by end March 2025
- By August 2024 we will have reviewed other HIU provision to ensure it is in line with the national HIU framework

Social Prescribing

- A refreshed Social Prescribing model to be developed and commissioned from 1st April 2025

Primary Care Networks

- All PCN will have in place agreed objectives, aligned to system objectives by December 2024
- All PCN managers will have undergone a Leadership Programme delivered through an independent specialising in PCN Manager development by March 2024

Partnerships

- Strategic partnership model between ULHT/Primary Care/ICB agreed by March 2025
- Strategic partnership model with VCSE (LVET) agreed by March 2025
- Model of MDT working in place in every PCN by March 2027
- Integrated delivery models in place for community therapy and nursing in every PCN by March 2027
- Implement quality framework across all PCNs by March 2027

Ageing well and Long Term conditions

Ageing well – older age

Frailty

- Reduce the progression from mild to moderate and moderate to severe Frailty by 5% by 2028
- Deliver the opportunity identified in the ‘Bed Right Size’ modelling to reduce the growth in numbers of beds from the ‘do nothing scenario’ by 70 beds by 2028

Enhanced health in care homes

- Reduce unplanned admissions of people living in a care home by 5% by 2026
- 90% of people living in a care home to have a PSCP in place by 2026
- 100% of care homes having access to weekly ward round with evidence of access to appropriate MDT working, including access to care coordination and social prescribing, supporting by access to shared record keeping by 2025
- By 2025 all relevant partners constitute the MDT across all PCN areas

Palliative & end of life care

- New commissioning and delivery model (lead provider) by Q2/3 2026
- To increase our recognition of people deteriorating from a life limiting condition – target average is 1.2% of the population
- 70% of people in the last year of life to have a care plan by December 2025, 80% by December 2026
- 65% of patients identified as being for palliative or end of life have a ReSPECT conversation recorded at least 6 months before the end of their life by March 2026
- 10% less people in their last year of life have an unplanned admission by 2026

Dementia

- Recover the dementia diagnosis rates in those aged 65 and over to the national ambition level (66.7%) by 2025

Community Waiting Lists

- Improve community services waiting times, by reducing over 52 week waits by 80% by March 2025

Primary Care, Communities & Social Value

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4. Projected impact on patients and system partners

Ageing well and Long Term Conditions

Ageing well – older age (cont.)

Falls

- 70% of high-risk fallers will have received a holistic falls assessment from an appropriately skilled professional and will have a proactive care plan in place by 2025
- 10% more patients stay at home post fall response by 2025
- 10% more patients who receive a falls response and need an onwards referral will access directly relevant diagnostics, SDEC or speciality teams by 2025CVD

Long Term Conditions – working age

Heart Failure

- 85% (90.8%) of the expected number of people with AF are diagnosed by 2029 (Joint NHSE/ PHE ambition)
- 90% (89.6%) of patients with AF who are known to be at high risk of a stroke to be adequately anticoagulated by 2029 (Joint NHSE/ PHE ambition)
- 80% (63.66%) of the expected number of people with hypertension are diagnosed by March 2025 (Joint NHSE/ PHE ambition)
- 80% (57.9%) of the total number of people diagnosed with hypertension are treated to target as per NICE guidelines by March 2025 (Joint NHSE/ PHE ambition)
- 65% (55.3%) of patients aged between 25 and 84 with a CVD risk score greater than 20% on lipid lowering therapies by 2026 (IFF)
- 85% (awaiting NACR (audit) January 24) of those eligible access cardiac rehabilitation by 2026 (Long Term Plan)
- 40 (20) Virtual Ward beds established for Heart Failure by 2025

Diabetes

- NDPP – No. of patients referred to service and No. of patient who achieve at least the first milestone on the programme (contract ends Nov 25):
- April 24 – Mar 25 = 5,200 referrals and 2,582 Milestone 1s (MS1)
- April 25 – Nov 25 = 3,450 referrals and 1,721 MS1s
- Remission - 250 patients per year/ 500 24/25 and 25/26
- T2DAY - 1,410 patients to be offered the service by 23/24 and 1,410 patients (plus growth) by 24/25

Respiratory

- Increase the number of patients with a diagnosis of COPD accessing pulmonary rehabilitation by 5% by December 2025
- % COPD patients where diagnosis confirmed by spirometry (% and delivery date TBC)
- % of patients with a COPD review in last 12 months (% and delivery date TBC currently 83.5%)
- % COPD patients with flu immunisation (% and delivery date TBC currently 66.6%(respiratory))

Note:

(%) = actual
Further scoping required to confirm baselines and trajectories

Primary Care, Communities & Social Value

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5. What's needed to make this happen

Key enablers

Refreshed governance	• Integrated Care Committee which has oversight of key programmes of activity, is responsible for system wide delivery, risk mitigation and horizon scanning to inform future direction of travel
Population Health Management	• Utilised across all programmes of work to proactively identify opportunities where intervention will have greatest benefit and to support ongoing assessment of impact
Workforce	• Agree the workforce requirements to support delivery of the programmes of activity • Develop delivery plans with a focus upon future planning, recruitment and retention, development of innovative career pathways and roles, culture and organisational development and education and training. • Develop shared programmes of both OD and training/education to facilitate integrated team working across organisational boundaries
Digital	• Programmes of work will be supported by cross cutting digital programmes of activity including systems to capture performance data, shared care records, digital monitoring technology, robotics and enhanced digital access to appointments and advice and guidance
Estates	• Primary and Community based estate is a key enabler in delivering integrated models of care and yet the current estate varies in suitability for its function. Development of an Estate strategy, and alignment with system infrastructure workstream, will enhance understanding of availability, any additional capacity required to deliver key areas and work and support targeting of investment
Commissioning and Contracting	• Utilise a spectrum of contracting and commissioning arrangements including enhanced services to support delivery of integrated services across providers. This will include developing a rigorous and transparent approach to agreeing whether to reinvest, change the specification or disinvest dependent upon assessed population needs, national and local ambitions, resource availability, value for money and assessed performance, in line with national and international guidance and law
Personalisation	• Personalised care is a key thread which runs through out all the programmes delivered by PCC&SV. Supporting patients to jointly agree the interventions proposed, including empowering them to self-manage their conditions and access social prescribing and personal health budgets will support improved outcomes and experience
Quality Improvement	• Embracing an approach of continuous improvement with a view to enhancing quality of care, patient safety and experience based upon learning from delivery of services.
Communication and Engagement	• Ensuring staff, patients and the public are proactively involved in co-design and implementation of services and kept updated as to any changes.

Primary Care, Communities & Social Value

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6. What could make or break progress

Key risks to delivery

- Workforce capacity negatively impacting resilience across primary and community care
- Variable levels of resilience across the provider landscape within primary care
- Rural geography impacting upon patients' ability to access services and the development of efficient models of delivery
- Insufficient programme management capacity to enable transformation across a variety of agendas at pace.
- Lack of clarity at a national level as to expected direction of travel with some areas of the portfolio
- GMS contract detail may cause deterioration in service and engagement from GP practices and PCNs
- Competing priorities such as operational pressures and requirements of other programmes of work impacting managerial and clinical capacity available to focus upon transformational change.
- Capacity to transform whilst delivering business as usual
- Shared commitment to change across both provider and commissioner organisations not always in place
- Difficulties in being able to demonstrate impact, including financial, of integration – some measures will be qualitative rather than quantitative.
- Variation in maturity of PCNs
- Maturing third sector
- Delay or lack of investment will impact the delivery of the benefits.
- Variation in ability to capture accurate data to evidence performance and delivery i.e., specific information regarding
- Commissioning and contracting arrangements are not always transparent and consistently implemented
- Financial position within the Lincolnshire Health and Social Care System may impact the ability to invest in transformation, in particular 'invest to save 'schemes.

7. Planning assumptions

Prioritisation of interventions across this portfolio has been driven by:

- National priorities/imperatives i.e. General Practice access targets, Delivery of ARRs roles, Cardio- vascular disease, EHCH
- PHM data identifying cohorts of patients with whom we can have the greatest impact i.e., Frailty, High Intensity Users
- Provider feedback and performance data gathered via the contracting process (this will be further developed into the future as part of the review of commissioning arrangements)
- Opportunities identified within the 'Bed right sizing 'analytics exercise to reduce the predicted growth in requirement for bed utilisation, driven by changes to both demographics and overall demand, from the do-nothing scenario – PEOL
- Requirements of other programmes i.e., Urgent and Emergency Care requirement to reduce demand at the front door by providing suitable and safe alternatives in the community and further developing prevention and proactive care

Key constraints to delivery:

- Available additional funding to support delivery of pilots and new community- based services with a view to investing to save
- Programme management capacity to deliver across a complexity landscape and a variety of interconnected programmes whilst managing the business of usual aspects of the job e.g. primary care commissioning activities and performance management/risk assessment of a wide range of community-based contracts, held with a wide variety of providers of varying size and organisational capacity and capability
- Risk appetite of the system partners to deliver new, innovative and as yet untried solutions and act as system trail blazers
- Bandwidth from partners to engage with pathway redesign whilst delivering against challenging business as usual targets, exacerbated by workforce challenges i.e., recruitment and retention and industrial action

Planning, scoping, implementation, and delivery will be coordinated by the Primary Care, Communities and Social Value ICB team, supported by programme management capacity, managerial and clinical expertise from the providers and analytic capability from both the CSU and the PHM team. Additional specialist capability and capacity may need to be externally procured where this does not exist within the system.

Primary Care, Communities & Social Value

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8. Stakeholders

Stakeholder	Benefit	Engagement Requirement
Patients and the Public	• Improved access to primary care when acutely unwell • Early and proactive identification of longer-term health and care needs • Right treatment at right time by the right professional • Access to the right advice, guidance and information to support proactive self-management	• Willingness to engage with proactive management of their own health • Support to codesign services • Provision of regular feedback to support evaluation of services • Willingness to work in partnership with Health and Social care colleagues to access right services in right place
ULHT	• Reduction in attendances at ED • Reduction in number of bed days utilised • Fewer days between patient being 'discharge ready' and leaving the hospital • Co-development of innovative pathways away from the acute setting • Opportunity to test benefits of new group model	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Provision of programme management/QI capability and capability to support system wide change • Willingness to utilise workforce differently and to support introduction of innovative roles and different cross system ways of working • Willingness to explore, co-design and participate in new models of commissioning/Lead provider delivery models
LCHS	• Opportunity to deliver of newly commissioned services • Opportunities to integrate services with primary care • Opportunities to build upon existing services and secure financial sustainability • Opportunity to test benefits of new group model	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Provision of programme management/QI capability and capability to support system wide change • Willingness to utilise workforce differently and to support introduction of innovative roles and different cross system ways of working • Willingness to explore new models of integrated deliver with primary care colleagues with a view to meeting locally identified need • Willingness to explore, co-design and participate in new models of commissioning/Lead provider delivery models
Primary Care	• Opportunity to create sustainable models of delivery whilst maintaining income • Opportunity to create a sustainable workforce • Opportunity to create improved work life balance, manageable workload, and interesting case mix	• Willingness to explore and co-create new delivery models at both practice and PCN level • Willingness to undertake shared risk taking –financial, operational and reputational to support delivery of new models of care

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8. Stakeholders

Stakeholder	Benefit	Engagement Requirement
ICB	• Improved access to primary care • Improved delivery against nationally agreed performance against nationally agreed targets • Improved patient experience • Improved targeting of resource to gain greatest impact • Opportunity to support realisation of cost avoidance opportunities identified within the bed right sizing analysis • Opportunity to horizon scan with a view to understanding future requirements of the provider landscape and proactively manage the market	• Provision of financial support to allow new community-based initiatives to be piloted with a view to investing to save • Invest in programme management support to allow change to happen at pace. • Agree risk appetite and thresholds for exploring new operating models and new models of commissioning • Support development of workforce, information sharing and digital strategies to allow programme aspirations to be realised • Provide ongoing PMH support to allow populations to be identified and impact of change to be quantified • Provision QI and other support from the Care and Quality Directorate to allow new clinical pathways to be co-created, validated, critically appraised •
LPFT	• Improved partnership and MDT working within the community setting to address both physical and mental health needs of patients • Opportunity to further enhance community-based model of delivery, reducing the need to inflate bed numbers, in a context of population growth	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Willingness to utilise workforce differently and to support introduction of innovative roles and different cross system ways of working •
Voluntary Sector	• Opportunity to influence future direction of travel and pathways of care • Opportunity to deliver new services	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Willingness to utilise workforce differently • Willingness to support engagement with the public in innovative ways

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

1. Future state

Across Lincolnshire, current pressures on urgent & emergency care services remain high, further impacted by periods of Industrial Action. Additionally, demand upon all aspects of health & social care is expected to increase year-on-year due to population growth, the impact of an ageing population and the growing number of people living with Long Term Conditions. By 2030, it is predicted that in order to meet this inflated demand on non-elective care, costs will increase nationally by over 35%. Lincolnshire's age & deprivation profile suggests that the local increase is likely to be higher than that predicted nationally. As of 2021 the percentage of people aged over 85 in Lincolnshire represented 2.9% of the population against 2.4% of the East Midlands population. By 2041 this is projected to make up 4.9% of Lincolnshire's resident population and 4.1% of East Midlands.

The scope of the UEC programme includes the full UEC pathway of care, including discharge and intermediate care, and has significant crossover and interdependence with other system programme areas such as Primary Care, Community Services and Long-Term Condition management. It is important to acknowledge that some of the work to deliver the UEC strategy in Lincolnshire will be completed within other Programme areas, and some of the UEC funded initiatives will transition post mobilisation into BAU within other programme areas. . In order to ensure that patients receive seamless care regardless of where they choose to be cared for (particularly in border areas), close working with neighbouring systems is imperative to ensure that our registered population are able to access appropriate care (including across borders) in a timely way.

Additional publications that are interdependent with UEC programme delivery include:

- Lincolnshire Integrated Care System Strategy 2023-2028
- Health and Wellbeing Strategy and Joint Forward Plan 2023-2028
- Lincolnshire Frailty Strategy 2023
- Elective Recovery Plan
- Group ED Recovery Plan
- EMAS Recovery Plan
- Primary Care Access Recovery Plan
- Fuller Report
- UEC GIRFT recommendations

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

2. What's being done to get there | Overview

The UEC Programme has four key elements to delivering its aims: Prevention; Out of Hospital Urgent Care; Front Door Flow; and In Hospital Care and Discharge, however not all aspects of transformation with sit directly within the UEC Programme. The Prevention elements of the pathway will be co-delivered within the PCCSV programme.

The UEC programme consists of the following:

- Delivery of the national UEC recovery plan, including implementation of all 10 High Impact Interventions
- Implementation of investment initiatives with full evaluations of impact
- Lincolnshire Intermediate Care Programme
- Reviews of existing services and pathways
- Implementation of agreed GIRFT recommendations
- Utilisation of a robust UEC strategic dashboard to aid decision making
- A recovery plan for delivery of the key UEC metrics that sit within the Group model with system assurance and support
- System focus on the improvement against and delivery of the CAT2 mean metric
- System approach to capacity and demand modelling
- Collaborative strategic and tactical/operational working with neighbouring systems on both transformation and BAU

The UEC Programme's governance structure is designed to support its oversight and delivery, with a Programme Delivery Group (PDG) meeting is monthly and reports into the Urgent and Emergency Care Partnership Board (UECPB). UEC system projects and initiatives feed into PDG with the majority of these being captured and recorded on the ICB led Project Management Office (PMO) Aspyre.

Projects plans, milestones, deliverables, risks and issues etc. are recorded on an individual project basis and at programme level and are overseen by the UEC Programme enabling interdependencies and cross overs to be considered.

The current KPIs are the UEC performance metrics, but will be regularly reviewed by the Performance and Planning Group to ensure appropriate metrics are monitored to support decision making and evidence impact.

The governance is revisited and refreshed each year to ensure that it supports the requirements of the National Operational Planning process, and the system priorities each year. This includes specific task and finish group across the system to ensure that protected time and focus is in place to deliver the plans and requirements of the programme.

The UEC allocation in 2023/24 and in 2024/25 has been committed recurrently to a number of system initiatives, but these will be fully evaluated to understand impact and effectiveness in order to support decisions around ongoing and future prioritisation of investment for improved outcomes. The overall UEC investment is reported through the System Sustainability and Investment Panel.

The newly developed UEC Strategic Dashboard supports robust decision making and will be further developed to include benchmarking to ensure that all opportunities for improvement are maximised where there is any evidence of variation.

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

3. What's being done to get there - Detail

2023-2026

The Current UEC System Programme reflects the national recovery requirements, investment initiatives and local priorities for review of service provision and pathways of care. The UEC strategy in place currently covers 2023-2027.

High level ambitions for the UEC programme are:

- Support patients and professionals in accessing the right services in the right way
- Increased and improved communications with public and professionals
- Simplify the provision of services and access processes
- Review services on an ongoing basis to ensure continuous improvement and maximum impact with improved outcomes for patients
- Ensure that regionally commissioned services such as NHS 111 and EMAS are mobilised and delivered in such a way that supports the local pathways and ambitions of Lincolnshire
- Ensure that there are workforce and digital plans in place that support the delivery of the UEC programme and national requirements
- System approach to capacity and demand modelling
- Support the full system focus on improving patient flow across all services
- Minimise the impact of UEC pressures on wider plans including Elective Recovery

10 High Impact Interventions:
The development and delivery of these initiatives are overseen on a monthly basis by the Programme Delivery Group and the Service Delivery and Performance committee with monthly review of progress. The self-assessment against requirements is revisited routinely to provide assurance of progress.

Achievement of the performance standards:
ULHT within the new group model arrangements in 2023 have established a programme of work with executive oversight to deliver the 4 hour performance standard and improve the 12 hour wait in department position. The focus on delivery of these standards will continue with ULHT continuing to lead on these areas of improvement reporting and assuring through UEC system governance. The ICB are a member of the ULHT internal improvement group meetings to represent the system for escalation and engagement/support. Action currently ongoing include revisiting escalation processes and operational management of patients on ambulances and in the department, as well as the flow of patients through the ward areas and on to discharge.

The improvement against the CAT2 mean position in Lincolnshire is supported by the above improvement plan, but the system Ambulance performance and alternatives to ED governance group further supports the delivery of an improved position through reduced conveyance and increased support to patients in community. This includes review of community pathways of care to ensure integrated delivery of services that support people in their own homes and increases in the availability of alternatives to ED. While Virtual Wards have now been implemented and embedded in 2023/24 work will continue to ensure that the specialist community service provision is sufficient to support delivery of VWs and that the appropriate digital infrastructure is available. The ULHT focus on alternatives to ED within acute services will continue to ensure maximum impact of utilisation of areas such as SDECs.

Frailty:
The UEC programme continues to include projects focussed on the frail cohort, nursing and care homes and touches on end of life care. While these initiatives form part of the UEC programme which has oversight and receives assurance, al frailty work is don't in conjunction with the Frailty Programme and the frailty leadership group has responsibility for the wider implementation. UEC supported frailty initiatives will continue to include Frailty SDECs and Frailty Assessment Units, expanding both with increased capacity and geographical coverage in line with population need.

Urgent & Emergency Care

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3. What's being done to get there - Detail

Lincolnshire system approach to the Intermediate care ask:
The Lincolnshire Integrated Care Board (LICB) and Lincolnshire County Council (LCC) committed to exploring joint commissioning opportunities and building on the existing strengths within the current intermediate care system to make the best use of available resources and funding commitments (including BCF discharge funding). Moving towards a system-wide and outcome-based model which prevents unnecessary acute hospital admission, supports timely discharge and maximises independent living.

Strategic review of the current landscape and summary recommendations were endorsed by Chief Executives at the Better Lives Lincolnshire Leadership Team (BLL LT) meeting in May 23. System leads have defined a transformation journey to develop a shared delivery model for intermediate care with a pooled budget enabling collaborative commissioning with one partner holding contracting responsibility.

The next phase of the programme is to determine governance to drive and support delivery of the future model in a phased approach.

The focus of the model which has been developed is to deliver a therapy-led service where every patient can receive a standard level of therapy input, supported by the physical infrastructure and wider features to enable their reablement and rehabilitation.

2026-28

The detailed focus areas for 2026-2028 will be determined by the annual operational planning guidance but will continue to include:

- Delivery of national performance standards relating to UEC including 4 hour performance, ambulance response times, discharge metrics and community service response requirements.
- A focus on increasing care closer to home and reducing the requirement for patients to attend EDs in order to access services both in acute and community
- Evolution of simplified access for both patients and professionals (including HCP SPAs and NHS 111)
- Increased integration of services across pathways of care to ensure seamless care and less handoffs
- Move towards commissioning of pathways of care rather than individual services
- A focus on ensuring workforce and digital plans support the requirements of the UEC programme and provision

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
UEC	Capacity & Demand Schemes		P	I	D	D	D	D E	BAU	BAU	BAU	BAU	BAU	E	I	BAU	BAU	E	I	BAU	BAU	BAU
UEC	Delivery of High Impact Interventions		S	P	I	D	D	D E	D E	BAU	BAU	BAU	BAU	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU
UEC	Discharge & Flow Programme		P	I	I	D E	D E	BAU	BAU	E	BAU	BAU	BAU	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU
UEC	Intermediate Tier Transformation		P	P	P	C	C	I	D	D E	D	BAU	BAU	BAU	BAU	BAU	BAU	E	D	BAU	BAU	BAU
UEC	Commissioner review of UTCs			S	C	C	I	D	D	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU	BAU	BAU	BAU	BAU
UEC	Furrther development and expansion of Virtual Wards		P	C	I	D	D	D	D	E	BAU	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU	BAU	BAU
UEC	Review of UEC service specifications			S	P	C	I	I	I	I												
UEC	Bed Right Sizing UEC specific inititalves	X				S	P C	I	I	D	D	D	D	D								
UEC	Seasonal and operational planning			P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
High Impact Interventions	Same Day Emergency Care		P	P	I	D	D															
High Impact Interventions	Frailty															Implement continuous improvement, learning and refinement						
High Impact Interventions	Inpatient Flow and LoS		P	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Community Bed Productivity and Flow		S	P	I D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Care Transfer Hubs		I	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Intermediate Care Demand and Capacity		P	P	P	C	C	I	D	D E	D	BAU	BAU	BAU	BAU	BAU	BAU	E	D	BAU	BAU	BAU
High Impact Interventions	Virtual Wards		D	D P	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Urgent Commmunity response		E	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S
High Impact Interventions	Single Point of Access			S	P	D	D	E S														
High Impact Interventions	Acute Respiratory Infection Hubs						E															

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

4. Projected impact on patients and system partners

- Improved patient experience – reduction in complaints from patients and professionals, reduction in long waits in EDs and in community for ambulance attendance. Reduction in the number of patients accessing acute services via EDs
- Improved patient outcomes – increase in the number of patients returning to their own home, reduction in long term care requirements, reduction in incidents reported within the UEC pathways
- Reduction in waiting times – in both UTCs and EDs with delivery of the 4-hour performance target and the wider time to first assessment and triage metrics
- Reduction in readmissions – fewer patients requiring re-admission following discharge from hospital
- Increase in the number of patients supported at home avoiding attendance at ED or hospital admission
- Reduction in acute length of stay and acute bed occupancy – ambitions to be developed as part of the planning round
- Reduction in agency/bank and locum spend

Robust system capacity and demand modelling will support the determinations of impact trajectories.

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
High Impact Interventions implementation and delivery	• C&D and BCF funding • Non recurrent regional funding • Additional System funding sources will be required • System transformation resource • System clinical resource • Additional workforce • PCCSV programme support	Support recovery of three key Tier 2 metrics: • 76% ED Performance • 12 hours in department • 30min CAT2 mean delivery Protect elective capacity Mitigate risk of harm and improve patient outcomes and experience	Deliver national performance standards. Mitigate Non Elective Growth Support protection of elective capacity and delivery of the elective recovery plan Mitigate risk of harm and improve patient outcomes and experience	To Be Determined	✓	✓	✓	✓
Capacity and Demand schemes (UEC and BCF investments)					✓	✓	✓	✓
Urgent Treatment Centre Commissioner Review	• UEC Programme capacity • PCCSV capacity • Primary Care support • ICB Contracting and Finance • Business Intelligence • PHM and Health Inequalities support • Comms & Engagement Support	Recommendations around commissioning intentions for future UTC commissioned services based on population need and addressing health inequalities	• Deliver national performance standards. • Mitigate Non Elective Growth • Support protection of elective capacity and delivery of the elective recovery plan • Mitigate risk of harm and improve patient outcomes and experience	To Be Determined	✓	✓		
Delivery of UEC elements of Bed Rightsizing recommendations	Awaiting confirmation of UEC elements and actions to determine inputs, outputs and outcomes						✓	

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Discharge and Flow Programme delivery	System wide: • C&D and BCF investment • Operational • BI • Contracting • LA ASC resource	Improvements in: Discharge quality Patient outcomes and experience Joint working and shared workforce Delivery of Discharge Date Ready Metric (DDR)	• Further improvements in discharge • Move to blended workforce model	TBC	✓	✓	✓	
Intermediate Tier Transformation implementation	System wide: • BCF investment • Operational • BI • Contracting • Commissioning and procurement • OD support • Consultancy support (Impower)	Scope and determine agreed plan and measurable patient outcomes	Full joint re-commission of the whole intermediate tier (health and care) Pooled budget ambition Improved intermediate care pathways with efficiency and financial improvements Improved patient outcomes and experience	TBC	✓	✓	✓	✓
Seasonal and Operational Planning	System wide: • Operational • Finance • BI • Strategic planning • Contracting • ICB UEC and wider programmes	Winter plan 2023/24 Operational Plan 2024/25 Commissioning intentions with rebased contract values and potentially updated IAPs	Summer and Winter plans Annual Operational Plans Commissioning intentions with rebased contract values updated and new specifications and potentially updated IAPs	Summer and Winter plans Annual Operational Plans Commissioning intentions with rebased contract values updated and new specifications and potentially updated IAPs	✓	✓	✓	

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Communications and Engagement – Public & Professional	• ICB and provider Comms & Engagement support	• Improved HCP and patient experience • Timely access to services • Increased care at home and reduced reliance on front door services • Increased public understanding of how to access and utilise services	• Improved HCP and patient experience • Timely access to services • Increased care at home and reduced reliance on front door services • Increased utilisation of most appropriate services first time	• Improved HCP and patient experience • Timely access to services • Increased care at home and reduced reliance on front door services • Increased utilisation of most appropriate services first time	✓	✓	✓	✓
Review of UEC service specification in ICB contracts with appropriate re-design and re-commissioning	• UEC programme commissioning capacity • ICB contract and finance capacity • Provider transformation capacity • Potential additional funding requirements (TBC)	System understanding of workplan for review of specification and capacity to support planned into ICB teams and providers High level commissioning intentions set	Revised specifications start to be CV'd into contracts Fit for Purpose services in line with updated health and care needs including consideration of health inequalities. Potential financial and workforce efficiencies	Revised specifications start to be CV'd into contracts Fit for Purpose services in line with updated health and care needs including consideration of health inequalities. Potential financial and workforce efficiencies	✓	✓	✓	✓

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

5. What's needed to make this happen

- Digital and IG support to ensure that innovative solutions are implemented to support provision of non-acute services such as Virtual Wards, CAS virtual assessment and stack pull capabilities and the integration of HCP SPA with wider partners such as EMAS
- Digital support to link services/partners to ensure that all care plans and current monitoring information is accessible to support decision making that keeps people at home with additional support
- Workforce support to move to more integrated use of workforce both across partner organisations and services to deliver seamless care without barriers or hand offs of patients. There are specific risks around some parts of the UEC pathway such as Frailty which needs focussed support through the PCCSV programme
- Workforce support to better plan for periods of escalation and to ensure that capacity is flexible to meet demand
- Continued engagement of partner transformation teams and operational teams with clinical support
- Future support from PHM to evidence impact and support stratification of priority cohorts within the pathway
- On-going recurrent allocation of the UEC investment made in 2023/24
- Comms and engagement support to continue with flexible and creative public and professional messaging

6. What could make or break progress

The UEC programme delivery and success is interdependent with the following:

- PCCSV programme prioritisation and delivery – Primary care, frailty and long-term condition management programme delivery are key to the success of the UEC programme delivery
- Elective recovery – UEC has the potential to impact delivery of the elective recovery plan and vice versa
- Enablers: Digital and Workforce
- System partners: ULHT, LCHS,LCC, LPFT, EMAS
- Neighbouring systems pressures

Risk/ Challenges	Mitigation
Workforce	Recruitment and retention as well as sickness and absence; reliance on agency and locum staff. Frailty workforce is a particular risk across the UEC and Frailty programmes
Industrial Action	
Increasing patient demand and acuity outstripping capacity	Continue to develop admission avoidance pathways and initiatives to provide more appropriate and timely support
Funding	Utilise additional national UEC and BCF monies to fund interventions with greatest impact
Public behaviours	Comprehensive comms and engagement strategy required
Rurality	Care closer to home will be adopted as a guiding principle when commissioning services with community hub-based models delivered in partnership with PCNs with Virtual Wards supporting patients to receive acute care at home

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

7. Planning assumptions

- A robust system demand and capacity plan is to be developed as part of the national operational planning process.
- Current assumptions are that we will plan to deliver national performance targets.

8. Stakeholders

- ULHT, LHCS, LPFT, EMAS, LCC
- Primary Care, Communities,& Social Value, Planned Care, MH and Cancer Programmes
- PCNs and wider primary care
- Social care commissioners and providers
- Patients and public
- Nursing and residential homes (LINCA)
- Voluntary sector
- Neighbouring commissioners/systems
- Midlands Regional Team
- NHS England

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

Vision

The overall vision for the Lincolnshire system is to reduce waits for patients who require planned care and diagnostics back to constitutional standards as soon as possible, improve patient access to these services and reduce inequalities across the county. In a recent patient and citizen survey (undertaken as part of the development of the Joint Forward Plan) 54% put improving waiting times for routine services such as diagnostic tests or operations as their top priority.

Background

Waiting times are still the most challenging aspect for elective recovery. Prior to the junior doctor industrial action, the Lincolnshire system was on track to eliminate waits of 78 weeks by the end of March 2023. Unfortunately, both this and the additional industrial action by consultants impacted on ability to achieve this, but the system is focussed on eliminating 78 week waits as soon as possible. ULHT as the main Acute Provider has multi-year programmes (Outpatient Improvement Programme & Productive Theatres Programme) to take forward the Elective Care improvements required which focus on key projects like High Volume Low complexity & Patient Initiated Follow Ups

National and Local Targets

Trajectories/targets up to March 2025 have been established nationally & locally as follows:

Eliminate 65 week waits by September 2024 and 52 week waits by March 2025.

- The system is on trajectory to eliminate 65 week waits by September 2024.
- Local ambition to eliminate waits of 52 weeks by March 2025.
- The system will achieve the reduction in these waits sooner than in some specialties.
- The Elective Activity Coordination Hub (EACH) will support longer waiting patients and their practices in managing their wait and looking for alternative options.

Increase patient choice.

- If patients are provided with greater choice at the point of referral the overall waiting list volume will reduce.
- If patients are provided with a proactive opportunity to move provider if waiting more than 18 weeks, the number of long waiting patients will reduce.

Increase Activity.

Increasing activity delivered will also drive a reduction in waiting lists. Each of the providers across the system have been set individual activity targets for 2024/25 as follows:

- United Lincolnshire Hospitals Trust 113%
- Out of Area Providers Including Contracts with North West Anglia Foundation Trust and North Lincolnshire and Goole Trust 105%
- All other existing Independent Sector Providers 100% plus locally agreed increases

To sustainably deliver the levels of patient activity required for 2024/25 onwards, all providers will need to increase productivity and efficiency of the services delivered. The detail of this will be part of annual planning rounds.

Demand Management.

- Reducing demand overall is a key priority to support waiting list reduction and the Elective Activity Coordination Hub (EACH) will continue to provide a system-wide single point of access for planned care referrals for Practices, Providers and Patients.
- In addition, promoting self-care and increasing activity within community services will reduce demand on both secondary care services and primary care and this will be a focus for 2023-28.

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

National & Local References

- The NHS Planning Guidance for 2024/25
- The National agenda around Elective Recovery currently:
  - PRN00496: Elective Care Priorities
  - PRN00673: Protecting & Expanding Elective Capacity
- The National Agenda around Patient Choice:
  - PRN00507: Patient Choice
  - National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (“the Standing Rules”)
  - National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (“the PPCCRs”).
- The National agenda around Primary Care Recovery:
  - PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023
- The NHS Lincolnshire Joint Forward Plan 2023-2028 particularly around Priority 3: Improving Access

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

2. What's being done to get there | Overview

Eliminate 65 week waits by September 2024 and 52 week waits by March 2025.

- All patients in the 65-week 'cohort' *(patients who, if not treated by 31 September 2024, will have breached 65 weeks*) will be given a first outpatient appointment before 1st July 2024 in most specialties to ensure their treatment pathway is completed by September 2024.
- Mutual aid will continue to be delivered predominantly from independent sector providers for challenged specialties.
- Any learning from a national 'Going Further Faster' scheme will be reviewed and implemented where appropriate. This scheme has focussed on eliminating 52 week waits sooner than the current March 2025 target.

Increase patient choice

- Implement a system level plan for patient choice which ensures compliance with the regulatory requirements and raises the profile of patient choice. This will include a local communication plan with both practices and patients to complement the national communication campaign. This will also be aligned to the Lincolnshire Joint Forward Plan priority around improving access as it will help Lincolnshire patients understand their rights and how to access the care they require.
- Ensure all opportunities to both request and offer mutual aid both within and outside of the DMAS system are regularly reviewed and progressed.
- Promote the use of the Elective Activity Coordination Hub (EACH) which offers choice to all planned care patients at point of referral.

Increase Activity

- ULHT will develop an overall clinical service strategy and establish a rolling programme of specialty clinical service strategies.
- Expand implementation of Getting It Right First Time (GIRFT) programme to other specialties.
- Expand the range of services and procedures to be delivered in the community and moved away from secondary care.
- Work with independent sector providers to deliver additional capacity where there are challenged specialties at our NHS providers
- Expand the programme of out-patient transformation and theatre utilisation to maximise capacity and efficiencies to reduce waiting times.
- Maximise capacity at the recently accredited Grantham Surgical Hub using HVLC principles.
- Implement and expand the estate strategy supporting modernisation and utilisation of space.

Demand Management

- Reducing demand overall is a key priority to support waiting list reduction and the EACH will continue to provide a system-wide single point of access for planned care referrals for Practices, Providers and Patients. Currently 6 specialties are clinically triaged via the EACH, but a review is planned to determine priorities for 2024-28 to ensure both effectiveness and to maximise on opportunities to re-direct to more appropriate services.
- In addition, promoting self-care and increasing activity within community services will reduce demand on both primary and secondary care services and this will be a focus for 2023-28.

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

Eliminate 65 week waits by September 2024 and 52 week waits by March 2025.

- Joint monitoring of long-waiting patients undertaken multiple times per week by ULHT/ICB and every two weeks with ISPs for assurance, to remove barriers and to source solutions where patients are undated.
- Close monitoring of patients waiting for specialist diagnostics etc. at out-of-area providers which may delay their overall pathway at ULHT.
- Monitoring of Lincolnshire patients at out-of-area Providers who may be suitable for repatriation into the Lincolnshire system.
- A rolling programme of Technical Referral To Treatment (RTT) Pathway validation for all patients waiting 12+ weeks to ensure they are on an appropriate pathway.
- A rolling programme by Providers and the EACH of administrative validation which includes contacting patients to ensure an appointment is still required.
- Continue with local mutual aid from independent sector providers for challenged specialties.
- Any learning from a national 'Going Further Faster' scheme will be reviewed and implemented where appropriate once data available. This scheme has focussed on eliminating 52 week waits sooner than the current March 2025 target.

Increase patient choice.

- Implement a system level plan for patient choice which ensures compliance with the regulatory requirements and raises the profile of patient choice.
- Ensure all opportunities to both request and offer mutual aid both within and outside of the DMAS (Digital Mutual Aid System) are regularly reviewed and progressed.
- Promote the use of the Elective Activity Coordination Hub (EACH) which offers choice to all new planned care patients at point of referral.
- Deliver a local programme of patient engagement and communication to ensure patients understand their options around choice and address transport issues where feasible to encourage patients to access the most appropriate provider with shortest waits.
- Maximise patient transport options by encouraging use of available resources including the national health care travel costs scheme, Non-Emergency Patient Transport Service and local alternative transport options.
- Reintroduce directly bookable appointments with Providers to increase choice as this is known to reduce missed appointments (previously known as Did Not Attend (DNA) and Was Not Brought (WNB)).

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

Increase Activity/Capacity.

- ULHT will develop an overall clinical service strategy and establish a rolling programme of specialty clinical service strategies. For planned care ENT and Gastroenterology are the priority. The strategy will be developed in line with the Lincolnshire Academy of Clinical Excellence (LACE)
- Expand implementation of Getting It Right First Time (GIRFT) to other specialties. This the backbone of service re-design and implementation and is the core of the improvement work planned in Lincolnshire. NLAG, ULHT and NWAFT (as the main NHS providers) have all integrated the principles of the Getting It Right First (GIRFT) initiatives to a greater or lesser extent. At ULHT the GIRFT programme is a substantial part of the improvement plan building on the success of previous schemes such as the Trauma and Orthopaedic and Urology redesigns delivered in recent years to great success.
- Alongside this is a programme of out-patient transformation for maximising capacity and efficiencies to reduce waiting times plus an estate strategy supporting modernisation and utilisation of space. The estate strategy includes maximising capacity at the recently accredited Grantham Surgical Hub using High Volumes Low Complexity (HVLC) principles.
- Expand the Community Surgical Scheme and other community services to increase number and type of procedures undertaken.
- The ULHT Grantham elective hub is driving though elective activity and supporting out of county patients.
- Reaching the GIRFT standards for High Volume Low Complexity will facilitate greater activity – e.g. 8 patients on cataract lists as a standard across all providers

Demand Management

- Reducing demand is also a key priority to support waiting list reduction and the EACH will continue to provide a system-wide single point of access for planned care referrals for Practices, Providers and Patients. This includes referral optimisation/demand management through primary care led triage, provision of specialist advice, application of the 10 interventions listed in the latest Evidence Based Interventions policy (List 3 published May 2023), ensuring Blueteq is widely used for requesting prior approval, maximising utilisation of ISPs and locally commissioned community services.
- The EACH will also support Onward Referrals where if a patient has been referred into secondary care and they need another referral the secondary care provider should make this for them rather than sending them back to general practice to a further delay before referred again. This will improve patient care, save time, and reduce bureaucracy for General Practice. The EACH will support by offering the patient an alternative choice of provider to access shorter waiting times for the onward specialty if appropriate.

Workforce

- The workforce will be encouraged to have a 'can do' approach which focuses on what matters to people and to think and act creatively to make things happen for them.
- Develop a variety of different workforce models utilising different skill sets and best practice including multidisciplinary teams to support one stop services.
- Within ULHT the Productive theatres programme has a workforce modernisation project which is focused on increasing skill mix of staff to have a more agile workforce to deliver elective care across all sites

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

Impact on Patients:

- Decreased waiting list – measured weekly via WLMDS submission.
- Decreased waiting times in line with, or better than, national trajectory - measured monthly via the national My Planned Care platform and the national electronic Referral Service.
- Reduction in harm caused by long-waits (measured through evaluation of harm reviews by Quality team)
- Increase in choice of Provider where appropriate – measured though the EACH and e-RS reports.
- Increasing the utilisation of the EACH gives patients a single point of access for all appointment queries – measured through EACH Practice utilisation reports and Practice visits.

Impact on System Partners:

Impact on system partners is being worked through as part of the current planning round and will be discussed when the annual planning guidance is released

5. What's needed to make this happen

- Increased activity within acute provider including reducing current inefficiencies. This is dependent on delivery of the improvements in the outpatient transformation and HVLC programmes.
- Increasing independent sector contracts to allow for equalising/reducing waiting lists by outsourcing, insourcing and transferring patients where patients can be treated quicker.

6. What could make or break progress

Challenges, Issues & Risks

- Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit.
- Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.
- Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.
- Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity.
- Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.
- The PIFU target is measured against all outpatient New and Follow-up activity. There is a risk the target will not be met as some specialties are not suitable for PIFU but their New and F/up activity will still be included in the figures.
- There is an established system-wide governance programme for planned care and diagnostics. All risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

7. Planning assumptions

- Current assumptions are that referrals remain static, and the system is working on using the available capacity to its maximum efficiency.
- That all national targets will be met, and remedial action will be implemented should performance be adverse to trajectories.
- All planned care programmes are interdependent and contribute to the delivery of waiting list reduction. Targets for this are set nationally.

8. Stakeholders

Stakeholders

- Acute Providers
- Independent Sector Providers
- GP Practices
- Lincolnshire Clinical & Care Directorate (including Lincolnshire Academy of Clinical Excellence (LACE), Clinical & Care Academy (CCA) and Lincolnshire Learning Network (LLN))
- Health and Well Being Board

Project team

- ULHT COO & SRO for Planned Care
- ULHT Deputy COO, Planned Care & Cancer
- ULHT Head of Elective Access
- ULHT Clinical Lead for Planned Care
- ICB Planned Care and Diagnostic Programme Director
- ICB Deputy Planned Care Manager & EACH SRO
- ICB & ULHT Contracting Teams
- ICB Chief Medical Officer

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

Outpatients

- It is widely discussed and highlighted in the NHS Long Term Plan that the current model of outpatient services is outdated and needs transforming to meet the current demands on the NHS. Over the next four years the Lincolnshire system will work together to develop new models of outpatient care including increasing the virtual offer as well as considering how artificial intelligence and other digital solutions could streamline services and make them more efficient.
- The ambition for the Outpatient Improvement Programme is to reduce risk of harm to patients as a result of excessive waiting times by recovering OP capacity in excess of 19/20 levels and to reduce the number of OP follow-up activity. This is at all providers to support the elective recovery with the short-term ambition at ULHT to increase new outpatient and outpatient procedure activity to 113% of 19/20. This will be amended depending on national planning guidance and system need in future years. These ambitions will be delivered through a number of initiatives outlined in the NHSEI Personalised Outpatient Programme using the evidence-based principles, specialty guidance and framework of Getting It Right First Time (GIRFT).
- There are significant opportunities for digital improvements within the outpatient programme including electronic communication with patients, using automated robots for some simple communication, the ability to change appointments electronically, better interfaces with the NHS app and enhancing the offer of virtual consultations. The Electronic Patient Record (EPR) and Electronic Prescribing and Medicines Administration (EPMA) are key enablers in these improvement solutions. These are due to be implemented before 2028.
- There are opportunities to expand on the current Further Faster work which has produced a recovery plan to increase out-patient productivity. This plan identifies ENT, Cardiology, Ophthalmology, Trauma and Orthopaedics as the specialties with largest opportunities.
- It is accepted that the main opportunity is increasing the number of 1st outpatients and increasing the efficiency of clinics. This will support the elective recovery fund ambitions as well as the waiting list recovery. All of the above schemes will contribute to this, but there needs to be a focus on dating as many new referrals as possible.

Ensure the out-patient improvement programme continues to align and expand on the NHSE Improving Elective Care Coordination for Patients (IECCP) Programme including the following:

Virtual Consultations

- Objective: To maintain virtual consultations at a minimum of 25% for all specialties (where clinically appropriate) in line with national requirements. To scope the opportunities for different options including clinicians being at one site and patients and outpatient nurses being at another site. This includes using GP practices and Community Diagnostic Centres. This would be better for patient as it would support access and reduce travel; and be better for the environment as it would reduce the number of patient journeys.

PIFU

- Objective: Average of all specialties to achieve 5% of all outpatient activity with stretch targets for those specialties that achieve this. This will support the ambition to reduce follow-ups in line with national requirements. It will also increase personalisation of care for patients including Personalised Stratified Follow-Ups for cancer patients.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

Specialist Advice

- Objective: Increase the pre referral specialist advice usage in line with National requirements which will enable patients to be given advice without the need of a referral to secondary care.
- Increase Provider level usage of specialist advice to at least 16% of new outpatient appointments and roll this out to all specialties enabling patients to be managed without the need for a referral which will help to reduce to waiting times. Where specialties are already achieving this, stretch targets will be discussed to ensure continuous improvement.
    - Whilst the majority of specialties offer A&G in ULHT, improvement is needed on the turnaround times to encourage increased uptake in primary care.
    - The remaining outpatient specialties at ULHT will fully engage with embedding and delivering advice and guidance.
    - NWAFT and NLAG specialist advice services are part of their system outpatient improvement plans. There is regular engagement between Lincolnshire and neighbouring systems to ensure any best practice and challenges are shared.
- Review of the specialist advice dashboard shows that the system has achieved over 30% specialist advice requests, with some months as high as 36%. The future assumptions are that current performance maintains for the post-referral specialist advice services.

Increasing Clinic Utilisation

- To increase and maintain clinic utilisation to 95% via a variety of programmes including implementing the 6-4-2 Process, directly bookable appointments, and reducing missed appointments.

In/Out of scope

- Specialist Advice/ Virtual Consultations and Follow Up reductions – All Specialties in scope.
- PIFU – Majority of Specialties (Some Specialties are not suitable for PIFU, working with National team and Acute providers to identify those that are out of scope)
- Out of area providers will be monitored separately and performance managed through their own system governance.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

2. What's being done to get there | Overview

All acute providers are part of their system outpatient transformation programme. In Lincolnshire the ICB and ULHT work closely together to develop and implement improvement actions. ULHT have established an Outpatient Improvement Programme with resource of a Programme Delivery Manager and Project Managers who lead on the outpatient transformation schemes, including, Advice and Guidance, Virtual Consultations, Patient Initiated Follow Ups (PIFU) and outpatient follow up reduction. The project managers work closely with operational colleagues from the divisions to develop bespoke action plans for each specialty and monitor the implementation. The Outpatient Recovery Improvement Group is embedded within ULHT governance and has robust objectives and responsibility for delivering the necessary improvements. The Outpatient Programme of work also reports into the Planned Care and Diagnostic Programme Group at a system level.

The system are implementing the initiatives and opportunities both identified and outlined in the NHSEI Personalised Outpatient Programme using the evidence-based principles, specialty guidance and framework of Getting It Right First Time (GIRFT).

The system has monthly meetings with NHSE on the outpatient programme to provide assurance and understand if there is anything additional the system could be introducing. Both ULHT and ICB representatives are in regular contact with NHSE Subject Matter Experts and engage in best practice reviews and lessons learned.

Digital solutions to improve patient experience and improve the efficiency of outpatient services are already being scoped. Automated robots are due to be implemented for simple queries and to help patients navigate the outpatient booking processes, and the current outpatient patient portal is due to be linked to the NHS app in the next year.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

Virtual Consultations

- The system are meeting the National requirement of 25% and the ambition is to maintain this performance.
- The data is regularly monitored to ensure the system maintain this usage.
- Further work to be done internally by providers to monitor on a specialty level to ensure those specialties who are not meeting the target increase their virtual consultation usage, where clinically appropriate.

Patient Initiated Follow Ups (PIFU)

- Re-visit specialties where PIFU is live to maximise utilisation.
- Explore opportunities with Divisions to rollout PIFU to the smaller specialties across the Trust and develop a programme and commence rollout where appropriate.
- Explore opportunities with Divisions for discharging/outcoming a patient to PIFU post ward stay/surgery and post-op and implement where appropriate.
- Explore opportunities to utilise available system funding for Remote Patient Monitoring
- Continue to engage with NHSEI Outpatient Transformation forums to share and disseminate best practice.
- Promote the utilisation and benefits of PIFU through communication and engagement.
- Conduct patient satisfaction surveys.
- PDSA the systems and processes that support the PIFU function.
- Continue to monitor and report on the PIFU utilisation against plan.

Specialist Advice

- Specialist Advice – Continue to perform better than the national target of 16% of new outpatient attendances; and work towards increasing the provider level usage. Where specialties are meeting the 16%, stretch targets will be agreed.
- Reviewing response times by specialty for A&G through e-RS for all providers. Actions to be agreed with each specialty where this is outside of the 48-hour response period.
- Develop a feedback process on the quality of advice and guidance responses. This will be done linking in with the Clinical and Care Directorate in the ICB.
- Review the conversion rates of A&G to referral and work with primary and secondary care to review pathways and agree necessary actions. This will be done across all providers where there are significant levels of Lincolnshire patient activity.
- Develop a communications plan to encourage take up within Primary care and to liaise with the Primary Care team on the PCN Impact and Investment Fund indicators.
- Benchmark performance across providers and specialties and learn from best practice. The system improvement plan is to now engage with those specialties that are not hitting the 16% target and plan to drive the use and response rates up.
- Development of an A&G tracking tool by ULHT to help with monitoring and pulling together a plan to continue those conversations with the specialities who are not hitting the 16%.

Increasing Clinic Utilisation

- 6-4-2 Process: Implement the 6-4-2 process for booking patient slots.
- Directly bookable: Expand directly bookable functionality to all major specialties (aligned to the GIRFT framework) allowing for appointments to be directly booked following patient choice discussions undertaken in the EACH. This will reduce DNAs and increase administration capacity within the Choice and Access team.
- Reducing Missed Appointments (Did Not Attend (DNA) and Was Not Brought (WNA): Expand on current programme to reduce Missed Appointments to <6% by implementing directly bookable slots as above, ensuring choice discussions are had with patients, utilising full digital functionalities to advise patients of appointment including text services and digital letters.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

- Improved patient experience – reduction in complaints from patients and General Practice queries
- Reduction in waiting times – to support the national ambition to eliminate waits of 65 weeks of more by 31st September 2024
- Reduction in DNAs - this has been part of the national 'Action on Outpatients' programme and is embedded as a key enabler in ULHT's Integration and Improvement Plan
- Reduction in agency / bank and locum spend.
- Impact on system partners is being worked through as part of the current planning round

5. What's needed to make this happen

- Digital support from the System and ULHT to ensure innovative solutions are implemented to support booking processes. This includes support to suggest what could be done differently as well as the capacity and capability to move at pace when solutions have been identified.
- Engagement from clinicians and operational teams with the improvement programmes across the system (both primary and secondary care)

6. What could make or break progress

Interdependencies with other programmes/organisations

- Outpatient Improvement Programme – ULHT
- GIRFT
- NHSEI POP
- Digital programme

Challenges, Issues & Risks

- Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit.
- Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.
- Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.
- Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity.
- Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.
- The PIFU target is measured against all outpatient New and Follow-up activity. There is a risk the target will not be met as some specialties are not suitable for PIFU but their New and F/up activity will still be included in the figures.
- There is an established system-wide governance programme for planned care and diagnostics. All risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

7. Planning assumptions

- Current assumptions are that referrals remain static and the system is working on using the available capacity to its maximum efficiency
- That all national targets will be met and remedial action will be implemented should performance be adverse to trajectories
- All planned care programmes are interdependent and contribute to the delivery of waiting list reduction. Targets for this are set nationally.

8. Stakeholders

- Suganthi Joachim – Divisional Clinical Director, ULHT
- Sameedha Rich-Mahadkar - Director of Improvement & Integration, ULHT
- Sarah Brinkworth – System Planned Care & Diagnostic Programme Director, ICB
- Claire Probert - Deputy Director of Integration Directorate, ULHT
- Joanne Quigley – Programme Manager, ULHT
- Jade Nottingham – System Planned Care Project Manager, ICB
- Project Managers ULHT
- ICB Primary Care Leads
- Clinical and Operational resource needed for each specialty
- Digital leads

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

The vision for the high volume low complexity (HVLC) programme is to support the elective recovery and deliver the national ambitions around planned increase in day case procedures and theatre utilisation. This will be done through developing a system approach which utilises primary care and community services to support delivery in an integrated and seamless way.

The objective is to deliver the elective recovery by improving theatre utilisation and productivity in line with Getting It Right First Time (GIRFT) principles, reducing the backlog of patients waiting for operations and improving patient outcomes. The national HVLC programme focusses on six specialities (orthopaedics, ophthalmology, ENT, gynaecology, urology, general surgery) with the potential for additional specialities being added by the national team in future years.

The aim of the programme is to:

- Increase day case rates to 85% e.g. HVLC cataract should be 8 patients per training list or 10 patients per non training list
- Apply the British Association of Day Surgery recommendations – minimum of 85% of patients being treated as day case
- Improve Theatre productivity.
  - Improve average late start – aim to ensure all theatres start on time
  - Improve average early finish – aim to ensure that theatre capacity is fully utilised
  - Improved capped theatre utilisation.
  - Improve pre-op assessment for all specialities.

In/Out of scope:
Only the nationally identified specialities are within scope. The GIRFT recommendations will be used to drive change

2. What's being done to get there | Overview

- Driven by GIRFT ULHT have undertaken a review of the specialities to inform the future direction of travel and prioritise the programme of work.
- The system have taken part in gateway reviews for each of the six specialties under the HVLC programme as well as full system review meetings with the national GIRFT lead.
- The Trust have established a theatre productivity work programme to increase day case rates and theatre utilisation. There are formal governance arrangements behind this to discuss, challenge and escalate any issues.
- Grantham has been approved as a National Surgical Hub: As a surgical hub this needs to be developed to include a range of specialties, as well as improve sessional utilisation and expand to 7 day working. The system needs to ensure productivity and efficiency is increased over the next 5 years and to look at mutual aid opportunities and providing capacity to other systems.
- ULHT are scoping the potential for Louth to be the system ophthalmology Hub for HVLC.

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

- ULHT have established a theatre productivity programme with resource of a Programme Delivery Manager and Project Managers who lead on the theatre productivity schemes including, increasing day case rates, increasing theatre utilisation and improving pre-operative assessment. The project managers work closely with operational colleagues from the divisions to develop bespoke action plans for each area and monitor the implementation. The theatre productivity work programme is embedded within ULHT governance and has robust objectives and responsibility for delivering the necessary improvements.
- The system have engaged in gateway review meetings for all six HVLC specialties. These are chaired by the national GIRFT lead for that specialty and involve a presentation delivered by the relevant clinical teams. Action plans are then developed and monitored through quarterly review meetings with the national GIRFT lead. These action plans continue to be updated and new improvement actions identified.
- The Grantham surgical hub was given formal approval during 2023 and the delivery plan for future years includes expanding this to 7 day working and increasing the number of sessions per day. This is supported by the Productive Theatres programme at ULHT which is increasing theatre utilisation and day case rates. The intention over the next 4 years is to increase the range of specialties and procedures that take place in the hub and to support neighbouring systems with their elective recovery. There is a plan to increase day case surgery rates to ensure compliant with British Association of Day Case Surgery (BADS).
- ULHT are scoping the potential to use Louth Hospital as an ophthalmology hub. This worked well during the initial covid recovery and managed to support the backlog of review patients. More detailed work is needed to understand the benefits and challenges of developing this.

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

- Improvement in appointment times: patients will have a reduced wait for an outpatient appointment.
- Improvement in waiting times for surgery: patients will have a reduced wait for a surgical procedure.
- Improvement in quality outcomes – as system matures, so will the clinical experience and clinical outcomes improve.
- Increased productivity in day case procedures – completing more activity than before in the same time.
- Reduce the number of bed nights by utilising day case.
- Manage day case more effectively through Productive Theatres negating the risk of an overnight stay e.g.. schedule more complex day case first thing in the morning rather than last thing at night
- Reduce LOS following elective surgery by implementing discharge plans on admission e.g., for hip replacement – have physio and OT in place to mobilise patient on return from surgery, ensure appropriate adjustments had been made at home.
- If GIRFT principles are followed - it will ensure a positive impact on system partners in terms of increased activity, engaged workforce, reduce financial pressures improved patient satisfaction.
- Impact on system partners is being worked through as part of the current planning round

5. What's needed to make this happen

Input from providers

- Patients:
- Primary/Community Care:
- Optical Practices:
- Acute Service:
- 3rd Sector:

Requirements from

IT Connectivity

- Integrated technology
- Where possible multi-disciplinary team working (both in person and virtually)

Other support requirements: the ICS already engages well with many community assets – this needs to be business as usual across Lincolnshire

- 3rd sector
- Voluntary sector
- Community assets
- Volunteer sector

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

6. What could make or break progress

- Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit.
- Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.
- Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.
- Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity.
- Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.
- There is an established system-wide governance programme for planned care and diagnostics. All risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

7. Planning assumptions

- Current assumptions are that referrals remain static and the system is working on using the available capacity to its maximum efficiency
- That all national targets will be met and remedial action will be implemented should performance be adverse to trajectories
- All planned care programmes are interdependent and contribute to the delivery of waiting list reduction. Targets for this are set nationally. Current baseline position is being assessed, and trajectories developed, via planning discussions currently underway with partners. National planning guidance is still awaited before finalising.

8. Stakeholders

- Patients
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Integrated Care Board
  - Planned Care
  - Primary Care
  - Cancer and E.O.L
  - Diagnostics
- Integrated Care System – Better Lives Lincolnshire

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

- Continued development on the expansion of CDC services at Grantham and the implementation of two new CDC facilities at Lincoln and Skegness to expand capacity for the main key diagnostic tests including MRI, CT, ECHO, NOUS, DEXA, and plain film, in addition to other services such as AAA, DESP and the delivery of some forms of chemotherapy in the east of the county.
- CDC capacity may be flexed to respond to regional demand if required. This additional capacity will support the natural increase in existing demand across the county, support the identification of unmet and hidden demand, reduce total waiting lists, improve 6ww and 13 ww compliance to meet the 95% target in March 2025, and address the need to increase capacity in areas of inequality and deprivation.
- Scoping, feasibility, development and implementation of a fourth CDC facility in the Boston area of the county to respond to local demand and address the local needs in an area of deprivation and inequality.
- Delivery of a new endoscopy unit and PET CT unit in Lincoln will provide the required levelling up to 3.5 endoscopy rooms per 100,000 population over 50 years of age and support cancer targets with the provision of additional capacity
- Development of new patient booking system to enable patients to book appointments electronically once their referral has been vetted and approved by clinical teams. In addition to freeing up workforce time, the system will also provide flexibility for patients to arrange appointments which are convenient to them and provide them with a text reminder service to facilitate a reduction in DNAs. This will improve productivity and efficiencies across the system and. support a more effective system to maximise available capacity.
- Capitalise on new digital and technological opportunities with the utilisation of electronic systems to maximise existing capacity and increase clinical performance and efficiency with the implementation of remote scanning software such as RadCockpit to enable remote supervision and the introduction of artificial intelligence software in radiology to reduce times from referral to diagnosis.

2. What's being done to get there | Overview

- A CDC project group and related governance support meetings has been set up to oversee the development and implementation of the CDC facilities across the county, with ULHT being identified as a lead provider.
- Continued review and development of a robust communication and engagement strategy to ensure that the views, opinions and insights from stakeholders are at the core of the decision-making process to improve diagnostic provision and ensure that the needs of the community and the system are met. This will contribute to the ambition to address health inequalities, as well as being aligned to the Lincolnshire Joint Forward Plan ambition to improve access and support the public in understanding how best to access services.
- Continued review and interrogation of demand & activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities, and to support optimal locations are identified for future CDC sites. This will be refined and continue throughout the during of the CDC project.
- Continued consultation and collaboration with existing and new system partners, including those from the independent sector, to ensure services are delivered effectively, efficiently and as productively as possible.
- Work with the System main provider to ensure that development of the new endoscopy and PET CT facilities are delivered as planned.
- Implementation of a 6-month trial of the SwiftQ booking process 6-month trial which is being funded by EMRAD.
- Implementation of the Rad Cockpit software which has been funded and approved as part of the CDC programme and progress the bids for AI funding to trial AI software in radiology.
- Continued engagement with both regional and national project leads for the CDC programme to maximise any additional opportunities for Lincolnshire patients. This will enable us to have advance notice and allow us time to be responsive and flexible in our design and implementation approach.

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

- Appropriate governance structures have been put in place to ensure the CDC project addresses its aims and objectives to increase diagnostic capacity and provision across the county, support Covid recovery, improve accessibility for rural and deprived communities, contribute to the reduction of health inequalities, and maximise productivity and increase efficiencies across diagnostic service provision. This project has been ongoing since 2021 and is currently expected to continue until 2025 which is when the national project is planned until, however it is extremely likely that funding will continue beyond this point. A system project team has been identified to implement the agreed delivery plan, with collaboration from a wide range of stakeholders including NHS, local authority and independent sector provider colleagues, together with input from patients and members of the public through surveys, engagement events and a patient co-production group. Following the successful implementation of the CDC project, we will oversee the effective integration of CDC services into business as usual from 2025 onwards.

- Continued review and development of a robust communication and engagement strategy to ensure that the views, opinions and insights from stakeholders are at the core of the decision-making process to improve diagnostic provision and ensure that the needs of the community and the system are met. This includes the creation and ongoing development of a patient co-production group to support the plans for CDC provision across the county, together with a proactive engagement campaign to raise the profile of CDCs and seek further feedback, ideas and suggestions to improve services across the county. This will continue for the length of the project until March 2025, following which a review will be undertaken to agree any further actions which may be required.

- Continued review and interrogation of demand and activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities, and to support optimal locations are identified for future CDC sites. This will be refined and continue throughout the during of the CDC project, as we gain more intelligence on the nature and demand of unmet need, hidden demand and clinical improvements in diagnostic advancements. Following the implementation of CDCs, the requirements for ongoing demand and capacity modelling will be embedded into day-to-day management processes and annual planning.

- Initial consultation and collaboration with existing and new system partners, including those from the independent sector, to support clinical pathways, enhance partnership working, increase diagnostic capacity and ensure good levels of productivity and efficiencies. This work has already commenced and will continue throughout the life of the CDC project. It is expected that continued collaboration with multiple partners will become the norm as we embrace provider collaboratives as a key component to system working, to support the planning, delivery and transformation of clinical services to meet the need of our community now and in future years.

- Work with the System main provider to ensure that development of the new endoscopy and PET CT facilities are delivered as planned.

- Review of the SwiftQ booking process 6-month trial which is being funded by EMRAD. Following the initial trial, which is being led by our main provider, continue to provide support to ULHT and EMRAD to progress the effective implementation of an electronic booking process across the Trust.

- Implementation of the Rad Cockpit software system to support remote supervision across CDC facilities, and trialling of AI software to enhance current radiology effectiveness and reduce times from referral to diagnosis.

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

- Grantham CDC and development of additional facilities in Lincoln, Skegness and potentially Boston.
- Increasing diagnostic capacity to reduce waiting times, address unmet need and improve performance metrics. This will be for planned and unplanned care, as well as cancer pathways. By moving outpatient diagnostics off the main acute sites, capacity will be created to improve UEC pathways and for more complex patients include cancer and cardiac tests.
- Meet the aim to provide diagnostic tests to 95% of patients within 6 weeks by March 2025. Progress will be monitored and evaluated on monthly basis through analysis of patient waiting times data.
- Improve productivity and efficiency through the transformation of clinical pathways, with the provision of co-ordinated diagnostic testing and inclusion of new technology.
- Significant increases in planned diagnostic tests for 2024/25 and 2025/26 as the two new CDC facilities become fully operational, where it is anticipated that activity will be in excess of 150,000 tests in total for all three sites. To date the CDC programme has delivered more than 63,000 additional diagnostic tests at the Grantham site. CDC activity data is monitored weekly and reported through to internal system governance structures and national report databases.
- Increase in digital interoperability and connectivity across the system to provide greater information sharing between system partners and enable improved management of complex cases, in addition to providing patients with more choice when booking their appointments through an electronic system and at CDC sites which are closer to home and easy to access. Patient utilisation of CDC facilities and DNAs will be monitored to measure effectiveness and provide intelligence for future planning.

5. What's needed to make this happen

- System collaboration and local engagement with NHS and SP stakeholders to progress the CDC programme.
- Continued support from regional colleagues in the development of CDCs, sharing and learning from experiences.
- Continued revenue and capital funding from national CDC initiatives to support the CDC programme and other digital innovation.
- Collaboration with Regional workforce teams to support international recruitment and other workforce initiatives.
- Ongoing review and implementation of advancements in technology to improve efficiencies and maximise capacity of diagnostics.

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

6. What could make or break progress

- Non-elective pressures/capacity: Access to theatre capacity may be reduced due to competing Emergency and Elective pressures and insufficient provision of post op beds will have a negative impact on carrying out elective procedures thereby limiting the reductions in waiting list times. There will be a requirement for the system to support discharging patients who are medically fit at the earliest opportunity to maximise bed capacity and for the development of aligned clinical pathways to maximise efficiency and productivity of diagnostics at CDC site.
- Workforce: Significant workforce issues may arise due to high levels of sickness & absence; difficulties in recruitment and retention in key geographical areas and inability to recruit workforce with the required skills to staff new and existing clinical facilities. A reduction in existing workforce may also occur with staff moving into specialist roles and difficulties with/or the inability to recruit to more junior roles. There may also be a reluctance to undertake additional sessions due to exhaustion and a heavy reliance on locums or agency workers. Transformation planning requires the same clinical and operational staff as business as usual and industrial action may impact on availability of workforce, particularly in respect of the junior doctors and consultants. Failure to support the University of Lincoln Radiology courses as part of the CDC programme, may delay the future availability of qualified students and the ambition to encourage a locally developed workforce.
- Patient complexity: Disease progression of those patients waiting for treatment will result in longer operating time requirements, more clinical complications and longer recovery times. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.
- Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics & elective activity
- Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service may impact of elective recovery as diagnostic diagnosis is speeded up and diagnostic waiting lists are reduced.
- There is an established system-wide governance programme for planned care and diagnostics. All risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

7. Planning assumptions

Demand drivers:

- Demand for additional diagnostic capacity occurs as a result of population increases and the need to address significant inequalities which are present in a number of existing areas with high levels of deprivation and geographical challenges. It is anticipated that these areas hide significant unmet demand as patients live in areas of multiple deprivation and are unable to access existing services, which may require significant travel, due to a number of reasons including financial or socio-economic hardship.
- There is also a national focus for all systems to address large waiting lists with national targets being set to reach 95% of patients seen within 6 weeks by March 2025.

Productivity, capacity & resource enablers and constraints:

- Workforce: Availability of suitably trained and skilled diagnostic workforce is likely to limit the recruitment of NHS workforce to undertake all CDC roles, and there will therefore be a need to work collaboratively with the independent sector in order to fulfil the ambition to deliver all CDC tests as planned.
- Recruitment & retention within Lincolnshire is often challenging. As a result there will be collaboration with system, regional and national partners to increase the availability of skilled workforce through international recruitment initiatives, upskilling and retraining of existing workforce and developing links with the University of Lincoln School of Radiography to train and retain students within the local area.
- Digital: Exploration and development of digital solutions to maximise productivity and efficiency of NHS services. This includes electronic booking systems, utilisation of artificial intelligence systems and the use of remote supervision technology such as Radcockpit.

8. Stakeholders

- NHS Lincolnshire ICB
- United Lincolnshire Hospitals NHS Trust
- Regional and National NHSE Colleagues
- Regional System colleagues and Independent Sector Providers
- Wider Lincolnshire System NHS partners, including LCHS, PCNs, GPs
- Local Authority, including Public Health, Town, District and County Council colleagues
- Lincoln University colleagues
- CDC Co-production group; Patients and public stakeholders

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

1. Future state

Operational 1&2 years Cancer Care Vision

- All schemes identified will support the delivery of the Cancer Waiting times recovery. The next 2 years will see the programme for cancer recover to a pre-pandemic position. The focus will be on achieving the 28-day standard to 75%, reducing the backlog of patients waiting over 62 days, achieving the 31-day treatment standard and achieving the 62-day standard.
- The Lincolnshire Living with Cancer Strategy 2023 – 2025 is our 4th Strategy and sets out our approach and plans for the next 2 years with a forward view to 2028. It builds on the work carried out over the last seven years which was set out in the previous Living with Cancer Strategies. The approach put is 'we are creating a better and sustainable future for supporting people LWC, involving and integrating all relevant parts of the health and social care system, using the assets we already have, supporting people in the place they would like and in the way they would like, and placing people at the centre of everything we do.'
  - Return the number of people waiting for longer than 62 days to 217 by March 2024
  - Achieve 28-day Faster Diagnosis standard 75% by March 2024
  - Achieve Combined standard for 62-day performance 70% by 2024
  - Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways
  - Scope, review and implement a health inequalities programme of work focussing on the Colorectal pathway to include improving staging outcomes, improve screening uptake and reduce emergency presentations.
  - Implement new CUP pathway.
  - Finalise Galleri Trial 2024
  - Targeted Lung Health Checks national priority- this will contribute to the ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer.

Strategic 2-5 years

- Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.
- Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028.
- Scope, develop and commence transition of PFUP protocols and models of working to support other LTC specialities aligning with PIFU.
- Scope and commence transition of personalised care models of working to support people living with other LTCs in Lincolnshire
- Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening

National/local requirements

- Performance is driven by NHSE and is mandatory to achieve.
- EMCA set priorities for the year TLHC and BPTP are also mandated.

Evidence base

- NICE Guidance
- Personalisation guidance
- CWT Guidance
- LACE process
- ECAGs
- Speciality specific clinical evidence.

In/out of scope

- Liver Surveillance is out of scope.
- UGI Cytosponge pathway is out of scope.
- Capsule endoscopy is out of scope.

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

2. What's being done to get there | Overview

- Currently in the NHSE assurance Tier one meeting weekly with NHSE to discuss performance and sustainability of improvement.
- ULHT and the system are leading Intensive Support meetings with the divisions to monitor 28-day performance backlog reduction and combined classic performance.
- Cancer recovery and delivery meetings overseeing acute improvement work with ULHT.
- All future improvement projects will be taken through the LACE where pipelines available.
- Wrapping SDF finances around delivery programme
- System wide working to develop projects.
- Living with Cancer Strategy
- Integrated Cancer Workforce Development Strategy
- Cancer Digital Strategy

Response to potential improvement opportunities

- All improvement projects follow a QI methodology to determine the warranted variation.
- All improvement projects are implemented a national agenda. e.g. performance

3. What's being done to get there - Detail

- 28-day FDS – 75% by March 2024
  - Actions - twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project manager working with ULHT to deliver improvement plan

- 31 Day - 96% -
  - Actions- twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project managers working with ULHT to deliver improvement plan.

- 62 Day Performance – 70% March 2024 –
  - Actions -twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project managers working with ULHT to deliver improvement plan.

- Backlog Reduction – 217 by March 2024-
  - Actions- twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project managers working with ULHT to deliver improvement plan.

- Further deliverables with be set nationally for 2024/2025- As of 20th December
  - Actions - awaiting National Guidance for Cancer 2024/25 plan.

- Implement Personalised Follow Up Pathways (PFUP) with remote monitoring in further 4 pathways by March 2025-
  - Action- Adopt guidance protocols and SOPs and take through ULHT Governance, work with Clinical and Operational team to adopt PFUP and RMS as BAU. Continue Living with Cancer in the community to facilitate supportive self-management and community-based support.

- Ensure interdependence with the Planned care programme to ensure read across of productivity plans

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cancer	Return the number of people waiting for longer than 62 days to 217 by March 2024																					
Cancer	Improve performance for diagnosis and treatment standards– Achieve 28-day Faster Diagnosis standard 75% by March 2024 Achieve Combined standard for 62-day performance 70% by 2024																					
Cancer	Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways																					
Cancer	Scope, review and implement a health inequalities programme of work focussing on the Colorectal pathway to include improving staging outcomes, improve screening uptake and reduce emergency presentations																					
Cancer	Implement new CUP pathway																					
Cancer	Finalise Galleri Trial 2024																					
Cancer	Targeted Lung Health Checks national priority- this will contribute to the ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer.																					

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cancer	Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.																					
Cancer	Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028.																					
Cancer	Scope, develop and commence transition of PFUP protocols and models of working to support other LTC specialities aligning with PIFU.																					
Cancer	Scope and commence transition of personalised care models of working to support people living with other LTCs in Lincolnshire																					
Cancer	Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening																					

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

- Backlog reduction -Only impact on activity levels form the backlog reduction because as patients remain on the backlog, they may seek support form Primary care.
- FDS performance will see a reduction of the impact on primary care therefore they are not reliant, and they have been given a diagnosis/ removed from the pathway.
- PFUP 24/25 (26-28)- There may be increased activity for complex patient for LCHS, Primary care and patients may require access to psychological services in LPFT, increased demand in voluntary and community sector organisations.
- Colorectal pathway – will potentially increase uptake of bowel screening and impact on diagnostic services at ULHT in endoscopy/ histology- however a positive impact would be on reduction in emergency presentation via ED.
- CUP pathway - Reduce number of referrals from PC and visits to PC from the patient with revision of pathway.
- Galleri trial- Reduce visits to PC as patients being diagnosed through alternative route- it will however increase referrals to ULHT for diagnosis and treatment.
- Targeted Lung Health Checks- this programme has potential to have significant impact on PC due to the identification of incidental findings form the CT scans. It will increase number of referrals into ULHT for suspected Lung cancer which will have a knock-on impact of diagnostics and pathology, numbers indicate that there will be an increase in treatments at tertiary centre Nottingham which could lead to a backlog of patients awaiting treatments- this could impact on [patients requiring emotional and psychological support. Working up activity number to qualify problem.
- Model of Personalised care – Increased demand on community and voluntary sector services – increased demand for LPFT and LCHS with more complex patients supported out of hospital – reduce demand on ED presentations. Improved patient experience.
- PFUP protocols and Model of Working to support other LTCs specialities aligning with PIFU- 24-28- OPAs saved to reduce backlogs and waiting lists for all LTC pathways, increased demand on voluntary and community sector, reduce demand on PC. Improved patient experience.
- Actuarial modelling: System support from finance and Arden Gem/PHM to model pathway through form screening to treatments and understand impact across pathway.

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Return the number of people waiting for longer than 62 days to 217 by March 2024	– Staffing; project, transformational and operational to continue BAUS whilst also implementing improvement – Clinical buy in and change in working practices – Funding; additional capacity	Reduce number of patients waiting over 62 days to 217.	Return performance back to pre-covid levels (and beyond)	Continue to reduce backlogs as far as possible.				
Improve performance for diagnosis and treatment standards	– Staffing; project, transformational and operational to continue BAU whilst also implementing improvement – Clinical buy in and change in working practices – Funding; additional capacity	– Ensure 28FDS performance reaches 75% by the end of March 2024	Return focus back to 62 day performance and meeting 62 day targets as laid out in new constitutional standards. - 62-day referral to treatment standard: combined performance of 70% by March 2025 - 28-day Faster Diagnosis Standard 77% by March 2025	Continue to improve performance and roll out early diagnosis interventions.				

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways	- EMCA identify priority pathways. - ECAGs agree regional protocols - Clinical buy in - Staffing. - IT – procure next RMS Modules	PFUP and RM operationalised in 4 additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits.	PFUP and RM operationalised in 4 additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits.					
Scope, review and implement a health inequalities programme of work focussing on the Colorectal pathway to include improving staging outcomes, improve screening uptake and reduce emergency presentations	– Clinical buy in – Access to data held by screening programme – HIE to transform and implement changes.	Scoping, Data drill down, consultations, engagement with Coproduction groups,	Implement and measure Impact of coproduction groups	Delivery and evaluation				
Implement new CUP pathway	– Clinical buy in from Primary Care & Secondary Care. – Change in working practices & implementation of new pathway.	New streamlined pathway for CUP patients to ensure they are not delayed in getting a diagnosis.						

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Finalise Galleri Trial 2024	– Clinical buy in – Support from Cancer Team and pre diagnosis team	Lincolnshire patients will undergo final blood test to look for cancer markers aiding earlier diagnosis. Results will be reviewed and a decision made about long term.						
Targeted Lung Health Checks national priority- this will contribute to the ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer.	– Clinical buy in – Funding from EMCA – Procurement and contracting team support		Roll out of targeted lung health check programme leading to earlier diagnosis of lung cancer patients.					

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.	- EMCA identify priority pathways. - ECAGs agree regional protocols - Clinical buy in - Staffing. - IT – procure next RMS Modules		PFUP and RM operationalised in additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.	PFUP and RM operationalised additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.				
Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028.	- System buy in ICB, acute, PC, VCS. - Staffing. - Packages of funding for e.g. training.		Improved patient experience.	Improved patient experience.				
Scope, develop and commence transition of PFUP protocols and models of working to support other LTC specialities aligning with PIFU.	- Clinical buy in. - Staffing – recurrent funding for roles. - IT – RM systems.		OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.	OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.				

Cancer

Programme: Cancer	SRO:	Programme lead: Sarah Brinkworth	Clinical/Technical Lead:

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Scope and commence transition of personalised care models of working to support people living with other LTCs in Lincolnshire	- System buy in ICB, PC, VCS.		Improved patient experience	Improved patient experience.				
Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening	EOI with CRUK to support the work to be lead across system		Scope, Plan and Consultation, Implementation, Delivery and Impact	Evaluation				

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

5. What's needed to make this happen

Backlog/ FDS/ 31 day and 62 combined standards
- Maintain existing activity and staffing levels.
- Ensure GPs are referring appropriately.
- Recurrent investment required for colorectal CNS and navigator teams.
- Right sizing review of services as improvements are made.
- Histopathology – further review of roles in workforce to support national turnaround ambitions.
- SDF funding reviews to ensure monies being spent and impact – futures BCs identified and supported by the system

Patient initiated follow-up 2024-28
- ULHT to adopt guidance protocols and SOPs to make this BAU.
- Primary care to adopt / deliver quality improvement in Cancer Care reviews.
- Review number of Care co-ordinators in ULH/ PC/ Community
- Increase resilience and capacity and community sector.
- Adoption of personalised approaches across the system
- Collaboration with Health Inequalities team/ Personalisation team and PHM
- External funding required for specific work programme e.g., volunteering.

Colorectal screening
- Support from the health inequalities teams
- Potential use of voluntary support to engage populations.
- The project is not at a stage where we understand the constraints to identify what finance streams are required.

CUP (carcinoma of unknown primary) pathway
- There is a concern but the projects is not at a stage to understand- but there may be an impact on demand – and therefore we may to increase workforce to deliver

Galleri trial
- Expected referral demand approx. 20 referrals across all specialities therefore the demand is spread and no impact on workforce or finance.

Targeted Lung Health Check
- 2023-28: over this period, we will anticipate to diagnose circa. 700 cancers
- Initial investment to screen these patients will come from national funding, however future funding will be from centralised commission as this will become part of the routine screening programme.
- Programme is currently scoping options to provide pilot study for Lincs and future provision for screening programme.

Model of Personalised care
- Increase resilience and capacity and community sector.
- Adoption of personalised approaches across the system
- Collaboration with Health Inequalities team/ Personalisation team and PHM
- External funding required for specific work programmes e.g., volunteering.

PFUP protocols and Model of Working to support other LTCs specialities aligning with PIFU- 24-28
- Increase resilience and capacity and community sector.
- Adoption of personalised approaches across the system
- Collaboration with Health Inequalities team/ Personalisation team and PHM
- External funding required for specific work programme e.g., volunteering.

Actuarial modelling
- Funding required to support modelling from PHM.
- PHM to ensure access to datasets.

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Risks / Challenges	Mitigation
Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit.	Working closely with ED teams – ensuring decision making is considered and impact is understood
Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.	System adoption of Integrated Cancer Workforce Development Strategy 2023 – 2025 and development of subsequent strategies. Focus on recruitment and retention of staff and training and support of existing staff. System adoption of Aspirant Cancer Career and Education Development programme.
Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.	Clinical review meetings prioritising patients based on clinical need are undertaken regularly. The backlog is continuing to decrease beyond expectations of NHSE therefore the number of patients having lengthy waits is also reducing.
Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity	Regular communication between planned care and cancer teams will allow for a better understanding of demand for diagnostic services. It will also allow us to work collaboratively to identify bottlenecks and adjust capacity where possible based on demand fluctuations. Clear clinical criteria are also available to ensure patients are prioritised based on clinical need. By working collaboratively, we can also develop improvement initiatives to potentially enhance efficiency & quality of diagnostic services.
Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.	Work is ongoing to improve pre-operative assessment services within ULHT. Agreement has been reached that cancer patients will always take priority for pre op assessment capacity.
Financial Recovery including 30% reduction in ICB running costs	Cancer is funded by external source – however unsure when this funding will come to an end, recurrent funding for posts following Alliance funding needs to follow governance process to ensure recurrent funding
Geography – difficult to source mutual aid due to travel distances	Living with Cancer Programme takes whole system, place-based, asset-based and person-centred approach. Emphasis on supporting patients closer to home in own communities and meeting patient needs including transport issues. Implementation personalised follow up pathways and remote monitoring for clinically suitable patients.
IT systems – Difficult to track total patient journey through ULHT as use different systems at each stage	Implementation of Care Portal across the Lincolnshire system.
Data quality issue	Commissioned Insource a company who will provide validation of PTL

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

7. Planning assumptions

Productivity, capacity & resource enablers and constraints:

- Workforce: This does not take into consideration any Industrial Action - NHSE have been clear that we should plan based on no industrial action taking place.
- Digital: System Digital Programme implements digital solutions which are adopted system wide; Deployment of Care Portal and Patient portal .
- Finance: Cancer receives an allocation from EMCA each financial year to support programme and recovery 23/24 circa 3 million- awaiting allocation for 24/25, committed 1.5m already that will be covered plus further allocation. Align with planned care ERF as part of planned care activity. ULHT has identified further Colorectal roles for Navigators and XCNS that need recurrent funding currently awaiting to go through CRIG

8. Stakeholders

Stakeholders

- Acute Providers
- GP Practices
- Lincolnshire Clinical & Care Directorate (including Lincolnshire Academy of Clinical Excellence (LACE), Clinical & Care Academy (CCA) and Lincolnshire Learning Network (LLN))
- Health and Well Being Board
- LVET Board
- It's all about People Board
- Health Inequalities Board

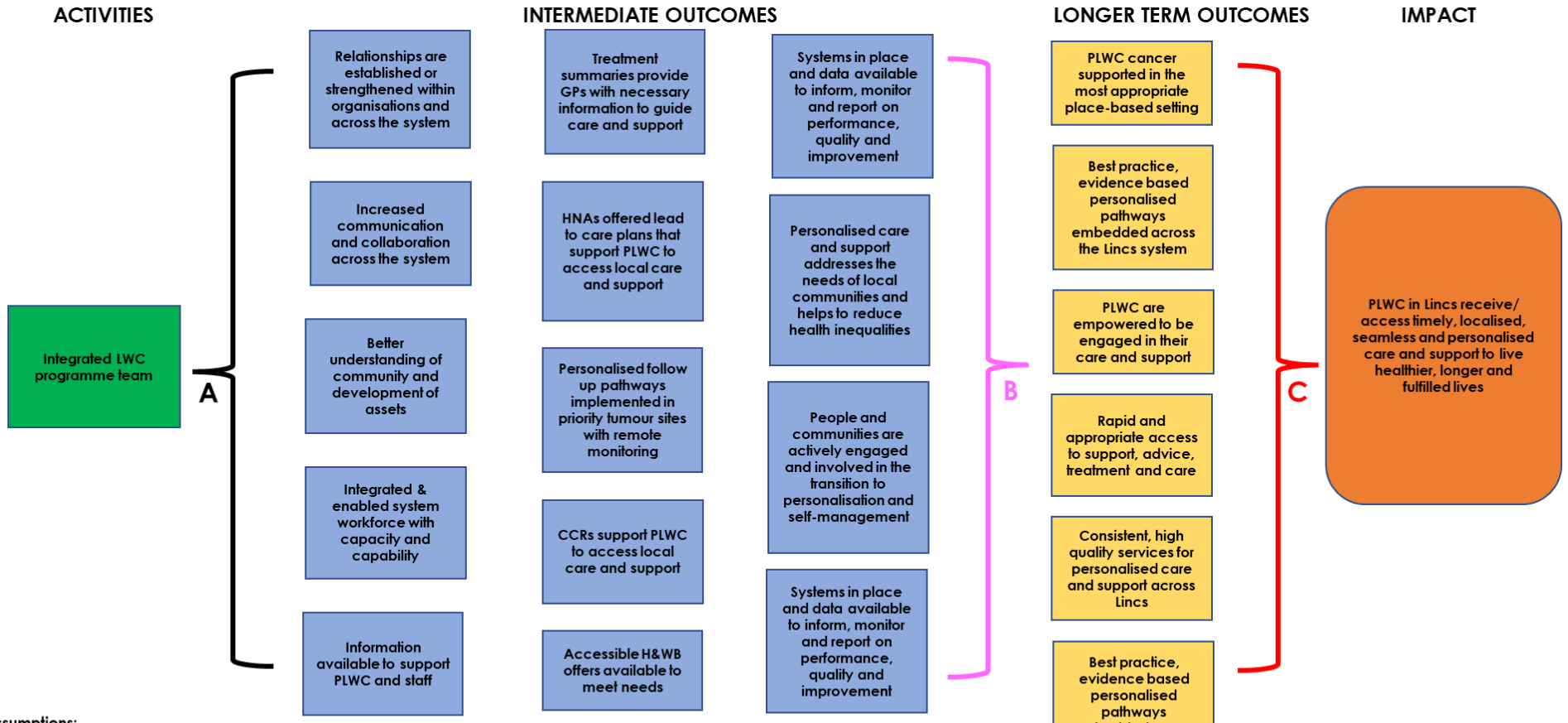
Project team

- ULHT COO & SRO for Cancer
- ULHT Deputy COO, Cancer
- ULHT Clinical Lead for Cancer
- ICB Cancer Programme Director
- ICB Deputy Cancer Programme Manager
- Macmillan Living with Cancer Programme Manager
- ICB Chief Medical Officer
- ULHT Cancer Lead

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Theory of Change Model for Living with Cancer Programme



Assumptions:

- Health and care staff across the system will collaborate and work in an integrated way
- There is the capacity for people to come together to work in new and different ways
- Clinicians and their teams engage in changes and improvements
- Senior system stakeholders sign up to and see the benefits of the outcomes and impact to the system as a whole
- System level governance processes provide support and authorisation for transformational change
- Current and future IT systems will support required data requirements and alignment

Pathways of change

A	Programme level activities set the standard for, inform, infiltrate and support the integrated approach projects take
B	Integrated system communications, relationships and understanding leads to joined up and long-term place based personalised care and support outcomes
C	Evidence of longer-term outcomes influences and drives a significant impact on the lives PLWC across Lincolnshire

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

1. Future state

On 30 March 2023 NHS England published its three year delivery plan for maternity and neonatal services.
The plan sets out a series of actions for Trusts, ICBs and NHS England to improve the safety and quality of maternity and neonatal services with a focus on personalised care and equity and equality.

It combines a number of existing maternity and neonatal requirements including the original Better Births (2016) report, the Long-Term Plan (2019), Ockenden (2020 and 2022), East Kent (2022), Saving Babies Lives Care Bundle v3, CSNT requirements, MBRRACE reports, BAPM7, Neonatal Critical Care Review (NCCR) and with subsequent Neonatal GIRFT Report and (AWAITING ULHT CONFIRMATION) equity/race related guidance.

The report sets out the 12 priority actions for Trusts and systems for the next three years, across four themes:

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures.

The strategic agenda for Neonatal Care

- The Neonatal Critical Care Review sets out key findings and an action plan for locally led improvements to neonatal services and works together with system partners, to ensure the best outcomes for babies and their families. Addressing these recommendations in collaboration with the East Midlands Neonatal Operational Delivery Network are the foundation for Neonatal care in Lincolnshire together with LMNS Neonatal workstream. **Allied Health Professional (AHP) Provision by end 2024 – Business Case ongoing since Dec 2020. Proposal to move this forwards by end of year needs focus.**

2. What's being done to get there | Overview

Our focus will be on the report's four key pillars, as below.

- **Listening to women and families with compassion** which promotes safer care.
- **Supporting our workforce** to develop their skills and capacity to provide high-quality care.
- **Developing and sustaining a culture of safety** to benefit everyone.
- **Meeting and improving standards and structures** that underpin our national ambition

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

3. What's being done to get there - Detail

Our focus will be on the report's four key pillars, as below.

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.
- In 2023, NHS England's new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
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Maternity and Neonatal	3 Year Delivery plan Theme 1: Listening to Women																					
	3 Year Delivery plan Theme 2: Workforce																					
	3 Year Delivery plan Theme 3: Culture and Leadership																					
	3 Year Delivery plan Theme 4: Standards																					
	Neonatal Critical Care Review																					
	Personalisation																					
	Saving babies lives																					
	Continuity of Carer (Full implementation)																					
	PMH / MMH																					
	Equity and Equality – Strategy to be published March 2024																					
	Maternity Tobacco Dependency Service																					
	Digital / Data																					
	Co-Production																					
	3 Places of Birth Choice																					
	Maternal Medicine Network (Uni. Leicester Hosp. Lead on delivery)																					

Please Note:	- **3-year delivery plan with 1-year technical guidance.** - **The Maternity and Neonatal Programme is Nationally prescribed.**

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

4. Projected impact on patients and system partners

The maternity and neonatal programme is scheduled by the NHSE 3-year delivery plan, benefits measured through the LMNS assurance framework and challenges escalation to QPEC for executive oversight.

Listening to and working with women and families with compassion

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey.
- We will also utilise and involve our MNVP Leads and follow the ambition set out in the publication of November 2023. NHS England » Maternity and neonatal voices partnership guidance
- The importance of parental partnership in care within all neonatal and maternity settings is underpinned by evidence. Family-integrated care (FiCare) should be considered the gold standard, in neonatal units. - BAPM_FICare_Framework_November_2021.pdf
- Progress measures against the following will also be progresses and monitored;
  - Perinatal pelvic health services and perinatal mental health services are in place. Bereavement services also need to remain a focus
  - The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.
- The proportion of maternity and neonatal services with UNICEF BFI accreditation. All NNUs should seek to comply with Bliss Baby Charter as well as UNICEF Baby Friendly Initiative - Baby-Charter-booklet-2020.pdf , UNICEF UK Baby Friendly Initiative - Guide to the Neonatal Standards.

Growing, retaining, and supporting our workforce

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- A well-trained workforce now relies on embedding the Core Competency Framework - NHS England » Core competency framework version two. This is linked to CNST Safety Action 4 - Clinical Workforce Planning alongside the Birthrate+ audit. All staffing groups are reviewed for assurance that a service is well led and safe

- Our progress measures will be;

  - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
  - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.
  - To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

4. Projected impact on patients and system partners (cont.)

Developing and sustaining a culture of safety, learning, and support

- Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.
- Implementation of the National PSIRF Framework, monitoring, reviewing interpretations to ensure clarity and transparency in services following incidents.
- The British Association of Perinatal Medicine (BAPM) has published toolkits to support delivery of the Perinatal Optimisation Pathway developed in conjunction with the Maternal and Neonatal Safety Improvement Programme. Implementation of these toolkits will ensure National Neonatal requirements for preterm labour are addressed. Including Saving Babies Lives Vol.3 element 5.
- Neonatal safety champion- executive and non executive. QI Toolkits | British Association of Perinatal Medicine (bapm.org)
- Recommendations in line with the Thirlwall Enquiry will also be required to comply against, inclusive of awareness of Martha's Rule in relation to neonatal/paediatric care.

Standards and structures that underpin safer, more personalised, and more equitable care

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births.
- The progress measures we will use are:
  - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
- Recognition and compliance against CNST safety standards Maternity Incentive Scheme - NHS Resolution
  - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care
  - The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme. This also will reference Transitional Care access and services
  - A periodic digital maturity assessment, enabling maternity services to have an overview of progress in this area.

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

5. What's needed to make this happen

- Collaborative and transparent compliance to national guidelines with providers
- Enablers:
  - Digital
  - Estates
  - Workforce
  - Business intelligence
  - Population health management,
  - Personalisation
  - Education
  - ODN
  - Co-production,
  - Active Lincolnshire
  - Voluntary sector,
  - Public health
  - Health inequalities
- Resource requirements:
  - Finance investment – NHSE (Core and Transformational) commitment to the maternity and neonatal programme, recurrent and non-recurrent funding.
  - Non-financial: capacity, leadership, data and data-sharing, commitment to the LMNS.

6. What could make or break progress

- Discourse and inability to work collaboratively and transparently between ICB/s and Trust.
- Sustainable funding, to include maternity and neonatal service provision.
- Digital infrastructure.
- Implementation of new MIS.
- Insufficient funding to support smoking in pregnancy at time of delivery and smokefree homes.
- Financial infrastructure to develop three birth choice.
- Financial and workforce commitment to offer continuity of care.
- Data sharing
- Consistency of training compliance in all professional bodies.
- Collaborative and transparency of workforce planning.
- Decisions by the System Investment Panel

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

7. Planning assumptions

- 3 Year Delivery Plan – (in conjunction with SBL, CNST and NCCR recommendations)
- Better Births Vision
- Joint Forward Plan

8. Stakeholders

- Throughout this strategy we have described how we are already working collaboratively to design and deliver integrated maternity and neonatal care. We bring together representatives from a wide range of organisations to develop our work plans whilst working towards establishing shared clinical and operational governance arrangements to enable cross-organisational working and ensure the care we provide is seamlessly the right care in the right place, at the right time.

- System members at Board level and LMNS subgroup level include, provider United Lincolnshire Hospital NHS Trust, 0-19 Services/Health Visiting, Children's Centres and Early Years inclusive of the new Family Hubs project, Steps2Change, Primary Care, Community Health, voluntary sector, Education, MNVP, Healthwatch, Active Lincolnshire, Mental Health Services, East Midlands Neonatal Operational Delivery Network and members of the Integrated Care Board Programme team and varying specialities.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

1. Future state

The Children and Young People (CYP) programme is an integrated programme of work bringing together key partners in Children and Young People's health and well-being.

The Lincolnshire Integrated Care Board (LICB) works collaboratively with Lincolnshire County Council (LCC) including Children's Services, Public Health Directorates, and key providers within the East Midlands region.

The LICB and LCC jointly fund and oversee a Children's Integrated Commissioning Team (CICT) who undertake part of the programme for CYP.

The work of the programme is overseen by the CYP Integrated Transformation Board (ITB) which has a mission statement: **'Everyone working together to maximise the health and wellbeing of all children and young people, ensuring the voice of children and families is heard throughout our work'.**

One of LICB's key objectives is **'Improving the health of children and young people'** reflecting the LICB's commitment to CYP in Lincolnshire.

All projects within the CYP programme Joint Forward Plan for 2023 – 28 will support 'Improving Access' to the right health support for local CYP. This may be through increasing the capacity of CYP that can be supported in services, making services more accessible for CYP with SEND, or making CYP services more accessible in local communities.

The CYP programme has recently been formalised and most of our priorities are in their infancy and/or scoping phase. Improving access is a thread which runs throughout our priorities, the advantage point being for a newly established programme, is the opportunity to develop/improve existing and/or new services for CYP with improving access at the forefront of all we do.

Headline actions for the CYP programme are:

- Develop our services so that they align with the needs of our CYP population.
- Develop the teams that deliver these services to our CYP with a range of skills and expertise relevant to the service offer.
- We will strive to simplify the processes for accessing health services for CYP.
- We will support CYP to understand the health care they require and how best to access it.

The CYP programme incorporates national and regional priorities and there is a key focus on ensuring our local priorities are addressed. This is informed by the intelligence we gather about the local population we serve, the communities they live in, our stakeholder partners and the staff who deliver the services. National drivers shape our priorities such as Martha's Rule and the implementation locally of the Paediatric Early Warning Scoring Tool (PEWS). Locally PEWS is in situ across ED and inpatient areas. SPOT funding has been allocated to the provider who are currently in discussions as to how effectively to utilise the NHSE funding with an established PEWS process in situ.

The programme continues to be driven by data and intelligence, including an evolving use of population health management information to ensure work being undertaken understands and addresses health inequalities within our CYP population within Lincolnshire.

The national CYP Core 20 Plus 5 programme outlines the key priorities from a health inequalities perspective. The 5 clinical priorities for CYP are, Asthma, Diabetes, Epilepsy, Oral Health, and Mental Health. The CYP programme directly aligns to these priorities. The plus elements for Lincolnshire are CYP in care, care leavers, CYP in the justice system, CYP not in education, CYP open to social care, CYP with learning difficulties, Autism & SEND, CYP who are young carers and CYP from ethnic minorities.

New national deliverables from NHSE are expected in the future relating to the CYP Core 20 Plus 5 programmes, for example, co-production with CYP and their families in capturing the CYP voice.

The CYP programme also incorporates CYP safeguarding transformation work, which sits under the responsibility of Lincolnshire Safeguarding Children's Partnership. This work is a fundamental part to meeting the needs of our local CYP.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

1. Future state

Transition from children's services into adult's services will be an integral part of consideration for all our projects. NICE guideline NG43 defines transition as "the purposeful and planned process of supporting young people to move from children into adults' services". (Please see current updated NICE guidance received Transition from children's to adults' services).

In the NHS Long Term Plan, NHS England have committed to moving to a 0–25-year service model where appropriate to enhance CYP's experience of health, continuity of care and outcomes, and experience of transition between services. This model encompasses a comprehensive offer for 0-25-year-olds that spans mental health and physical health services for children, young people, and young adults.

An expected framework by NHSE providing principles, models, and resources to support a 0-25-year service model alongside deliverables implemented by 2025. NHSE tasked ICB's to lead on 5 core speciality areas: Asthma, Epilepsy, Diabetes, CYP Mental Health and Complex Medical Needs.
The CYP programme is leading on behalf of the ICB in implementing the ICS Transition Network.

The NHSE vision for Transition is that by 2028, no child, young person or young adult should become lost in the gaps between children's and adults' services. Their experience of accessing, moving between or stepping down from services should be safe, well planned and prepared for and that they feel supported and empowered to make decisions about their health and social care needs.

Recommendations for ICB's are; Commissioners should support the delivery of developmentally appropriate healthcare. Pathways of healthcare transition should be jointly commissioned by adult and children and young people's services. All healthcare staff should have access to training in the care of young people as they move through services, including healthcare transition pathways.

Our local Lincolnshire ICS Transition Network strives to reflect this vision and recommendations as we begin to implement key core principles for Transition across our system.

Whilst this sits within the CYP programme, it is important to emphasise that the most significant change will need to happen within adult services. An area of local focus as reflected in the recommendations for ICB's, will be the way adult services are commissioned or delivered with differences in criteria which cause challenges for patients and families as they transition into adult services.

The Lincolnshire ICS Transition Network reflects our commitment for improved processes for CYP transitioning to adult services.

There are further local improvements to CYP services that are out of scope of the CYP programme. These include a review of:

- The Children's 0-19 Health Service (LCC)
- CYP Continence Review (LCC)
- CYP Mental Health, Learning Disability and Autism programme (LCC)
- Lincolnshire Maternity Neonatal Service (LICB)
- Urgent Emergency Care (LICB)

All these services/programmes provide updates into the CYP ITB and have their own governance arrangements that oversee delivery of their respective plans.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

2. What's being done to get there | Overview

- We have established strong integrated governance, co-chaired by the LICB and LCC and partnership working across system partners.
- We have a jointly funded CICT that has been in place since 2017 that works alongside the CYP LICB team and the ITB.
- We have a co-chaired CYP Integrated Commissioning Steering Group that jointly plan and oversee commissioning related activity across LICB and LCC including Public Health, CICT and the Children's Strategic Commissioning Service.
- We directly report into Regional and National CYP Integrated Transformation Board.
- We are working with the Lincolnshire Safeguarding Childrens Partnership (LSCP) to understand and respond to the safeguarding needs of our CYP.
- We have set out our next 5-year priorities specific to our CYP population in Lincolnshire.
- We are improving our understanding of health inequalities for our local CYP population. LICB are leading a project to analyse health inequalities for CYP, and this will enable system partners to identify any gaps in support, to better target existing services and develop new services where needed.
- We have identified current issues with services and are responding rapidly to make improvements, for example, focused work on reducing waiting times for CYP Speech and Language Therapy (SALT) and further LCIB investment to reduce waiting times for CAMHS treatment which is demonstrating positive shift in 50+% reduction in CYP waiting over 12 weeks.
- We are working with the Planned Care Team Elective Recovery Programme within the ICB to better understand wait times/disparity and identify underlying health inequalities within the waiting lists for surgical/non-surgical procedures.This involves partnership working with our acute trusts to better understand demand and capacity issues. Key areas of focus within Lincolnshire are Dermatology, Cardiology and CYP waits for Community Paediatrician consultations. Alongside this is a project led by the provider to understand the significant numbers of 'was not brought' and missed appointments for CYP within Lincolnshire.

Summary of our identified CYP Projects 2023-28:

- Children Strategy Discussions - CS Front Door.
- Diabetes.
- CYP Child Protection Medicals.
- Clinical Intervention in Schools Review.
- Asthma.
- Epilepsy.
- CYP Therapy Review.
- CYP Voice/Data Intelligence.
- Children's Community Nursing (CCN) Review.
- Palliative End of Life Care for Babies, Children & Young People (BCYP).
- Integration of assessment Processes and support for CYP with Special Education Needs and Disabilities (SEND).

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Highlighted below are KEY deliverables & milestones taken from each Project. Approx' dates for completion of Milestones are identified below within each priority and further embedded within the table below which gives a summary of the identified CYP Project phases. Detailed individual Project Delivery Plans underpin this programme plan.

Children Strategy Discussions 'Front Door'

Deliverables:

- Business Case considered at Financial Sustainability and Investment Panel (FSIP) April 2024; making recommendation in relation to changes; analysis of options; resource and cost requirements to ensure health meets its statutory responsibilities under Working Together (2023).
- Proceed through governance pathways for approval.
- To produce a robust joint Information Sharing Agreement.
- Provide interim measures for health representation at Strat discussions.
- Address the outstanding red rated 'issue' on the LSCP risk and issues log regarding sharing of health information at children's front door safeguarding strategy meetings.

Milestones:

- Business case presented to the Directors of Nursing on 31 October 2023 for agreement on preferred model and route for financial decision making.
- Operational processes for the interim measures to be reviewed end Q3 2023-2024 and again Q4 2023-2024 – completed, further review undertaken Q1 2024-2025 with escalation of associated risk to SQPEC May 2024
- Business presented to the Investment Panel on January; March; and May 2024
- Business case to be presented to Finance and Resources Committee – date TBC by FSIP
- Due to delays in financial decision-making timeline for implementation cannot be confirmed but anticipated to be 3-6 months from point of decision.

Diabetes

Deliverables:

- Reduce variation of care to ensure CYP have equal accesses to all care processes. December 2024.
- Increase CYP utilising technology to manage and control their Diabetes. March 2025.
- CYP with Diabetes having access to psychological support services. March 2025.
- Improve awareness and health outcomes of CYP with Type 2 Diabetes. March 2025.

Milestones:

- Pathways across primary and secondary care reviewed and updated to address gaps and/or changes in clinical guidance. March 2024.
- ULHT CYP Diabetes dashboard to be created so that CYP activity can be monitored and highlight any areas of concern. June 2024.
- An increase in establishment of CYP diabetes services to enable increased support for CYP with diabetes; achieving care processes, education and training in schools/nurseries to support CYP with diabetes in settings. March 2024.
- Community connectors group to be established to engage with CYP/parents/carers for views on variation in care provided and access to technology.
- Raise awareness by implementing a communication plan and timeline for health messaging.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Child Protection Medicals

Deliverables:

- Decision regarding model for delivery of capacity and capability required to consistently deliver timely Child Protection medicals to required standards.
- Draft initial business plan.
- To offer 2 appointments a day (Mon - Fri) for child protection medicals, which would be 3 days a week at Lincoln County Hospital and 2 days a week at Boston Pilgrim Hospital.

Milestones:

- Preliminary discussions to be held with consultant community paediatricians as they are more suited to undertaking child protection medicals for specific conditions such as severe neglect; whilst acute paediatricians are more likely to see children suspected of having sustained a non-accidental injury.
- Business plan to be produced by ULHT (expected to be in Q3 2024-2025).
- Decision regarding route for financial decision making.
- Delivery and impact shall be monitored and reviewed from date of implementation.
- An evaluation phase will follow by latest 1 quarter post implementation

Clinical Intervention in Schools Review

Deliverables:

Project activity and deliverables shall align with expectations cited within the seven nationally identified Key Lines of Enquiry:

- Model Delivery Approach
- Staffing and Competencies
- Clinical Intervention Framework.
- Service Planning and Monitoring
- Transport
- Transition
- Commissioning
- The design of a necessary model for Lincolnshire shall take place over January – June 2024.
- A recommended model shall be presented for approval to all partners and stakeholders by latest December 2024.
- Full implementation of an agreed model shall take place between latest January – June 2025.
- Delivery and impact shall be monitored and reviewed over July – September 2025 by LICB, LCC, Special Schools and through engagement with the relevant cohort of parents/carers/CYP.

Asthma

Deliverables:

- An integrated care pathway for CYP Asthma. March 2024.
- Access to diagnostic hubs and/or community spirometry and FeNO testing. April 2024.
- Implementation of NHSE National Asthma Bundle. March 2025.
- To improve the outcomes of CYP with Asthma, including difficult to manage Asthma; there will be an increase in the workforce establishment of CYP community respiratory services. March 2025.

Milestones:

- Primary Care Pathway reviewed. March 2024.
- Secondary Care Pathway reviewed - incorporating A&E, inpatient, outpatient, and discharge. December 2024.
- Developing clinical asthma network to support updates and education around asthma. June 2024.
- Business case to be created for CYP respiratory team by ULHT. June 2024

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Epilepsy

Deliverables:

- Reduce variation in care- all CYP with epilepsy to have access to an Epilepsy Specialist Nurse, timely access to care and procedures to ensure NICE guidance compliance. December 2024.
- To improve the outcomes of CYP with Epilepsy and enabling the service to be NICE guidance compliant; there will need to be an increase in the workforce establishment of CYP community Epilepsy service. December 2024.
- CYP with epilepsy will have access to appropriate mental health and psychological support services. March 2025.
- All CYP who meet criteria for tertiary neurology referral should have timely access to the relevant tertiary specialist with expertise in managing complex epilepsy. March 2025.
- Improved transition between CYP and adult epilepsy services. March 2025.

Milestones:

- A review of Secondary Care Pathways to identify gaps in service and improve delivery of current service. June 2024.
- Business case to be completed for the CYP Epilepsy service. March 2024.
- A review of mental health support service available for CYP with Epilepsy and identify gaps in service delivery. March 2024.
- Secondary care dashboard to be completed to support review and audit of current cases, unplanned admission numbers, treatment. June 2024.
- Epilepsy to be part of a wider transition group that needs to support improved transition from CYP to adult providers. January 2024.
- Engagement with tertiary services to agree pathways and referral processes, including provided with outreach services. March 2024.

CYP Therapy Review

Deliverables:

- Carry out full Review of CYP Therapy services across the system, urgently starting with the SALT service.
- Engage with service users and system partners to review and co-produce necessary improvements across the health, care and education system to ensure CYP are seen/supported by the right therapist, at the right time, in the right place.
- Explore whether specification amendments are required.
- Develop fully costed Business Cases, presenting an improved low-level-need universal offer, an improved targeted offer and a fit-for-purpose specialist offer for CYP with assessed complex speech and language needs.
- Seek formal decision for recommended changes.
- Implement approved changes
- Produce fully costed Commissioning Plan and Delivery Implementation Plan.

Milestones:

- Review current SALT pressures, gap analysis, options appraisal and trajectory planning. Engage SALT service users and system partners to co-produce necessary improvements. Explore whether SALT specification amendments are required. Produce fully costed SALT Business Case. Seek formal decision. Implement. Begin scope of cross-cutting CYP therapy services: specialist physiotherapy and OT services (both Children's Services and ICB). January – March 2024.
- Monitor delivery and impact of new SALT service. Begin planning and engagement activity with partners and service users across physiotherapy and OT. Explore whether current specification amendments are required. Produce fully costed Business Case for physiotherapy & OT, including evaluation of new SALT service. Seek formal decision. SALT becomes business as usual. April – March 2025
- Implementation of any agreed change across all CYP Therapy services. April – June 2025.
- Create processes to record and monitor success/failings and impact of delivery, make small, approved changes if necessary. July – September 2025.
- Evaluation of all CYP Therapy services to ensure fit-for-purpose, make small, approved changes if necessary. October – December 2025.
- All CYP Therapy services become business as usual. January – March 2026.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

CYP Voice/Data Intelligence

Deliverables:

- Development of joint processes to use information gathered from service users and data to inform and shape service delivery.
- Mapping of current CYP groups and engagement activity already taking place across the system.
- Gap analysis.
- Development of joint communication and engagement methods to provide information that can be effectively analysed.
- Build a process to use the analysed intelligence to support positive change and future development.
- Finalising an Integrated dashboard for CYP with SEND, including health data – national guidance expectation.
- Identifying opportunities to improve the quality of intelligence in our integrated dashboard for SEND, including health data through use of the ICS Joined Intelligence Dataset.
- Identifying essential CYP related data flows to add value to the existing ICS Joined Intelligence dataset.
- Redesign current systems and governance to allow flows of the necessary information.
- Establish skills and capacity required to create continued intelligence mapping and analysis that can lead to effective evaluation for positive change.
- Investigate the legal basis and appropriate information governance required for data sharing across the system. Seek current levels of data intelligence and service user engagement to establish what is working well, where there are gaps and what feasible improvements need to be made.
- CYP Voice: Establish what is meant by 'lived experience'. Data Intelligence: Implement the Integrated dashboard for SEND including health data. Scope activity to incorporate information from the ICS dataset that will add value. October 2023 – March 2024.
- CYP Voice: Co-produce effective ways to engage with CYP and their families to hear their lived experiences and what matters to them. Co-produce future templates and processes to be shared across the system, to be populated and returned for early analysis and to test draft design. Data Intelligence: Evaluate and monitor the Integrated Dashboard for SEND including health data to ensure full commitment and continued input from identified LCC and Health representatives. Design and implement a jointly agreed review process for the Integrated Dashboard for SEND, including health data. April – December 2024.
- CYP Voice: Facilitate and host communication, engagement and participation activity events across the system to test draft designs with service users and partners. Make necessary amends. Seek approval. Data Intelligence: Work with LICB's Intelligence & Analytics Division to ensure CYP data is being captured from across the system and that information collated is accurate and can be easily reviewed for analysis to aid future planning.
- Write, seek approval, share a robust joint Information Sharing Agreement: January 2025 – September 2025
- Implement approved recommendations, including expectation to monitor success or failings ahead of evaluation phase during which small changes can be made where necessary. October 2025 – June 2026.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Children's Community Nursing Service

Deliverables:

- CCN service to be enabled to deliver services which are reflecting best practice/clinical guidance in line with local CYP needs within this cohort.
- Achievement of ICB UEC deliverables associated with funding allocation to provide an out of hours support service.
- CYP/parent/carer voice will be captured to support and maintain ongoing service improvement.

Milestones:

- Review of National policy and current recommendations/guidance to ensure our CCN service is fully NICE guidance and legally compliant. Q1 24/25.
- Options appraisal paper to be written to present different service models for provider consideration. Q4 25
- A gap analysis of current service provision/pathways completed; identification of key areas where service improvement is required. Completed Q3 23.
- The CCN service to have access to electronic records system for improved information sharing across partners and to provide a safe and effective 24/7 out of hours service. Completed Q2 24.
- Development of an electronic platform to capture CYP/parent/carer voice across specialist support areas and develop performance metric reporting to support service development. Q4 25.

Palliative End of Life Care for Babies, Children & Young People

Deliverables:

- Right care at the right time in the right place for BCYP who require PEOLC.
- LICB is the accountable organisation to deliver PEOLC service offer for BCYP within Lincolnshire.
- PEOLC for BCYP to be NICE compliant in providing 24/7 out of hours specialist clinical support/advice rota for fellow professionals who are managing end of life for BCYP. Fulfilling ICB statutory requirements.
- LICB to implement allocation of NHSE grant for registered CYP Hospices providing PEOLC by April 2025.

Milestones:

- Scoping of available BCYP PEOLC providers across Lincolnshire to improve care provision, access and choice of venue of death for BCYP. Q1 25.
- LICB to provide a mid-year report to NHSE in 2024/2025 to evidence how funding has been distributed to BCYP hospice providers. Q3 24/25.
- Ensure the service is engaging and capturing the CYP voice alongside performance metrics agreed with CYP hospice providers. Q4 25.
- PEOLC Medical Consultant Lead to provide support for the CCN core service as well as the PEOL caseload across Lincolnshire, fulfilling NICE compliance and statutory requirement for ICB's for BCYP who require PEOLC.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Integration of assessment processes and support for CYP with Special Education Needs and Disabilities (SEND)

Deliverables:

- Scope and plan review elements required within three sub-categories:
    - Education, Health, and Care (EHC) SEND process.
    - Independent Placements for CYP with SEND.
    - Children's Continuing Care (CC) Review for CYP with SEND.
- Write and present relevant governance documents for consideration and approval e.g., NHS Case for Change, LCC Briefing Paper.
- Write further required governance documents, e.g., Business Case, Commissioning Plan and Delivery Implementation Plan for fully costed change.
- Facilitate engagement activity with all Stakeholders, including service users to ensure co-production.

Milestones:

- Mapping full scope of required work and individuals required to support the work across all three elements. April – June 2025.

July 2025 – March 2026:

- SEND EHC process: Audit developed health-led quality assurance process. Explore how health partners could review draft EHC Plans that have a health contribution before Plan is finalised. Review system response to SEN and partnership responsibility for CYP in 52-week placements.
- Independent Placements for CYP with SEND: Review local arrangements which may need to be revised to respond to the SEND National Standards. Review and evaluate the commissioning of independent residential placements (mainly respite) following hospital discharges including inpatient for CYP that are not Children in Care – explore possible expansion of Adults' brokerage process.
- Children's CC Review for CYP with SEND: Review of current policy and process to ensure delivering best practice and best collaborative use of resources. Research and benchmarking against other ICB areas. Review process for allocation of funding and develop improvements based on findings. Design a single joint panel process for all CC reviews.

April – December 2026

- Present review findings and recommended models for change.
- Seek approval and commitment from all partners.

January – December 2027

- Implementation of approved recommendations, full delivery of new models including expectation to monitor success or failings ahead of evaluation phase during which small necessary changes can be made.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CYP	CS Front Door	See separately shared FRP																				
CYP	Diabetes																					
CYP	CYP Child Protection Medicals																					
CYP	Clinical Intervention in Schools Review																					
CYP	Asthma																					
CYP	Epilepsy																					
CYP	CYP Therapy Review																					
CYP	CYP Voice/Data Intelligence																					
CYP	Children's Community Nursing Review																					
CYP	Palliative End of Life Care BCY																					
CYP	Integration of assessment processes and support for CYP with SEND																					

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

4. Projected impact on patients and system partners

The high-level outcomes of this programme will be:

- Improved access to services.
- Improved safety and effectiveness.
- Care in the most appropriate environment and as close to home as possible.
- Improved experience for CYP and their families.
- Improved health and wellbeing outcomes.
- Reducing health inequalities.
- Fully integrated and seamless services.
- Smooth and safe transition into adult services.

The projected impact on patients and system partners will include:

- Improved access to services for CYP and families, CYP will be supported closer to home.
- Health can meet its statutory safeguarding responsibilities.
- CYP services are NICE compliant, aligned to best clinical practice.
- Measured reduction in complaints and negative feedback from our CYP, their parent/carer and our stakeholder partners.
- It is anticipated that system risks will reduce and, for example in relation to Childrens Front Door, mitigation is in place to address current red rate issue; CYP with SEND, there will be an anticipated reduction in Tribunals that have a health provision component.
- The projected impact of a reduction in complaints, negative feedback and Tribunals will result in bolstering our LICB reputation and improving services and health outcomes for our CYP of Lincolnshire.
- A workforce focused on delivering highly safe and effective care is evidenced in recruitment and retention of staff and results in our CYP receiving quality healthcare services from motivated and invested staff.
- We are aware that nationally there are recruitment workforce challenges and this may restrict our ability to deliver improvements. For example, the LICB is aware that the region requires a consultant with a special interest in PEOLC for BCYP. This is a gap in service provision which can impact on our BCYP and our system partners to provide NICE compliant PEOLC for our BCYP in Lincolnshire.
- We will need to work closely with our partners where it is a known area of workforce challenge. We will need to be innovative and develop models to “grow our own” and review and revise skill mix to maximise workforce capacity and effectivity.
- It is anticipated that as models of care are developed, cases for change will be worked up for each of the Projects, which will include consideration of how existing resources can be used most appropriately to address need within the context of new models of care, alongside the development of business cases where there is a recognised need in terms of resource gap to meet the needs of our local CYP.
- It is understood that there may be opportunities as the ICS develops, to establish new ways of working, for example a ULHT/LCHS Group Model of partnership working is in progression, with likely opportunities for better integration of services which the programme will look to capitalise on and to ensure we maximise on the areas of improvement presented to us.
- We know there are changes to some funding streams, for example, BCYP hospice funding allocation changes, where the responsibility for allocation of hospice funding is proposed to devolve from NHSE to ICBs in April 2025. There will need to be consideration of how the LICB meets its commissioning responsibilities within the context of these funding stream changes and to meet NICE compliance and statutory requirements for BCYP PEOLC.
- Financial investment is sought for Child Strategy Discussions – CS Front Door.

Children and Young People

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5. What's needed to make this happen

- Providers are already fully engaged through the CYP ITB. However, we will be reliant on the clinical expertise and service leads for the technical input into the programme and some of this may require consideration of backfill requirements. There is a need to ensure we support what are often very small and fragile services within CYP specialties. The success of the programme is also dependent on engaging the primary care pathways effectively and as such we will require input from primary care/clinical leads/GPs.
- Health partners are fully engaged in Safeguarding Partnerships relevant to CYP i.e., Lincolnshire Safeguarding Childrens Partnership (LSCP); Safer Lincolnshire Partnership (SLP); and Lincolnshire Domestic Abuse Partnership (LDAP). To support safeguarding transition requirements collaboration is also taking place with Lincolnshire Adult Safeguarding Board (LSAB).
- The programme is fully engaged with Population Health Management (PHM) and the Health Inequalities team, however there is significant work required to develop the required level of data and analytics to be able to ensure the focus is directed in the areas it is needed. We are aware of this and are working closely with our internal LICB partners, Public Health and LCC in resolving this issue.
- It is likely that any increase in workforce will require additional estate and infrastructure to support the increase and enable our staff to work effectively.
- There are some very specific interdependencies with local authority services that will need to be considered especially within Children's Services' Social Care, SEND, Education and Children's Health Services.
- Due to the specialist nature of certain CYP care pathways the engagement and ability to interface with tertiary care providers will be critical for successful programme delivery.
- There is an identified need for acute provider partners to undertake digital transformation. This will align services affected with our regional neighbours and offer seamless communication and information sharing between integrated key partner services.
- All the priorities are reliant on existing financial funding. The only additional funding being sought through a business case being put forwards for approval is that of strategy discussions for Children – CS Front Door.
- It is likely as the CYP programme develops that additional funding may be required, particularly as investment in CYP services has historically been limited and there is evidence of growing service demand across several CYP pathways. The programme will always seek to maximise existing funding as a priority before seeking additional funding.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

6. What could make or break progress

- Workforce availability, a nationally recognised ageing workforce, recruitment, retention, and attraction of specialist posts into the region – the CYP programme continues to support provider initiatives to increase workforce and improve retention.
- Financial challenges across the system, creating a lack of assurance that the funding can be utilised in the right area – throughout our CYP priorities we aim to review existing services to explore cost efficiencies and to continue to influence utilisation of funding in the right areas.
- Data and analytical support for the programme – the CYP programme is working with provider and ICB data analytical teams, including the population health management approach to ensure data and intelligence informs our key priorities.
- Digital transformation impacting on services across the system. A lack of alignment to share critical information between providers to support timely management of cases and prevent unplanned escalation – the CYP programme continue to work with providers to support with the implementation of an electronic platform for records and highlight the issue nationally with NHSE to seek their support and influence.
- Delivering equity of service across large rural areas – the JFP action of 'Improving Access' will run throughout all our CYP priorities, ensuring we are meeting the headline actions and determinants of ease of access for our CYP.
- Increasing demand on existing services seen post Covid-19 pandemic – within the CYP programme's wider strategic priorities, we support the UEC programme and the elective recovery/planned care programme. Our priorities are focused on those areas of service delivery for CYP which have seen an increased prevalence post COVID 19 pandemic E.g., Epilepsy, Asthma and Diabetes.
- New themes of service demand on CYP healthcare concerns not acutely evident before the Covid-19 pandemic – the CYP programme continues to work with partner agencies to explore and examine key health themes which are developing post Covid-19 pandemic.
- A lack of system wide engagement with integration of services due to competing priorities such as operational pressures and priorities of other programmes of work pertinent to their own organisation.
- Acute providers working to a reactive cycle rather than having the space to be preventative – strengthened working relationships between CYP programme and key partners continues with regular updates from each organisation, coming together in a joined-up approach to ensure focus remains on prevention where possible and improving service offer for BCYP.
- Risk of operational and workload pressures may limit ability of stakeholders and our own CYP programme team to be involved in development and implementation of change – this is a system wide issue and we have escalated within our system the fact that we are a fragile programme with a limited workforce. Our priorities are set over 5 years which will allow the time required to make the case for change and effectively improve service offers.
- Fragmented programme that has co-dependencies with other programmes that may have differing priorities. e.g., PEOLC, Planned Care, Primary Care, LCC commissioned services, Education, UEC – this is a fundamental issue for the CYP programme; however, our children's integrated commissioning team are better together and includes NHS and LCC to work in partnership to support each other to progress our own CYP programme's priorities.
- Transition between children and adult services – this relates to ALL Projects. The Transition ICS Network is bringing together key partners from CYP and Adult services. Transition is everybody's business and will require a system wide approach. This work is supported by NHSE frameworks and deliverables expected for all ICB's.
- Clinical lead capacity for meaningful involvement in the programme – the clinical capacity to support transformation is limited. The CYP programme strives to work with our clinical experts, utilising skill set and experience across the workforce capacity.
- Clarity and delay of national funding streams from NHSE required which directly pauses transformation work – we continue to escalate to NHSE leads.
- Co-production with CYP, their families and key stakeholders is vital, and we will need to ensure there is appropriate capacity and capability to undertake meaningful co-production work – utilising existing established CYP voice networks, for example, Lincolnshire Young Voices and the Lincolnshire Parent/Carer Forum as a template for effective co-production and collation of our CYP voices.
- If the development of services relies on additional financial investment and if this is not agreed, then it may mean that pathways cannot be fully implemented or are delayed, and this may limit the outcomes delivered – directly impacting on quality of services available for CYP.

Children and Young People

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7. Planning assumptions

Demand drivers:

- Increased demand and evolving new presentation of health themes since Covid 19 pandemic on CYP services.
- Increased waiting lists for CYP and disparity in recovery to that of Adults.
- Identified gaps in meeting statutory responsibilities following changes to legislation.
- Identified gaps in service delivery to meet the demand of the changing landscape for CYP services.
- Provider; System; and Partnership risk registers.
- Workforce pressures in recruitment and retention of experienced, specialist skillset in Lincolnshire.
- National CYP Transformation Programme Deliverables and reporting (NHSE).
- Palliative and End of Life Care: statutory guidance for ICBs and devolvement of funding accountability (NHSE).
- Admission avoidance/ED attendance.

Productivity, capacity & resource enablers, and constraints:

Workforce:

- National shortage and regional shortage of key workforce and professions such as medical, nursing, AHP and psychologists.
- Often recruitment into new roles is filled by staff in existing roles which then leads to fragility in existing roles (e.g., ward-based nurses moving into community roles) it also impacts on bringing fresh skillset/experience into the region. Retention challenges of newly qualified paediatric nurses within the region and the timely availability of vacancies made available to newly qualified nurses upon completion of their qualifications.

Finance:

- It is anticipated that significant investment will be required to support the development of the CYP programme.
- Clarity and delay of national funding streams which directly pauses transformation work is required.

Service capacity & productivity:

- Partly unknown at this stage whilst priorities are within the pre-scoping phase.
- We are aware of service capacity issues which are directly highlighted to the LICB. For example, we know we have issues with service demand and workforce capacity in our SALT waiting lists for CYP. This is subject to a rapid review by LCC to ensure the service can deliver to an increased demand.
- Whilst the neurodiversity pathways work sits within the MHLDA Programme, there are some specific issues for community paediatric (ULHT) capacity and waiting times that are an emerging risk and will need some targeted work to address from the CYP programme.

Estates:

- Each priority will have different considerations in relation to estate space. The complexity of who owns and who pays the respective estate space will add an additional dimension that will need to be worked through. This may well be made easier by two providers working together within the group model (ULHT & LCHS).

Children and Young People

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8. Stakeholders

Stakeholders

- LCHS, LPFT, ULHT
- St Andrew's BCYP/Adult Hospice
- Rainbows BCYP Hospice
- NHSE
- Other NHS Trusts (Tertiary Centres)
- General Practice
- EMAS
- Children's Services, including Social Care, SEND and Education (LCC)
- Children's Health Services (LCC)
- Police
- Lincolnshire Parent Carer Forum
- CYP engagement, e.g., Lincolnshire Young Voices
- Other ICBs/Commissioners within the Midlands region

(Stakeholders will be different for each identified Project – please see project plans).

Work Programme team

- Vanessa Wort (LICB) Associate Director of Nursing & Quality
- Terry Vine (LICB) Deputy Director of Nursing & Quality/CYP Programme Lead
- Russell Outen-Coe (LICB) Designated Clinical Officer for Children and Young People with Special Educational Needs and Disability
- Sonia Currier (LICB) Children & Young People Programme Manager
- Becky Adgar (LICB) Children & Young People Commissioning Manager
- Linda Dennett (LCC) Assistant Director Childrens Health & Commissioning
- Charlotte Gray (LCC) Head of Service – Children's Strategic Commissioning
- Lucy Gavens (LCC) Consultant in Public Health
- Rosemary Akrill (CICT) Integrated Commissioning Programme Manager
- Joanne Fox (CICT) Integrated Commissioning Senior Programme Officer
- Rebecca Thompson (CICT) Integrated Commissioning Programme Officer

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

Diabetes Logic Model

Inputs

- Specialists with diabetes knowledge & leadership skills – acute and community paediatricians; specialist nurses; pharmacist/medicines management
- Psychological services
- Transition nurse(s)
- Education/schools representatives
- Programme Management
- Clinical input – primary & secondary care
- Co-production – with clinicians; CYP; and families/carers
- Support from community and voluntary organisations
- Data analytics – including support from Public Health Managements
- Finance (inc. funding opportunities)
- Digital support

Activities

- Review of NICE guidance and definition of national standards, including medication optimisation and implementation of Continuous Glucose Montioring (CGM)
- Mapping to understand gaps in access to service/support (equity & equality)
- Establish datasets and use to understand prevalence and outcomes in Lincolnshire; quality of care; trends across PCNs, including referral data;
- Develop care pathway for Lincolnshire that includes - Establishing role of primary care, including wider role of PCNs; early diagnostic /pre diagnostic support/medicines management input; accessible support for CYP and families, including social prescibing to support increased activity and reduce childhood obesity.
- Review available training & education for clinical and care professionals; schools; CYP & families/carers
- Review transition arangements and identify how will respond to identified gaps/challenges.
- Information resource for CYP, parents/carers and professionals to access.

Outputs

- Commissioned pathway of care in line with national best practice.
- Increased confidence of earlier recognition and diagnosis of type 1 and type 2 diabetes.
- Access to psychology services for CYP with diabetes who require support.
- Increase in confidence to manage diabetes of CYP, Parents/carers and education provision.
- Increase in understanding of the condition – CYP networks, in particular schools; activity/social groups
- Seamless transition through CYP services to adult services, seen by a reducation in the unplanned admissions and increased stability of diabetes in 16-25 year old age group.
- CYP utilising diabetes technology to support management of their condition.
- Diabetes data and intellifgence readily available to ensure that care is meeting the needs of CYP.
- Professionals and staff will work collaboratively and co-ordinate care through agreed pathways.
- CYP referred to and have access to phsycial activites and healthy eating to enable them to prevent type 2 diabetes developing.

Outcomes

- CYP will have the information they need to manage their care and Parents/Carers will have increased confidence in managing the child/young persons condition.
- Increase in the use of Continuous Glucose Monitoring and Insulin pumps, particularly in the most deprived population and ethnic minorities.
- Increase in the percentage of those achieving an HbA1c <48 mmol/mol
- Increase in number of children offered dietetic appointment.
- Increase in muber of children accessing psychological support.
- Increase in number of children with Type 1 & 2 diabetes receiving all NICE care processes
- Reduction in the number of CYP presenting in ED with diabetes and unplanned admissions to the ward
- Reduction in childhood obesity

Impact

Children and Young People (Parents/carers of) with diabetes will be empowered to manage their diabetes and improve their quality of life and there will be a reduction in health inequalities related to diabetes.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

Asthma Logic Model

Inputs

- Specialists asthma knowledge & leadership skills
- Public Health capacity & capability
- Staff time – health; social care; education; housing etc.
- Programme management capacity
- Data analytics capacity & capability
- Information sharing agreements
- Digital support
- Comms & engagement

Activities

- Confirm system asthma lead & governance arrangements
- Establish Lincolnshire asthma network; paediatric severe asthma network
- Benchmark Lincolnshire services against regional & national
- Map pathway of care – primary, secondary, tertiary
- Implement asthma bundle and adherence to minimum standards of care
- Develop joint policy between healthcare & education
- Develop joint policy between healthcare and local authority re CYP asthma and living conditions and air quality
- Staff CYP asthma training at level appropriate to role across health and education
- Professionals share appropriate asthma resources with parents/carers, including smoking cessation (needs to link in to LMNS smoking cessation work)
- Implementation of community Spirometry testing and asthma diagnosis for CYP.
- Information resource for CYP, parents/carers and professionals to access.

Outputs

- CYP receive appropriate care and support across healthcare and education with asthma pathways in place and used appropriately.
- Diagnostic hub is in place and sees all CYP who meet criteria.
- Compliance with asthma bundle and minimum care standards .
- All CYP with asthma will have an asthma plan in place that is reviewed annually.
- Parents/Carers of CYP living in homes with poor indoor airquality will be able to access advice and support to make imrpovements. Reduced reports of poor indoor airquality impacting on CYP asthma exacerbation.
- Parents and carers are motivated to stop smoking-Lower rates of smoking in parents/carers of CYP with asthma.
- Resources will be available for CYP, parents/carers to access to support their education around asthma.
- Education settings will have a strategy in place to support students with asthma.

Outcomes

- CYP will have the information they need to manage their care and Parents/Carers will have increased confidence in managing the child/young persons condition.
- Professionals and staff will work collaboratively and co-ordinate care through agreed pathways.
- > A reduction in the number of CYP presenting in ED and unplanned admissions with asthma, particularly in children aged 2-10 years; mixed ethnicity; and those living in most deprived quintile.
- > An increase in the number of CYP having annual asthma reviews
- > A reduction in the number of children being prescribed more than 3 reliever inhalers a year.
- > A reduction in the number of children having an exacerbation of asthma requiring inpatient stay

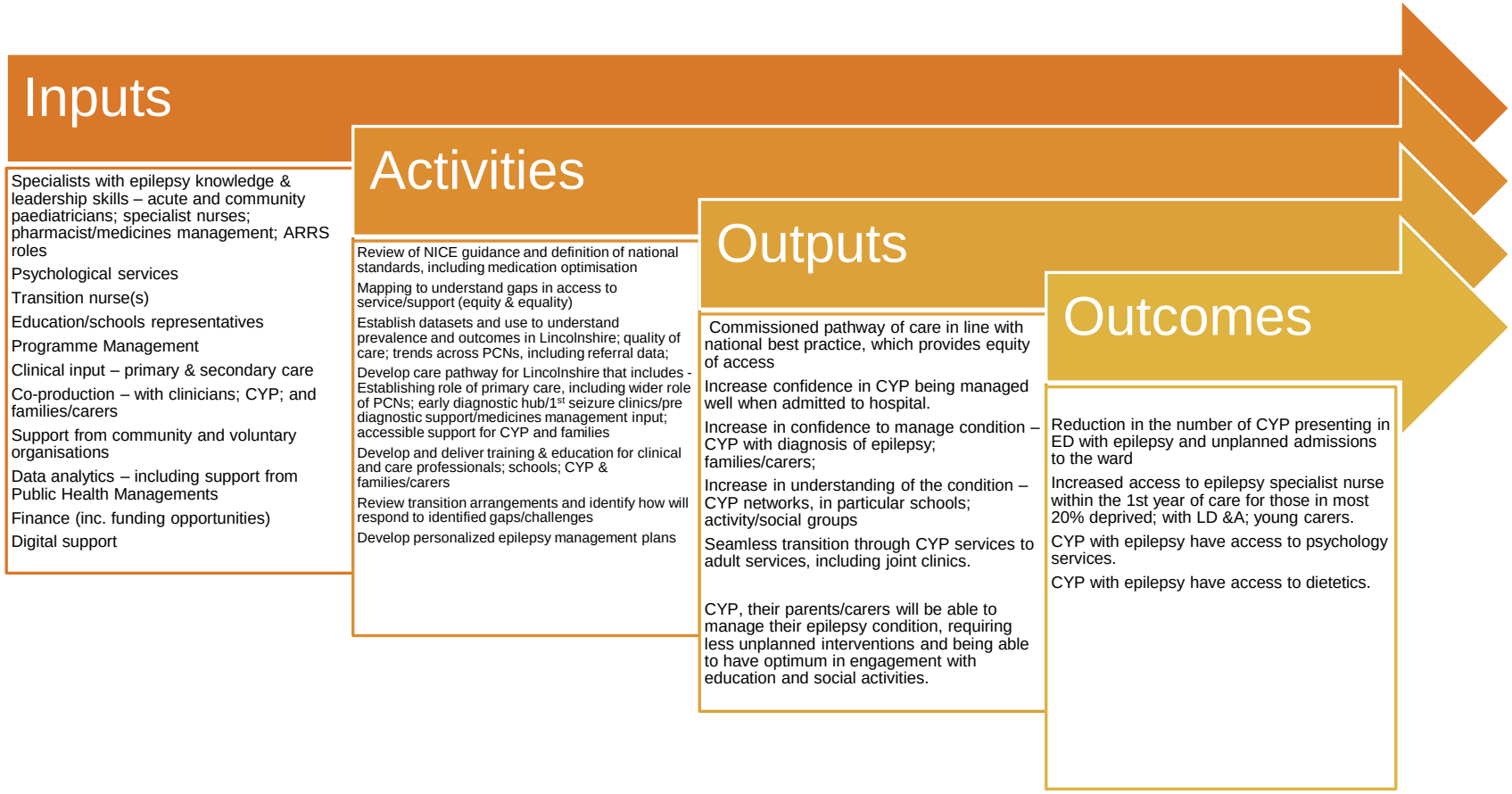
Impact

Children and Young People (Parents/carers of) with Asthma will be empowered to manage their asthma and improve their quality of life and there will be a reduction in health inequalities related to asthma.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

Epilepsy Logic Model



Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

1. Future state

There is a wide range of local and national evidence demonstrating a need for greater parity of children and young people's (CYP) mental health (MH) support, both in relation to physical health support and adult mental health support, based on a fast-growing need over recent years, exacerbated by the recent pandemic. The Lincolnshire Joint Strategic Needs Assessment's (JSNA) children mental health and emotional wellbeing topic sets out the evidence and need for transformation and development of these service in Lincolnshire. Half of all life-long mental health problems in the UK start before the age of 14 and three quarters start before the age of 25. Before the pandemic, the prevalence of mental disorders in children aged 5 to 16 was already increasing from 1 in 9 (2017) to 1 in 6 (2020). Anxieties caused by lockdowns, school closures, isolation from peers, bereavement, and the stresses on families have increased pressures. Demand modelling suggests that 1.5 million children nationally may need new or additional mental health support as a result of the pandemic. Risk and protective factors for mental health and wellbeing are well documented and include childhood abuse, trauma, or neglect, social isolation or loneliness, experiencing discrimination and stigma, social disadvantage, or poverty, bereavement, or being a long-term carer for someone. Understanding these factors can help us to target prevention activity to support mental health and wellbeing.

This CYP MH programme delivery plan is aligned under the Lincolnshire system Mental Health, Dementia, Learning Disability and Autism (MHDLDA) Alliance vision: *'Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities'*. It primarily supports the JFP priority around 'Improving Access', but also supports the health inequalities programme around 'Living Well, Staying Well', 'Integrating Community Care' through more join-up with Primary Care, and growing our 'Workforce' in Lincolnshire.

As part of the NHS Long Term Plan, published in 2019, and NHS Mental Health Implementation Plan 2019/20 – 2023/24, the NHS made a commitment that funding for CYP mental health services will grow faster than overall NHS funding, total mental health spending and each Integrated Care Board's (ICB) spend on mental health. It sets out the following priorities and ambitions for CYP mental health:

- Invest in expanding access to community-based mental health services
- Boost investment in CYP eating disorder services
- All CYP experiencing a mental health crisis will be able to access crisis care 24/7
- Embed mental health support for CYP in schools and colleges through MHSTs
- Develop new services for CYP who have complex needs that are not currently being met
- Develop a new approach to mental health services for 18-25-year-old's, supporting transition to adulthood.

Rather than set new ambitions for CYP MH, the NHS Planning Guidance for 2023/24 focuses on the need to make further progress in delivering the ambitions above in the NHS Long Term Plan and to continue transforming for the future. We will also align to the priorities across the Integrated Commissioning Strategy for SEND, the Lincolnshire Health and Wellbeing Strategy, Suicide Prevention Strategy, and work towards the ten year 'No Wrong Door' vision: https://www.nhsconfed.org/publications/no-wrong-door.

For the purposes of this programme delivery plan, it includes all CYP mental health services that are jointly funded by Lincolnshire County Council and Lincolnshire ICB. It does not include commissioned services that do not provide mental health support to CYP (except where they relate to transition to adult services), CYP mental health services outside of Lincolnshire (e.g. regional F-CAMHS), Tier 4/specialist inpatient mental health provision, adult and older people's mental health plans, and learning disability and autism/neurodevelopmental or dementia specific programmes.

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

2. What's being done to get there | Overview

In order to enable CYP to Start Well, we will:

- Ensure CYP stay healthy through increased public mental health promotion and prevention by building resilience, creating mentally healthy communities and maximising community assets and support/advice, including online and digital
- Empower parents/carers and professionals working with CYP to better identify and respond to their emotional wellbeing and mental health concerns, including more focus on perinatal mental health and parent-infant relationships during early years
- Increase access to timely and effective early intervention support or advice at the right level, in school or in their communities, so that problems are identified early and all CYP who need help, including those with complex needs, can do so
- Ensure that all CYP who are suffering from mental illness can access high-quality, evidence-based and timely mental health assessment and support in their community
- Avoid unnecessary specialist and acute mental health related hospital admissions, particularly for CYP with a learning disability and/or autistic CYP, by providing responsive assessment and support for CYP in mental health crisis, with appropriate community-based treatment, or facilitating prompt discharge or supporting transition where admission is unavoidable
- Work to embed seamless pathways between CYP and adults' mental health services to ensure smooth transitions between them.
- Much of the work for the CYP MH work programme will be driven through the CYP MH Transformation Programme. The vision, aims and objectives of programme are:

Vision	*'Together with CYP in Lincolnshire, we will review and transform services to improve emotional wellbeing and mental health support for CYP and families, enabling them to live independent, safe, well and fulfilled lives in their local communities.'*

Aims	**Priority Objectives**
We will focus on improving support for CYP and their families in relation to: • Public mental health promotion, prevention, community and early intervention support • Empowering parents/carers and professionals working with CYP to better identify and respond to their emotional wellbeing and mental health concerns • Increasing and improving access to community based emotional wellbeing and high-quality, evidence-based and timely mental health assessment and support • Avoiding unnecessary specialist and acute mental health related hospital admissions, particularly for CYP with LD and Autistic CYP.	The transformation programme will consider a wide-range of cross-cutting factors, including: • Understanding needs across Lincolnshire, equalities and population health management • Ensuring thee is the right capacity and skills of community support and mental health trained professionals to meet the needs of Lincolnshire CYP • Engage CYP and families and ensuring their views are used to help shape and co-produce services • Ensuring professionals work together, supported by integrated pathways, to provide the right support to CYP at the right time and remove barriers to co-delivery of support • Making the best use of the funding, workforce and other resources available to us so that services are sustainable and represent best value.

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

3. What's being done to get there - Detail

Programme	Initiative	Milestones		Timescales
CYP MH Transformation	Review CYP MH services	Understand local needs and intelligence; identify best practice, benchmark against evidence-based best practice; CYP and Family views; current service performance - to help shape future service provision		March 2024
	Design CYP MH Services	Using the review phase outcomes, design and agree new service models and appropriate sustainable funding		March 2025
	Implement CYP MH Services	New service models implemented; increase access; reduce demand on specialist services; reduce inpatient admission; improved community support available		March 2028
Prevention and Community Assets	Night Light Café pilot	Increase access to local community CYP emotional wellbeing/mental health support, to increase the overall access in Lincolnshire to achieve the LTP 11,829 1+ contact target		August 2024
Early Intervention	Online MH support service recommissioning	Increase access to a range of early intervention support for low/mild to moderate emotional/mental health concerns, to increase the overall access in Lincolnshire to achieve the LTP 11,829 1+ contact target		March 2024
	Primary care CYP MH Practitioner pilot			Ongoing
	Digital therapy for anxiety pilot			Sept 2026
	CYP counselling offer pilot			March 2025
	On-going delivery and expansion of MHSTs	More support in education settings to increase the number of CYP in Lincolnshire with good emotional wellbeing and MH, with at least 50% coverage of MHSTs by 2025	Waves 7 and 8	January 2024
			Wave 10	January 2025
			Wave 12	January 2026
Community Specialist Mental Health	Investment to increase staffing and reduce waiting times in community specialist mental health support	Improve waiting times so that 95% of accepted referrals are seen for assessment/support within 4 weeks by March 2025; reduce waiting times for specialist mental health support so that no CYP are waiting more than 12 weeks for treatment by March 2025 onwards		March 2025
	Introduce ARFID pathway	Increased access to specialist mental health assessment and support for CYP presenting with ARFID		March 2025
	Complex Needs Service review	Review of sustainability of service		March 2025
Urgent and Emergency Care	CYP MH liaison in Lincoln and Boston	Review and evaluation to develop longer term model		March 2025
	MHUAC all-age pathway	Reduced presentation of CYP in A&E (those with mental health needs), increased access to 24/7 mental health crisis support and assessment for CYP and families		March 2025
	Kooth digital online pilot	Review and evaluation to develop longer term model		March 2025
	Crisis respite	Reduction of inpatient admission; reduction of delayed discharge from inpatient; reduction of CYP in care in unregulated placements		TBC
Transitions Pathways	Ensuring transitions are seamless between CYP & adult MH services	Pathways in place		Ongoing

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CYP MH Transformation	N/A																					
Prevention and Community Assets	Night Light Café pilot																					
Early Intervention	Online mental health support service recommissioning																					
	Primary care CYP MH Practitioner pilot																					
	Digital therapy for anxiety pilot																					
	CYP counselling offer pilot																					
	Waves 7 and 8 MHSTs in Spalding, Sleaford, Grantham																					
	Wave 10 MHST in North Kesteven and South Lincoln area																					
	Wave 12 MHST planning and roll-out																					
Community Specialist Mental Health	Investment to increase staffing and reduce waiting times in CAMHS																					
	Introduce ARFID pathway/ CAMHS Eating Disorders																					
	Complex Needs Service review																					
Urgent and Emergency Care	CYP mental health liaison in Lincoln and Boston																					
	MHUAC all-age pathway																					
	Kooth digital online pilot																					
	Crisis respite																					
Transition Pathways	Ensuring transitions pathways are seamless between CYPMHS and AMHS																					

Mental Health & Dementia

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4. Projected impact on patients and system partners

Initiative	Outputs and Outcomes	
	Patients and Population	System Partners
Night Light Café pilot	- Increased access to out-of-hours crisis support in the community	- Reduced demand on CYP crisis services - Reduced A&E attendance and admissions of CYP for MH related problems
Online mental health support service recommissioning	- Continued access to early intervention support - Continued access to out-of-hours online support	- Reduced demand on face-to-face CYP MH services - Reduced escalation of need requiring specialist MH support
Primary care CYP MH Practitioner pilot roll-out	- Increased access to CYP mental health support in primary care - Improved MH patient journey and experience via primary care	- Better CYP mental health pathways from primary to secondary care services
Digital therapy for anxiety pilot	- Increased access to early intervention support	- Reduced demand on face-to-face CYP MH services
CYP counselling offer pilot	- Increased access to early intervention support	- Increased CYP workforce
On-going delivery and expansion of MHSTs	- Increased access to low-moderate MH support in schools/colleges - More Lincolnshire CYP have good emotional wellbeing and MH, teaching them self-care skills to develop and strengthen their own emotional resilience - More CYP with early indicators of emotional wellbeing and/or MH needs are supported in their education settings and prevented from needs escalating - Reduced health & wellbeing gap to prevent further widening of inequalities	- Better identification of good practice in education settings; improved whole-school approach to emotional wellbeing & MH; Better pathways via education into MH support - Increased knowledge, skills & confidence of the education workforce - Increased CYP workforce - Fewer CYP require alternative/more specialist educational provision or statutory intervention (unless appropriate to meet their identified educational needs)
Investment to reduce waiting times in community CAMHS	- Reduced waiting times for specialist mental health support - Increased support for CYP whilst waiting for treatment	- Reduced staffing turnover in community specialist mental health services - Increased CYP workforce
Introduce ARFID pathway	- Increased access to MH assessment and treatment for CYP with ARFID	- Reduced A&E attendance of CYP for physical health problems related to ED
Complex Needs Service review	- Reduced risk of CYP with complex needs or behaviours escalating and negatively impacting on their life chances	- Better integrated care available in the community for CYP with complex presentations, who may be engaging in risk-taking behaviours - Lincolnshire better able to meet the holistic needs of CYP with complex needs, including children in care and those in the youth justice system
CYP MH Liaison - Lincoln & Boston	- Increased access to 24/7 MH crisis support and assessment for CYP/families	- Reduced A&E attendance of CYP for MH related problems
MHUAC all-age pathway	- Increase in hospital admission avoidance and shorter stays (if admission is unavoidable) for all CYP, including those with LDA - Increased access to 24/7 mental health crisis support and assessment	- Reduced A&E attendance of CYP for MH related problems
Kooth digital online pilot	- Increased access for CYP to support during MH crisis	- Reduced A&E attendance of CYP for MH related problems
Crisis respite	- Increase in hospital admission avoidance and shorter stays (if admission is unavoidable) for all CYP, including those with LDA	- Reduced A&E attendance and admissions of CYP for MH related problems - Reduced delayed discharges from inpatient for CYP - Reduced CYP in care in unregulated placements
Seamless CYP and Adult MH transitions pathways	- Improved patient journey and experience for 18-25-year-olds from CYP to Adult mental health services	- Better CYP mental health pathways for 18-25-year-olds from CYP to Adult services

Mental Health & Dementia

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4. Projected impact on patients and system partners

Measures of success include:

- Increase in CYP accessing CYP MH Services (1+ contact) in Lincolnshire to achieve the LTP 11,829 1+ contact target
- Achieve at least 50% coverage of MHSTs by 2025
- 35% of CYP accessing 2+ contacts with CYP MH services in Lincolnshire
- Improve specialist MH waiting times so that 95% of accepted referrals are seen for assessment/support within 4 weeks by March 2025
- Reduce waiting times for specialist mental health support so that no CYP are waiting more than 12 weeks for treatment by March 2025 onwards
- 95% of routine eating disorder referrals seen within 4 weeks
- 95% of urgent eating disorder refers seeing within 1 week
- Increased access to specialist mental health assessment and support for CYP presenting with ARFID
- Achieve countywide coverage of 24/7 mental health crisis support and assessment for CYP and families
- Reduce hospital admissions (acute or specialist MH/LD) and shorter stays (if admission is unavoidable) for all CYP, including those with LDA – Target 0 MH inpatient CYP with LDA, target <2 CYP GAU inpatients
- Fewer presentations to A&E for CYP in mental health crisis
- Increased access for CYP to support during MH crisis
- Improved patient journey and experience for 18-25-year-olds transitioning from CYP to Adult mental health services

Mental Health & Dementia

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5. What's needed to make this happen

There are a number of schemes covered in this plan which will likely require additional financial resource. The majority would go through the MHDLDA planning process for prioritisation and will be identified where possible within the MHIS.

Initiative	Funding Plans
Night Light Café pilot	Non-recurrently funded pilot. Would look to fund recurrently beyond pilot timescales and expand to other areas of the county via CYP MH Transformation or MHIS
Online mental health support service recommissioning	Recurrently funded by LCC with non-recurrent top-up from S75 pooled fund until March 2026. Would look to fund recurrently beyond pilot via CYP MH Transformation or MHIS.
Primary care CYP MH Practitioner pilot roll-out	Recurrent funding available for partial funding towards 4 FTE Primary Care CYP MH Practitioner posts, 2 currently recruited. Further posts could be funded via further national ringfenced investment, specific ARRs funding, MHIS or CYP MH Transformation.
Digital therapy for anxiety pilot	Non-recurrent funding for pilot from MHIS underspend, beyond this would need to seek recurrent funding to commissioning a service beyond the pilot if successful.
CYP counselling offer pilot	Currently funded via deferred S75 income, beyond pilot would look to fund via recurrent S75 income or MHIS.
MHSTs	Funded via direct allocation from NHSE as new Waves are rolled-out. Would need to ensure continued allocation should funding become part of ICB baseline.
Reducing comm CAMHS waits	Recurrent funding fully released and invested.
Introduce ARFID pathway/ CAMHS Eating Disorders	Recurrent funding from SDF allocated to CYP-EDS and development of CYP ARFID pathway, need to ensure continued allocation once SDF moves into ICB baseline.
Complex Needs Service review	Funded directly by NHSE Health and Justice to LCC, currently agreed until March 2028. Beyond this date we may receive further national funding, otherwise we need to consider local funding via CYP MH Transformation or MHIS.
CYP mental health liaison in Lincoln and Boston	Recurrent funding from the ICB for Boston MHLS has been agreed via the Urgent Care Delivery Board. Lincoln MHLS is non-recurrently funded and it is a likely a similar business case will need to be drafted and considered to continue supporting urgent and emergency MH attendance at A&E.
MHUAC all-age pathway	Recurrent funding committed for staffing of MHUAC to deliver an all-age pathway. Capital funding in the process of being agreed to create a CYP only space within the existing facility.
Kooth digital online pilot	Non-recurrently funded pilot (regional funding). If agreed to continue in Lincs, we would look to fund recurrently beyond pilot via CYP MH Transformation or MHIS.
Crisis respite	Proposals for a crisis respite provision, jointly-funded by LCC and the ICB, are currently being developed. Capital investment is currently being sought initially; the proposals would include joint revenue funding from LCC/ICB.
Seamless CYP and Adult MH transitions pathways	Recurrent SDF funding is currently being used to fund transition posts, however further transitions work would likely be funded via CYP or Adult Community MH Transformation or MHIS.

- The CYP MH programme has sufficient support from finance colleagues, workforce, digital and business and performance analysis colleagues.
- Primary Care and Education sector support is key to delivery against the CYP MH Transformation Programme, more so for aspects related to improving early identification and access to early intervention, developing mentally healthy community. The CYP Urgent and Emergency Care activity will need to be aligned to the wider UEC pathways and LA plans around development of local residential accommodation for CYP, so will require involvement from LCC and ULHT, for example.
- We are working with the ICB around the health inequalities workstream using a PHM approach to work across MHDLDA, which will involve colleagues from the wider system (population health management, public health, health inequalities, PCNs etc). However, we are making sure health inequalities are considered as part of the CYP MH programme, across all workstream areas

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

6. What could make or break progress

Financial Investment
- Financial impact e.g. if MHIS is not achieved, which is a minimum expectation.
- Current//future plans presented largely require recurrent investment to be realised.
- Year on year increases in demand require additional capacity requirements through investment.

Workforce
- Lack of available workforce to fulfil recruitment intentions. This is a particular challenge in certain types of registered professions, but also in certain parts of the county (East Coast) where recruitment can be more challenging. Time to train and upskill the workforce is also key here.
- Alternative roles and new roles are being introduced more and more frequently and feature again in planning for 2024/25 and beyond. Non-registered professionals are increasingly being used within workforce models.
- Use of digital continues to be a focus in terms of both productivity but also as a mechanism to support recruitment and retention.
- Parity of CYP MH roles with Adult MH roles requires recurrent investment to support recruitment and retention within CYP services.

System Capacity
- Lack of capacity from system colleagues, such as primary care, to be able to support development and delivery of the workstreams.
- Other parts of the system working in a siloed way, developing competing or cross-cutting pathways or processes, for example, without the opportunity to work together.

Drivers/Policy Changes
- National or local direction of travel may change – post long-term plan expectations/new policy, greater understanding of local needs or future health or social infrastructure changes. Lincolnshire health and social inequalities are a challenge that need to be taken into account.

Interdependencies with Other Key Programmes
- LCC Families First DfE Pathfinder Programme
- LCC Family Hubs Programme
- Integrated Commissioning Strategy for SEND
- Children and Young People's Integrated Transformation Programme
- Community MH Transformation for adults and older adults.

7. Planning assumptions

- Workforce will continue to be challenging to recruit into certain professions such as psychiatry, psychology and nursing posts – using alternative posts to attract and retain staff including rotational posts, Children's Wellbeing Practitioners (CWPs), Clinical Associate Psychologist (CAPs) etc.
- Demand for services will continue to rise – this is evidenced by individual services by year-on-year increases in referrals. If strategies to fully recruit are successful, then investment will currently continue to meet demand for the foreseeable future, given continued growth in areas such as MHSTs.
- We will continue to have an increase in the mental health investment standard (MHIS) each year
- Assumption that local VCFSE organisations are able to support initiatives and 'scale up' in line with transformation plans
- Assumption that we will work together as an Integrated Care System (ICS).

8. Stakeholders

Key stakeholders beyond Lincolnshire County Council (LCC) Children's Services (Lead Commissioner), Lincolnshire Partnership NHS Foundation Trust (Lead Provider) and NHS Lincolnshire ICB include:
- LCC (Public Health)
- LCC (Adult MH Commissioning)
- Education sector
- NHS England
- Lincolnshire Primary Care and Primary Care Network (PCN) Alliance
- Parent/carers and CYP (particularly those with lived experience)
- Voluntary, Community, Faith and Social Enterprise (VCFSE) sector
- United Lincolnshire Hospitals NHS Trust (ULHT)

All stakeholders are engaged to varying degrees in the relevant individual initiatives outlined in this plan, and/or as part of the wider CYP MH Transformation Programme, via the Workstreams or Programme Governance groups.

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

1. Future state

As set out in the NHS Planning Guidance for 2023/24 we need to make further progress in delivering the key ambitions in the NHS Long Term Plan and we need to continue transforming for the future. We will also ensure we are strategically aligned with the Joint Forward Plan, LPFT Trust Strategy, Health and Wellbeing Strategy and Better Lives Lincolnshire Plan.

The vision is to deliver a five year roadmap for adults and older adults Mental Health services which is part of the MHDLDA Alliance vision: '*Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities'*.

We are also working towards the ten year vision outlined in the No Wrong Door document published by the Centre for Mental Health and NHS Confederation.
https://www.nhsconfed.org/publications/no-wrong-door

We will:

- Work to embed seamless pathways between children and young people's and adults' mental health services to ensure smooth transitions between them
- Continue to improve the range of strength-based community assets for mental health and wellbeing services, helping build resilience and reduce the need for acute, specialist or inpatient services and that there is "no wrong door" to services
- Work to improve access to services for those that do require them, ensuring they are a quality, evidence-based offer
- Ensure that people know how to access help and support that matters to them and respects their needs, assets, wishes and goals
- Reduce the stigma surrounding suicide and ensure a range of provision to support people so as not to lose hope and contemplate suicide as the only option, thereby reducing the rate of suicide in the county
- Ensure that we work together to better understand Lincolnshire's inequalities so that services are needs led and funding is utilised to support services at a locality level through a PHM approach
- Work to embed seamless pathways between adults and older adults' mental health services to ensure smooth transitions between them
- Aim to improve uptake of SMI health checks over the next two years, ensuring timely follow up and intervention to reduce the risk of dying prematurely.
- Utilise evidence-based practice to ensure continuous improvement and best outcomes for people, through adherence to the coproduced 'Together We Will' statements.

For the purposes of this programme plan it includes all adults and older adults' mental health and wellbeing provision. It does not include children and young people's plans, except transitions, learning disability and autism/neurodevelopmental or dementia specific programmes, which are detailed in separate plans. We are however ensuring alignment between them through the MHDLDA Alliance which has been formed through core strategic partners.

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

2. What's being done to get there | Overview

Prevention and Early Intervention: • Roll out of the Mental Health Prevention Concordat Plan • Continued development of alternative MH crisis provision. and Holistic health for the homeless expansion	The MH Prevention concordat promotes evidence-based planning and commissioning to improve mental health and wellbeing and reduce inequalities. The plan includes 5 domains: Understanding local need and assets; Working together; Taking action on prevention/promotion of MH&WB and to reduce mental health inequalities; Defining success/measuring outcomes; Leadership & Direction. Develop and maintain crisis alternatives provision/ MH support for homeless via expanded HHH Team. JFP Priorities: New relationship with the public; Living well/staying well; Improving Access; Delivering Integrated Community Care
Transformation of Community Services: • Model development • Care provision • Data and outcomes • Workforce • PACT and CRT services • IPS and EIP service improvements • Adult Eating Disorders pathways • SMI Health Checks	Commitment to achieve and embed the LTP objectives including the NHSE Roadmap for community transformation. Plans include: Increased investment into community-based provision targeting those areas most in need around suicide prevention and adult mental health and wellbeing; development of a MH VCFSE strategy – to build resilience, generate volunteering opportunities and improve sustainability of provision; continued investment into primary care roles and developing a primary care strategy to support locality mental health team provision; increase workforce and improve pathways for IPS/EIP services; continued growth of CRT and PACT services countywide; further development of the adult eating disorder pathways including prevention and early intervention; developing local model for SMI Health checks delivery including interventions to support aiming to reduce premature mortality and reduce co-occurring conditions. JFP Priorities: New relationship with the public; Living well/staying well; Improving Access; Delivering Integrated Community Care; Happy and Valued Workforce.
Mental Health Urgent and Emergency care: • MH UEC Pathways review and CRV provision • 111 option 2 service Provision • Boston Liaison service • Options appraisal and business case for East Coast provision • Right Care Right Person (RCRP) Programme	Review of the prevention and early intervention alternatives and acute provision of MH UEC including demand and capacity modelling to ensure seamless pathways are in place; NHS111 to be the first point of contact for anyone in a mental health crisis. Implement a Single Virtual Contact Centre for calls to 111 and 999 and a mandated Interactive Voice Response option (SPA); expanding the MH urgent assessment provision to the east of the county. Introduce Cloud contact centre. Working with Lincs Police and wider stakeholders to implement national RCRP programme JFP Priority: Improving Access
Inpatient services: • OT and Carer liaison • Out of area reduction • Inpatient review	Continuing to monitor the need for out of area provision and reviewing local inpatient services to improve quality and access for those needing it. Introducing additional roles to ensure therapeutic provision is available. JFP Priorities: Living Well/Staying Well; Happy and Valued Workforce
• NHS Talking therapies: Improve Access and experience • Perinatal Services: Improve Access and experience • Neuropsychology: Remote assessment pathway • Psycho-oncology: Assistant psychologist capacity • ME/CFS Pathway: Increase capacity to meet demand	Increasing workforce within NHS Talking therapies services, including supervision and long-term condition pathways, to reduce waits for first and follow up appointments, looking at digital options. Improving waiting times for perinatal services and ensuring provision meets need. Increase capacity to meet local population demand, reduce waiting times and improve patient experience in neuropsychology, psycho-oncology, ME/Chronic Fatigue service design and development. Ensuring model for dual diagnosis meets the needs of the Lincolnshire population. JFP Priority: Improving Access

This will be underpinned by a health inequalities workstream aiming to improve equality, across MHDLDA in Lincolnshire using a Population Health Management approach.

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

3. What's being done to get there - Detail

Work Stream	Initiatives	Milestones	Timing	Lead org	Stakeholders
Prevention and Early Intervention	Mental health prevention concordat plan	Plan progression	March 2025	Public Health	ICB; LPFT
	Crisis alternatives	Provision evaluation/impact; pathway review; options developed	March 2025	ICB	LPFT; VCSE
Community including Transformation Programme	Model development	NHSE Roadmap measures of success	March 2024	LPFT	ICB; LCC
	Care provision	NHSE Roadmap measures of success	March 2024	LPFT	ICB; LCC; VCSE
	Data and outcomes	NHSE Roadmap measures of success	March 2024	LPFT	ICB; LCC; VCSE; PC
	Workforce	NHSE Roadmap measures of success	March 2024	LPFT	ICB; VCSE
	Dedicated focused services (CRT, PACT)	NHSE Roadmap measures of success	March 2024	LPFT	ICB
	Adult eating disorders	NHSE Roadmap measures of success	March 2025	LPFT	ICB
	SMI Health checks	Increase uptake; interventions and pathways developed; target achievement	March 2025	ICB	LPFT; Public Health
	Perinatal, NHS Talking Therapies, IPS, EIP	Access targets; experience of services	March 2025	LPFT	ICB
Inpatient	Out of area reduction	Target achievement	On-going	LPFT	ICB
	Inpatient review/ commissioning framework	Quality improvements identified and 3 year strategy in place	March 2025	LPFT	ICB
Urgent and Emergency Care	MH UEC pathway review inc CRVs	Recommendations in place	March 2025	LPFT	ICB; ULHT; EMAS
	111 Option 2 pathway	Services developed and mobilised	April 2024	LPFT	ICB; 111
	MH Hospital Liaison Service (Boston)	Service business case developed and approved for investment	March 2025	LPFT	ULHT; ICB
	Right Care Right Person	Pathways identified and agreed; resource in place	March 2025	Lincs Police	LPFT; ICB; LCC
	MH UAC expansion east coast	Service business case developed. Further scoping and review.	March 2026/7	LPFT	ICB; ULHT
Specialist Areas	Neuropsychology: Remote assessment pathway	Service business case developed. Planned implementation	April 2024 2025/26	LPFT	LPFT, ICB
	Psycho-oncology	Service business case developed Planned implementation	April 2024 2025/26	LPFT	LPFT, ICB
	ME/CFS pathway	Service business case developed Planned implementation	April 2024 2025/26	LPFT	LPFT, ICB
	Dual Diagnosis	Strategy in place; progress reported		LPFT, LCC	ICB

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Prevention and Early Intervention	MH prevention plan	No																				
	Crisis alternatives	No																				
Community inc Transformation Programme	Model development	No																				
	Care provision	No																				
	Data and outcomes	No																				
	Workforce	No																				
	CRT & PACT	No																				
	Adult eating disorders	No																				
	SMI Health checks	No																				
	IPS, EIP	No																				
	NHS Talking therapies	No																				
	Perinatal	No																				
Inpatient	Out of area reduction	No																				
	Inpatient review	No																				
Urgent and Emergency Care	UEC pathway R/V	No																				
	111 pathway	No																				
	CRV/EMAS	No																				
	Right Care Right Person	No																				
	MHUAC East expansion	No																				
Specialist Areas	Neuropsychology	No																				
	Psycho-oncology	No																				
	ME/CFS	No																				
	Dual Diagnosis	No																				

Mental Health & Dementia

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4. Projected impact on patients and system partners

Initiative	Outputs and Outcomes	
	Patients & Population	System Partners
Mental health prevention concordat plan	Inequalities are reduced; people are more responsible for their own care; disease burden is reduced. Reduce variation in outcomes of patients receiving interventions	Integrated working across the system.
Crisis alternatives	Reduction in suicide rate. People better supported in communities. Improved self-efficacy.	Reducing number of people with Mental ill health needing to attend A&E, primary care and secondary MH services
ACMH Transformation: Model development and Care provision ; Data and outcomes; Workforce Dedicated focused services (CRT, PACT)	Locality MH Teams embedded countywide; Adheres to 6 key principles of co-produced commissioning; Access to holistic practitioners and evidence-based practice embedded. Increased access to psychological therapies, CRT and PACT services for those who need them; Organisations take a personalised approach to care, offering choice to accommodate the wide range of individual needs. Number of people who have had 2 or more contacts with transformed model of care meets LTP target	Greater skill mix in community settings inc PC, community MH Teams and VCSE. MHPs have been recruited in each PCN and are delivering brief interventions where appropriate, working with other PCN based roles to help address the holistic needs of people with complex MH problems & facilitating onward access to mental & physical health & biopsychosocial interventions. A more sustainable VCFSE sector. All PCNs transformed within the NHSE Roadmap definition.
Adult eating disorders	Increased access to AED services across the county providing the right care at the right time in the right place;	Greater skill mix in community settings inc PC, community AED Teams and VCSE All PCNs fully transformed within definition of NHSE Roadmap.
SMI Health checks	People with SMI are offered a comprehensive physical health check every year, with an increasing number taking up the offer and follow-up support; Target to deliver 4507 SMI Physical health Checks by 31.3.24.	Increased capacity to deliver physical health checks available
Perinatal, NHS Talking Therapies, IPS, EIP	Increased access to quality services; CMH services and Talking Therapies/PMH services work collaboratively, to ensure people seeking support are provided with that support; People with a suspected first episode of psychosis can start treatment within 2 weeks of referral ; All people aged 14 –65 years can access EIP services, as well as provision and effective pathways for people with an at-risk mental state;	All IPS providers are supported to expand access and are set up to receive referrals from all appropriate sources. Every service user should be able to access suitable evidence-based psychological therapies;
Out of area reduction	**More people supported within Lincolnshire; reduced inappropriate adult acute bed days out of area.**	

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

Initiative	Outputs and Outcomes	
	Patients & Population	System Partners
Inpatient review/ commissioning	This will be determined through the review. The aim will be to establish the changes we need to make.	
MH UEC pathway review **111 Option 2 pathway** **CRV and links to EMAS stack** **Right Care Right Person Programme** **MH UAC expansion east coast**	Some of the outcomes/outputs will be determined through the review process. The aim will be to ensure people are seen in the right place at the right time Improved self-efficacy	Reducing number of people with Mental ill health needing to attend A&E, primary care and secondary MH services
Neuropsychology: Remote assessment pathway		
Psycho-oncology	More people supported through the psycho-oncology pathway	
ME/CFS pathway	More people supported suffering from ME/CFS	
Dual Diagnosis	the coexistence of one or more mental disorders in individuals who also satisfy diagnostic criteria for a substance use disorder	

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

4. Projected impact on patients and system partners

Measures of success will include:

- Increase the number of adults and older adults accessing NHS Talking Therapies treatment
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Work towards eliminating inappropriate adult acute out of area placements
- Improve access to perinatal, EIP and IPS mental health services
- Achieve the local plan trajectory for SMI Health checks by 2025/26
- Improve the outcomes, access and experience for people accessing mental health and wellbeing services in Lincolnshire
- Reduction in waiting times
- Positive service user feedback
- Experts by experience are embedded in everything we do
- ‘Together we will’ statements realised
- JSNA Challenges better addressed
- Benefit realisation of MHDLDA Alliance Priorities

Benefits and impacts of these improvements on system partners include as follows:

- Anticipated reduction in A&E attendances in Boston where mental ill health is the only presenting condition
- Reduced impact on Police having to convey patients, freeing up policing time and improving productivity
- Anticipated reduction in Primary Care presentations for mental health and wellbeing concerns and/or more community-based provision available to provide support
- Increased uptake of SMI Health checks which may increase numbers requiring intervention or support but will ultimately aim to reduce co-occurring conditions and improve the risk of dying prematurely
- Continued increase in investment into the VCFSE, supporting resilience and sustainability
- Reduction in demand on certain secondary care mental health services so that they are able to provide responsive (reduced waiting times) and high quality services giving good clinical outcomes for patients
- Positive experiences for patients, families and carers.
- Reduction in waiting times
- No wrong door
- Reduction of caseloads in secondary care so more time can be spent with people that require it
- Left shift to prevention and improvement in self-efficacy

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

5. What's needed to make this happen

- There are a number of schemes above which require additional financial resource which will go through the MHDLDA planning process for prioritisation and will be identified where possible within the MHIS.
- The programme has sufficient support from finance colleagues, workforce, digital and business and performance analysis colleagues.
- Primary Care support is key to delivery against the community transformation programme elements including adult eating disorders pathways and SMI Health checks programmes, in particular. The MH UEC pathway review will need to be aligned to the wider UEC pathways and require involvement from ULHT and EMAS, for example. The 111 workstream initiative is part of a national programme roll out but will impact on the incumbent provider (DHU).
- We are developing our own health inequalities workstream using a PHM approach to work across MHDLDA but will involve colleagues from the wider system (population health management, public health, health inequalities, PCNs etc) to ensure synergy and integrated working for maximum outcomes.

6. What could make or break progress

Financial Investment

- Financial impact e.g. if MHIS is not achieved, which is a minimum expectation.
- Plans presented largely require investment to be realised.
- Productivity gains have been made for many years through various initiatives such as skill mixing, digital options and more recently outsourcing opportunities, however year on year increases in demand require additional capacity requirements through investment.

Workforce

- Lack of available workforce to fulfil recruitment intentions. This is a particular challenge in certain types of registered professions, but also in certain parts of the county (East Coast) where recruitment can be more challenging. Time to train and upskill the workforce is also key here.
- Alternative roles and new roles are being introduced more and more frequently and feature again in planning for 2024/25 and beyond. Non-registered professionals are increasingly being used within workforce models.
- Use of digital continues to be a focus in terms of both productivity but also as a mechanism to support recruitment and retention. Plans for the Neuropsychology remote assessment pathway typify this.

System Capacity

- Lack of capacity from system colleagues, such as primary care, to be able to support development and delivery of the workstreams
- Other parts of the system working in a siloed way, developing competing or cross-cutting pathways or processes, for example, without the opportunity to work together.
- Working in a siloed way such as system interoperability.

Drivers/Policy Changes

- National or local direction of travel may change – post long term plan expectations/new policy, greater understanding of local needs or future health or social infrastructure changes. Lincolnshire health and social inequalities are a challenge that need to be taken into account

.

Mitigations include:

- Prioritisation process determined by MHDLDA process based on core pre-agreed principles so funding will be determined over a phased approach
- A range of skill mix, retention and staff wellbeing initiatives are in place to recruit and support workforce
- Integrated working opportunities with system partners in a more proactive way to avoid siloed working
- Working closely with NHSE colleagues to understand national direction of travel and priorities to ensure plans are responsive and timely

Mental Health & Dementia

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7. Planning assumptions

- Workforce will continue to be challenging to recruit into certain professions such as psychiatry, psychology and nursing posts
- Demand for services will continue to rise – this is evidenced by individual services by year on year increases in referrals
- We will continue to have an increase in the mental health investment standard and will be able to invest at least this amount as a minimum each year
- Assumption that local VCFSE organisations are able to support initiatives and 'scale up' in line with transformation plans
- Assumption that outsourcing of some activity will continue, for example NHS Talking Therapies.
- Assumption that we will work together as an integrated care system.

8. Stakeholders

- ICB
- LPFT
- LCC
- VCSE
- Primary care
- Public health
- ULHT
- EMAS
- 111

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

1. Future state

The pending Major Conditions Strategy will aim to improve health outcomes and better meet the health and wellbeing needs of local populations. The strategy will recognise challenges facing society, specifically around multimorbidity in ageing populations. The strategic framework, which will underpin the final strategy, focuses action on:

- Primary prevention: acting across the population to reduce risk of disease
- Secondary prevention: halting progression of conditions or risk factors for an individual.
- Early diagnosis: to identify health conditions early, to make treatment quicker and easier.
- Prompt and urgent care: treating conditions before they become crises
- Long term care and treatment in both NHS and social care settings

We want to develop a Dementia Strategy for Lincolnshire- that will have a key focus on prevention of avoidable cases of dementia, improving experience of people being diagnosed and living with dementia and championing participation, innovation, and research.

The vision for the Dementia Programme is to work in partnership; Promote person-centred coordinated care and support, ensure access to information, advice and health and care services, and that this supports of all those living with dementia and their carers when and where they need it. Early identification of people with memory concerns, and ensure waiting times for assessment are timely, fair, and equitable across all our communities. That all people have access to information and advice to age well and reduce their risk of dementia.

Dementia is the leading causes of death in England and Wales in 2022. Dementia has a profound impact on the person with dementia's life, their family, and friends and the communities in which they live. Although age is the strongest known risk factor for dementia, dementia does not exclusively affect older people. Young onset dementia (defined as the onset of symptoms before the age of 65 years) accounts for up to 9% of cases.

Early detection, diagnosis and intervention can also lead to improved treatment and quality of life outcomes that delay onset of complex needs and institutionalisation.

Nationally there are 900,000 people living with dementia in the UK, and by 2025 it is expected that there will be over 1 million people living with dementia and by 2040 this could be 1.6 million.

In Lincolnshire there are currently 8300 people living with a confirmed diagnosis of Dementia, with 7948 (95.8%) people being 65+ the average age being 82, of this number there are 5829 (72%) of people that have Comorbidities, and there are also 352 (4.2%) people in Lincolnshire that have young onset dementia (under the age of 65). Dementia prevalence is predicted to increase across Lincolnshire in all districts over the next 5 years, and based on the projections provided by POPPI, in Lincolnshire the population is expected to grow by 11% by 2041, with 30% of the population to be over 65.

There are 1873 people in Lincolnshire that are identified as having a Mild Cognitive Impairment (MCI); Patients without a Dementia Diagnosis. Follow up by the GP is not mandatory, but there is an opportunity to do some focused work with people to make informed lifestyle choices to prevent and delay the progression to dementia, and to identify any other underlying causes for memory loss.

Research shows that supporting brain health and reducing dementia risk is not only the right thing to do – it could also save money for the public purse. Preventing dementia by targeting just three specific risk factors – tackling high blood pressure, providing hearing aids, and helping people to quit smoking – could save the economy £1.9 billion per year and reduce the number of cases of dementia by nearly 10%. Only 34% of UK adults think it's possible to reduce their risk of dementia. Health and care professionals can promote evidence-based messages to middle-aged adults to help reduce their risk of getting dementia.

There are national requirements to improve Dementia Diagnosis Rate (DDR). The current DDR for Lincolnshire is 66.4% in comparison with the national standard of 66.7%.

Reduction of inappropriate Antipsychotic (AP) prescribing for people with dementia, to be restored to pre-covid levels - NHSE Target, this increased during covid, Lincolnshire ICS to be under/in line with National average and not an outlier.

For purposes of this programme, it includes all people diagnosed with dementia, carers, people with mild cognitive impairment, people at risk of developing dementia, which includes people with a learning disability and autism, it does not include adults or older adults with mental health, or frailty, which are detailed in separate plans. However, there will be overlaps that we will ensure there is alignment between them through the MHDLDA Alliance which has been formed through core strategic partners.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

2. What's being done to get there | Overview

Dementia Strategy development-

- The approach to developing the strategy has been to have conversations with people with dementia, their carers, those who live in Lincolnshire and our partners in health, social care the Voluntary, Community, Faith and Social Enterprise (VCFSE), about their experience of health and care services and the impact of covid, what we should focus on to improve the care and support we provide. We have discussed all areas of dementia care, from activities aimed at preventing dementia, through to care at the end of people's lives.
- Co-production and Engagement with the people of Lincolnshire is fundamental to the development of dementia care pathways and support to empower all people affected by dementia this will continue through the life of the strategy.
- The strategy will be finalised and be launched at the early 2024, the goals identified for the strategy will be prioritised and added the current delivery plan to ensure that we achieve the changes required to improve dementia care and support for people affected by dementia
- We have continued with the following areas of work whilst we develop the new strategy for Lincolnshire to ensure we move forward and make improvements needed.

Prevention

- Increased investment in prevention in Lincolnshire; aimed at raising awareness of the importance of good brain health across all age and reducing the risk of dementia. Ensuring we address inequalities in the risk factors for dementia & give everyone who needs it the chance to access support to be active, eat well, continue to learn, and to stay connected.
- Even though there is no cure for dementia the most recent updated study on dementia prevention published (Lancet, 2020) found that around 40% of dementia cases worldwide might be attributable to 12 potentially modifiable risk factors. As such a proportion of predicted dementia is potentially preventable, by tackling the identified risk factors that we can change, such as smoking, diet, physical activity, and social isolation.
- Smoking is one of the biggest risk factors for dementia and can double an individual's risk, because it causes narrowing of blood vessels in the heart and brain, and oxidative stress, which damages the brain.

Dementia Diagnosis (DDR Target) and Care

- DDR Target: Nationally mandated DDR target of 66.7% - Lincolnshire DDR average is at 66%, ICB, LPFT, PCN to work together to identify ways of working that will improve dementia diagnosis and achieve or exceed the DDR target for Lincolnshire.
- Review and develop the dementia pathway/s to support people identified with Mild Cognitive Impairment (MCI).
- Antipsychotic Medication*:* Reduction of inappropriate Antipsychotic (AP) prescribing for people with dementia. Lincolnshire ICS to be under or in line with National average. Appropriate use of antipsychotic mediation and use of Nonpharmacological treatment
- All people diagnosed having a health care plan and care plan medication review in the preceding 12 months
- Promoting use of the Diagnosis Advanced Dementia Mandate Tool as part of the primary care dementia pathway for patients with advanced/severe presentation of dementia in care homes

Memory Assessment Service for Lincolnshire

- Moving toward a stand-alone Memory Assessment Service model to improve the dementia diagnosis rate for Lincolnshire and reduce waiting times for memory assessments
- Provision of memory clinics in GP practices where required to support assessments
- Demands of Older Peoples CMHT continue to rise year on year in-line with known predictive demographics of Lincolnshire as an ageing county. Lincolnshire currently has circa 180,000 + over 65s. This is predicted (Office National Statistics) to increase by 46% to 250,000 by 2041.
- People will receive faster/earlier diagnosis

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

2. What's being done to get there | Overview

Dementia (Memory) Support Service

- Assess the need for service and identify priorities and future service requirement for the current Dementia Support Service for Lincolnshire. Lincolnshire County Council Commission the 'Dementia Support Service' for Lincolnshire, the service is due to come to the end of its contract in October 2024.
- The system in Lincolnshire undertook a multi-agency review of the Dementia pathway and support services in 2021, this was given to the rise in demand, cost, and the ageing population. One of the key recommendations for this was to have a pathway wide dementia support service to be developed as a single point of access. Consideration of the findings and recommendations of the report will need to be taken account of in this review.
- There is now an opportunity for system partners including VCFSE to work collaboratively to consider the options available to support an appropriate pathway for dementia in Lincolnshire that will meet the needs of the population. This needs to include options for where this may need to be an integrated service.
  - Ensure appropriate peri-diagnostic support and care planning is available for all those with dementia, to avoid crisis and unnecessary hospital admissions.
  - Ensure dementia services are appropriately resourced and sufficient to meet dementia related population health and care need.

Complex Dementia – managing challenging behaviour (all settings)

- Improved offer of support for carers and care staff to support people with challenging behaviour, to develop protocols to support managing challenging behaviour in all settings across Lincolnshire, people with complex dementia to have improved health and care outcomes, and improve support for the workforce with awareness, advice, training.
  - To implement the role of Dementia Ambassadors in care homes
  - Appropriate use of antipsychotic mediation and use of Non pharma logical treatment
  - Improved offer of support for carers and care staff to manage challenging behaviour.

Palliative and End of life Care (PEoLC)

- Promote care planning whilst people can communicate their needs and wishes, to increase awareness that dementia can reduce life expectancy, supporting people to complete an advanced care plan and ReSPECT (Recommended Summary Plan for Emergency Treatment and Care) form. Increased number of people with dementia dying at their usual place of residence.

Developing specialist Young Onset Dementia (YOD) pathway for Lincolnshire

- New Pathway to be implemented*:* To ensure timely and appropriate diagnosis and support the development of age-appropriate support and care for people including information, resources and advice on the issues specifically faced by working age adults, that can help them remain active and living well in the community.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

To note: The new strategy with its delivery plan will have a clear project plan encompassing the workstreams below that will set out key deliverables and milestones, the Dementia programme board will have responsibility to oversee this.

Dementia Strategy development:

- We have spent a period of time having conversations and working with to people with dementia, their carers, and families and our partners in health, social care the VCSE sector, about their experience if health and care including the impact of covid, this has been this has been to help us establish our goals and identify what actions we need to take to improve the care and support we provide to people, so far we have used what people have told us to develop the draft goals for the strategy and we will continue to work collaborative to finalise the strategy.
- Completed a period of engagement on the draft strategy goals with system partners, people affected by dementia including Dementia UK and the Alzheimer's Society this will be reviewed to further develop the final draft strategy.
- Members of the Dementia programme Board (DPB) and people with lived experience are working together with the population health management team to develop a logic model identifying our activities and outputs including long/medium/short-term outcomes for the strategy delivery plan, utilising the intelligence/data to support this work.
- We are working with DAAs/DFCs this is to re-establish themselves to form a Dementia Network for Lincolnshire and be representative at the DPB, these groups pay a pivotal role in our communities to improve local support and access to services for people and will support development and delivery of the dementia strategy action plan.
- Every-One have supported the development of the strategy by empowering people to share their experience and have their voices heard, they are establishing a network of people with lived experience to work collaboratively with the DPB to identify opportunities for coproduction and codesigning service.

Prevention

Task and Finish group established with the following remit of work.

- Developing a pack with information and advice for people on preventing avoidable dementia encouraging people to age well,
- Highlighting the 12 modifiable diseases that increase the risk of dementia by embedding this into other associated public health campaigns.
- Raising awareness across the life course of what's good for the heart is good for the brain by developing a resource of video/animations, and marketing campaign, this will be accessible for the public and for professionals to use across health, care, and education.
- Review and develop protocols to encourage uptake of NHS health checks and ensure risks associated with dementia including early signs of dementia are recognised during health screenings and ensure appropriate advice and support is available.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

To note: The new strategy with its delivery plan will have a clear project plan encompassing the workstreams below that will set out key deliverables and milestones. The Dementia programme board will have responsibility of overseeing this.

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
New Joint Dementia Strategy JFP: PRIORITY 1: A new relationship with the public	Strategy - co-produced.	Coproduced final draft strategy.	Jan 24	LPFT	LCC/Every-one/ICB/VCFSE/ DPB
		Governance process to sign off Strategy.	June/July24		
		Launch Strategy	Aug 24		
	Logic model developed	Completed logic model encompassed into strategy	Feb 24	LPFT	ICB
	Establish baselines for data and metrics	Data sets for Dementia	Feb 24	Arden Gem	LPFT/ICB
		Develop a dashboard for data	Apr 24	Arden Gem	
	Reset the Dementia Programme Board – Board focus.	TOR for the dementia Core Dementia team and the Dementia Programme Board	Feb 24	LPFT	ICB/ULHT/LCHS/ VCFSE
		Reset membership for the DPB	May 24		
	Dementia Network for Lincolnshire	DAAs/DFCs re-established.	Sep 24	DAAs/DFCs	LPFT /ICB
		Dementia Network for Lincolnshire and be part of the DPB	Sep 24	DAAs/DFCs	
	Coproduction people with lived experience.	Established a network of people with lived experience	Feb 24	LPFT	DPB/LCC/Every-one/ICB/VCFSE
	Delivery Action plan – coproduced	Delivery Plan implemented	Sep 24		
	Project Management tool and metrics developed	Metrics set and dashboard developed	Apr 24		
Prevention Offer for Dementia JFP: PRIORITY 1: A new relationship with the public PRIORITY 2: Living well and staying well	Prevention - Task and finish group - Focused prevention programme raising awareness of the importance of good brain health across all age and reducing the risk of dementia.	Plan developed to identify prevention offer to reduce the risk of dementia.	Sep 23	LPFT	LPFT/LCC/ICB/PCN/VCFSE
		Information & advice available for use across the system - preventing avoidable dementia and ageing well.	Aug 24		
		12 modifiable risks that increase the risk of dementia embedded into other associated public health campaigns.	Apr 24		
	What's Good for the Heart is Good for the Brain-Universal bespoke resource	Animation resource developed.	Aug 24		
		Marketing plan developed	July 24		
	Health Checks – support increased number of HC and information on what to expect.	Info available on health checks inclusive of risks for dementia	Jan 25		
	Health Checks - ensure risks associated with dementia including early signs of dementia are recognised ensuring appropriate advice and support is available.	Assessment guidance/training re dementia risk available for practitioners carrying out HC.	Jan 25		
		Plan developed to incentivise GPs undertaking health checks	Mar 25		

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
Improved dementia Diagnosis and Care (DDR Target) JFP: PRIORITY 3: Improving access	Diagnosis - Care Homes (DiADeM assessment). EHCH work programme develop process supporting and increasing the use of DiADeM tool in care homes tool including potential development dementia ambassador's programme.	Embedded as part of the primary care dementia pathway for patients with advanced/severe presentation of dementia in care homes.	Sep 24	PCN (Support by ICB	LPFT/PCNs/LinCA/LCC
		Test project in one PCN area to establish a clear process and measure impact. Pilot lead by Frailty Nurse Specialist as part of the Lincolnshire Health Partnership PCN Enhanced Health in Care Home (EHCH) Team.	July 24		
		The pilot written up and presented at PCN Alliance to support rolling out across PCNs in Lincolnshire care homes.	July 24		
		The Dementia Assessment Referral to GP (DeAR GP) promoted, Care Homes to identify people who are showing signs of dementia.	Sep 24		
	Improve number of people diagnosed.	DDR Task and finish Group	Oct 23	PCN (support by ICB)	ICB/PCNs/LPFT/ Arden Gem
		Implemented pathway and road map for people with MCI	Nov 24		
		All practices provided with the information about the dementia quality toolkit (DQT) available on both EMIS and SystmOne and advised to run this annually	Oct 23		
		Annual review - patients with mild cognitive impairment (MCI) has been embedded as part the locally developed primary care dementia pathway and MCI annual follow up	Nov 24		
		GP handbook produced and launched across primary care - support case finding/MCI referral.	Jan 24	PCN (support by ICB)	
		Primary Care - All people diagnosed having a care plan and care plan medication review in the preceding 12 months.	Mar 25	PCN (support by ICB) /LPFT	
		NHS digital primary care dementia data and local data sets dashboard produced	Sep 24	Arden Gem	

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3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
Memory Assessment Service for Lincolnshire **LPFT** JFP: PRIORITY 3: Improving access	Working toward establishing a standalone Memory Assessment Management Service to offer timely assessment and reduce the waiting time for diagnosis	Fully costed business case submitted.	Nov 23	LPFT	ICB/PCNs
		Project plan considering outcome from the BC to fund the new service model, including phased recruitment plan	Aug 24	LPFT	
		Develop KPIs and Metrics for measuring the impact of the service changes	Aug 24	LPFT	
		Provision of memory clinics within GP surgeries	Dec 24	LPFT	
Dementia (Memory) Support Service JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Assess the need for service and identify priorities and future service requirement for the current Dementia Support Service for Lincolnshire.	Plan established for the 'Dementia Support Service' review.	Oct 24	LCC	LPFT/ICB/VCFSE /PWLE

Mental Health & Dementia

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3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
Antipsychotic Medication - Appropriate use of antipsychotic mediation and use of Non pharma logical treatment JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	In line with the National priority, a cross organisational task and finish group (LPFT, ICS, Primary Care, Arden Gem) has been running and has reduced AP prescribing in dementia back to the targeted pre-pandemic levels. Lincolnshire ICS to be under/in line with National average and not an outlier BPSD pathways reviewed and updated (NICE guidance, including AP prescribing)	AP Task and Finish Group established.	Sep 23	MMO (ICB)	PCN/LPFT
		Audits across primary care and care homes to identify where and why medication was initiated, frequency and quality of mediation reviews.	Nov 23		
		Secondary care BPSD Pathway – aligned to PC pathway. Updating pathways and non-pharmacological options/actions.	Feb 24		
		Primary care BPSD > CD + PC Clinical lead.	Oct 23		
		Refocus key ethos of AP review. Clear down-titration process/protocol (linked to 6-week review).	Oct 23		
		Clear GP discharge information standards. Review, discontinuation & re-access processes.	Oct 23		
		Digital Quality Outcomes framework	Nov 23		
		Reduction of antipsychotic medication restored to pre pandemic levels - Data from NHS digital	Apr 24		
Complex Dementia – managing challenging behaviour all settings. JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Review & develop education and training programmes for supporting people with dementia and improve access for carers and care professionals Develop a competency framework that includes mandatory training and is sustainable and available to health and care staff.	Dementia ambassadors in care homes	Jan 25	LPFT/LCC	ICB/LCC/LinCA/Arden Gem
		Review of education and training resource completed	Jan 25		
		Increased number of staff accessing training and a qualified upskilled workforce.	Mar 25		
		Competency framework in place	Mar 25		
	The recovery college and carers developing training to support carers in their caring roles.	Improved offer of training and support for carers to manage challenging behaviour.	Dec 24		

Mental Health & Dementia

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3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
Palliative and End of Life JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Review the Palliative and End of Life Care offer to support people with dementia, PEOL Delivery Group to agree how to strengthen the PEOL offer for people with dementia. Enhanced Health in Care Homes is dedicated to improving PEOL for people in care homes of which dementia patients are covered	Improved identification of people that are at end of life	Jan 25	PEOL delivery group (ICB)	ICB/LPFT/ULHT/ PCNs
		Improved offer of palliative care for people living with dementia	Jan 25		
		Increased number of people with Advanced Care Plan and with a ReSPECT form. NHS digital primary care dementia data	Mar 25		
		Increased number of people with dementia dying at their usual place of residence. NHS digital primary care dementia data	Mar 25		
	Competence framework to be developed in personalised palliative and end of life care across all care settings – including care professionals, unpaid carers, and volunteers.	Training programmes support staff and carers	Mar 25	PEOL delivery group (ICB)	
	PHM robust data -	Baseline established and data set for monitoring and reporting	Mar 24	Arden Gem	
Specialist Young Onset Dementia (YOD) pathway for Lincolnshire. JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Develop dementia diagnosis and support pathway for working age adults (<65)	Working group established to resume.	Aug 24	LPFT	PCNs/VCFSE/ PWLE
		New Pathway established and implemented.	Mar 25		

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Dementia Strategy																					
Dementia	Prevention agenda	No																				
Dementia	DDR Target	No																				
Dementia	Antipsychotic Medication	No																				
Dementia	Memory Assessment Service	No																				
Dementia	Dementia (Memory) Support Service	No																				
Dementia	Complex Dementia – managing challenging behaviour (all settings)	No																				
Dementia	Palliative and End of life Care (PEoLC)	No																				
Dementia	Develop specialist Young Onset Dementia (YOD) pathway for Lincolnshire	No																				

Mental Health & Dementia

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4. Projected impact on patients and system partners

There is strong strategic alignment with Joint Health and Wellbeing Strategy and the MHDLDA Alliance which prioritises dementia as areas for development and improvement.

Initiative	Benefits	System Partners
Dementia Strategy	• Clear vision and priorities for Lincolnshire to improve dementia support for the people of Lincolnshire. • People are aware of what we will be doing to achieve our delivery plan. • Opportunities of people to coproduce and design service. • Raise awareness and understand dementia better and encourage people to seek help. • Reduce people's fear and misunderstanding of people with dementia. treatment, care and support as needed after the diagnosis.	• Strategic direction for all partners • Clear delivery plan that can be measured and evaluated. • Professionals will be more aware of dementia and will understand dementia better. • Give clarity on treatment, care and support as needed before and after the diagnosis.
Prevention agenda	• People better informed on the modifiable risk factors and what they can do to self-care and reduce their risk of developing dementia. • Targeted supported for people who may be at risk and actively promote physical activity and exercise interventions. • Improved access to health checks and services that can advise and support on preventative measures.	• Increase the number of people having a health check. • Education for GPs and practitioners on the 12 modifiable risk factors, in carrying out health checks. • Reduced demand on statutory services. • Identification of high-risk groups to increase social, cognitive, and physical activity, and vascular health.
Improve Dementia Diagnosis & Care (DDR Target)	• Patients will receive faster diagnosis. • Timely diagnosis means that patients are not waiting as long, which in turn reduces their (and their families) anxiety and can lessen impact on wider health and care services, for example on primary care. • Equitable service and wait times across all district's groups and communities, taking account of health inequalities	• DDR exceeding national target of 66.7% Lincolnshire 65.1% • County Wide DDR attainment and associated QoF levels/payments to GP's. • Reduced demand on statutory services.
Reduction in the use of Antipsychotic Medication	• Reduce the risk of falls and stroke. • Improved cognition • Improved mobility	• Reduction of antipsychotic medication restored to pre pandemic levels - Data from NHS digital. • Reduce the number of patients on anti-psychotics, National average 9% Lincolnshire 8.8% currently. • Reducing hospital admissions

Mental Health & Dementia

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4. Projected impact on patients and system partners

Initiative	Benefits	System Partners
Memory Assessment Service	• Early detection, diagnosis and intervention can also lead to improved treatment and quality of life outcomes that delay onset of complex needs and institutionalisation. • Increased diagnosis rates are central to access for post-diagnostic support and planning for dementia. This is inclusive of advanced care and treatment decisions that can impact down-stream service use and access. • Timely intervention and treatment resulting in better outcomes; Ensures co-morbid conditions are recognised and treated. • Education programmes for carers and people who receive the diagnosis	• Reduce unnecessary attendance A&E and hospital admission which can be stressful for the person with dementia, • Staff have skills to support more complex dementia diagnostic. • Development of skills and pathways required for more complex dementia diagnostic groups such as young-onset dementia, dementia in Parkinson's disease/Learning Disabilities/Huntington's disease etc. that currently go under-served and can lead to out of area expenditure and resource usage. • Reduced demand on statutory services. • Increased number of staff available to support people accessing dementia assessment. • Improved recruitment and retention of staff • Reduce caseloads for CMHT
Dementia (Memory) Support Service	• Ensures people with dementia and relatives are aware of appropriate services and support which might extend independent living. • Increased access to the right support at a time when needed. • No wrong door approach -system work better together.	• Reduced demand on statutory services. • Improved resource and support in the system • Knowledge of services available to signpost and support people
Complex Dementia – managing challenging behaviour (all settings)	• People being cared for competently and compassionately in their usual place of residence. • Carers better able to continue their caring role. • Carers and unpaid carers are adequately supported to continue to care for the person in their usual place of residence. • Carer training/awareness on understanding behaviours and how to manage.	• Reduce unnecessary attendance A&E and hospital admission. • Local health and care partners – including staff from Primary Care Networks – working in a more joined-up way, through sharing information and working as one multi-disciplinary team. • Improved recruitment and retention of the workforce, that have to skills needed to support people with dementia. • Upskilled workforce – competent and confident • Support within the system for the workforce to manage difficult dementia behaviours
Palliative and End of life Care (PEoLC)	• Palliative support available from the point of diagnosis that includes people having the right support when it is needed and at the end of life • People and families, being able to live good lives and be independent for longer. • Remain closer to loved ones. • Receive one-to-one support. • Cared for by specialists. • Personalised symptom relief. • Peace of mind for the family.	• Less crises and reduced hospital admissions • Better planning and use of system resources • NHS digital primary care dementia data • Increased number of people with dementia dying at their usual place of residence. • Increased number of people with Advanced Care Plan and with a ReSPECT form.

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4. Projected impact on patients and system partners

Measures of success	Baseline Date	Current – Oct 2023 unless stated	Target 27/28
Increase in DDR	Oct 2023	65.1%	66.7%
Improve the DDR in practices in the Rural Group 80% and over	Oct 2023	55.2% average DDR	66.7%
Reduce the disparity in diagnosis between the 4 localities	Oct 2023	Locality Data: West (70.6), South (64.9%), Southwest (62.5), East (62.3%),	66.7%
Follow up and identify those with an MCI (Memory and Cognitive Problems)	Oct 2023	1873 (MCI) Lincs Rate Per 1000 9.8 England Rate per 1000 12.6 Prevent/Reduce the likelihood of those with an MCI from being diagnosed with dementia?	Plan in place to identify and support those with an MCI at each practice.
Follow up and identify those with Memory and Cognitive Problems (50-65)	Aug 23	4613	Plan in place to identify and support those with a Memory and Cognitive problem at each practice.
Increase in Health Check 5 year (50-65)	Aug 2023	64,419/172,289 (37.3%)	50%
Decrease of average time to assessment	Nov 2023	14.29 weeks	6 weeks
Decrease in the average time to diagnosis.	Nov 2023	23.25 weeks	Year on year reduction
Reduction in the waiting List (MAMs)	Oct 2023	1,400 – 1,600	200
Primary Care - Increase in the number of Dementia Care Plans	Oct 2023	2732	Maintain performance in line with or above the England Average
Primary Care - % Care Plan	Oct 2023	Lincolnshire 57%, England Average 59.9%	Maintain performance in line with or above the England Average
Increase in the number of Medication Reviews	Oct 2023	4761	Maintain performance in line with or above the England Average
Primary Care - % Care Plan and Medication Reviews	Oct 2023	Lincolnshire 33%, England Average 32.1% (QAF Indicator)	Maintain performance in line with or above the England Average
Reduction in Anti-Psychotic Prescribing	Oct 2023	Lincs 8.84%, England Average 8.8%	Maintain performance in line with or below the England Average - lower is better
Increase in people with advanced Care Plan & ReSPECT form	Aug 2023	35.6%	Year on year increase
Palliative Care (% of registered Dementia)	Oct 2023	Lincs 20% England 18%	In line with or above the England Average
Increase in those with dementia diagnosed in Nursing Homes	Oct 2023	Lincs 2% National Average 8.1% - Aug 2023	In line with or above the England Average
Review ethnicity data, those with a dementia diagnosis recorded as not defined is very high – highest in the Midlands	Nov 23	41.8% of all diagnosis recorded as not defined. 63/8138 were BAME (0.77%)	In line with the Midlands Average – Best performance Stoke on Trent and Staffordshire 0.2% not defined.

Mental Health & Dementia

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5. What's needed to make this happen

Initiative	Contributors	Enablers	Resource
Dementia Strategy	All System Partners	HEAT Plan Baseline data for Dementia – Dashboard Logic Model - clear metrics Active executive support Active engagement with people with lived experience on service design Opportunities for cases for change – Business plans Early risk analysis and ongoing risk management, Evaluation plan	Parity of investment – financial and non-financial
Prevention agenda	LCC Public health, PCNS, VCSE, HI/PHM teams, District Councils	Health inequalities data, PHM data	Increased investment in prevention; Committed Staff resource. Clear programme of priorities Integrated working for maximum outcomes
Improve Dementia Diagnosis & Care (DDR Target)	LPFT, PCNS	Standalone memory service Workforce DDR Data Sets and MCI Data	Integrated working for maximum outcomes
Reduction in prescribing Antipsychotic Medication	LPFT, PCNS	Education and training plan PHM Data sets	
Memory Assessment Service	ICB, LPFT, PCNs	Workforce Digital programme – tools Specialist support Active engagement with people with lived experience on service design HEAT Plan	Funding Workforce
Dementia (Memory) Support Service	LCC, All System Partners	HEAT Plan VCSE; Workforce Active engagement with people with lived experience on service design	Pooled funding to offer a one stop shop. VCSE investment Commissioning
Complex Dementia – managing challenging behaviour (all settings)	LPFT, ULHT, LCHS, LCC, LiNCA	Workforce; Education and Training Plan Active engagement with people with lived experience on service design Dementia Ambassadors	Workforce Funding
Palliative and End of life Care (PEOL)	ULHT, LCHS, Palliative Service (St Barnabas)	Specialist workforce; Education and Training Plan Active engagement with people with lived experience on service design	Possible funding – to assess needs. Workforce

Mental Health & Dementia

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6. What could make or break progress

Interdependencies

Other programmes and organisations that support the success of the Dementia Programme:
Frailty Programme; Adult MH programme; Personalisation programme; Digital Programme; EHCH delivery group; PEOL delivery group; LCC/ICB/ULHT/LCHS/VCSE; DAA/DFCs

Risks

Risks/Challenges	Mitigation
Funding: Recurrent funding needed to develop the standalone memory service needs to be established to ensure sustainability of the service Staff recruitment and retention difficulties People continue to wait longer for memory assessment/waiting list grow Access to new treatments when available delayed (outcomes for patients are maximised with early detection, diagnosis, and treatment.) Carers unable to cope with supporting the person with memory issues	Review current memory services resource and restructure where possible to improve offer for memory assessment. Memory clinics in communities (GP surgeries and community settings) Explore opportunities for funding to increase staffing needed to support memory services Work with the EHCH programme to increase the use of DiADem tool in care homes Work with people who have lived experience to develop service design to meet needs Carer support services aware of needs of people caring for someone with dementia – including mental health services support, case for change – business case developed
Recognising the importance of the VCFSE sector, VCFSE unable to provide that level of resources required across the county without investment from health and social care.	Work with partners/commissioners to map and identify gaps in services and what's needed to support people in their communities, to give clarity and guidance to the sector (LCC Market Position Statement) Work with DAAs and DFCS to gain support to from communities and identify barriers to access service and support, ensure they are part if the DPB Work with DPB/colleagues to complete business cases for investment/support changes needed and agree escalation routes Identify funding opportunities both non-recurrent and recurrent, signpost and support the VCSE sector and groups to apply Support VCSE to diversify and system to share knowledge and skills within the sector (provision of training)
Transport and housing being inadequate to serve our communities, to ensure access to hospital appointments, support and services needed is fair and equitable. Ensure that people with dementia can live independent at home for longer and feel safe, supporting dementia friendly communities. Getting to hospitals is particularly difficult for people without a car or who are living in places with inadequate public transport options. This lack of access can lead to missed health appointments and associated delays in medical interventions both of which limit their ability to access public transport and to travel longer distances to reach specialised health services and hospitals.	Work with Health Inequalities Team to identify inequalities for Lincolnshire and map these to support the dementia programme, include metrics to measure the impact and share with colleagues in housing and transport Work with partners in housing and transport and share information on inequalities and explore options to improve access and accommodation that is adequate/appropriate. Work with health colleagues to improve access to services for rural and deprived communities and people from BAME, farming and traveller communities HEAT tool to be developed and used to support the delivery of changes to be made

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

7. Planning assumptions

- Reduced waiting times for assessment and diagnosis, reduced waiting lists, people have an advanced care plan increases, early intervention for people diagnosed with dementia or that have MCI, reduced staff caseloads, sickness and retention of staff is stable - investment and funding are made available – development of a standalone MAMs services and community assets to support people waiting a diagnosis.
- Increased staffing levels for dedicated resource for dementia assessments, will need to work with other services on current staffing needs and resources available.
- Demands of older people mental health and dementia services continues to rise year on year in-line with known predictive demographics of Lincolnshire as an aging county and this will require additional capacity requirements through investment. Will need to work with public health partners to address wider health needs and prevention strategies to reduce the need for services and promote better self-care.
- Staff will have the competency to support people living with dementia -education and training for staff to support them to feel valued and confident in their roles, work with colleagues in the system to share skills and knowledge across partners and develop a resource for workforce competencies and education/training plan, have dementia ambassadors available across the county, fulfil recruitment intentions. This is a particular challenge in certain types of registered professions, but also in certain parts of the county (East Coast) where recruitment can be more challenging.
- Recruitment of staff in LPFT, and recruitment and retention in the care sector, skills to manage complex dementia.
- Use of digital will continue to be a focus in terms of both productivity but also as a mechanism to support recruitment and retention.
- People living in care homes having a diagnosis and have support available that meets their needs, support primary care to case find and identify capacity in PCNs to diagnose advanced dementia in the community via Diadem.
- National or local direction of travel may change greater understanding of local needs or future health or social infrastructure changes to be able to future forecast and plan services/finances, work to continue with colleagues in health inequalities and PHM team to develop the logic model and identify the priorities for the dementia programme and develop and dashboard for measuring this.

8. Stakeholders

Initiative	Stakeholders	Key People (more to be confirmed)
Dementia Strategy	LCC Public health, PCNS, VCSE, HI/PHM teams, District Councils, DAAs/DFCs, People with lived experience	Gina Thompson, Ramesh Prema, ICB Colleagues Members of the Dementia Board
Prevention agenda	LCC Public health, PCNS, VCSE, HI/PHM teams, District Councils, members of the public	Andy Fox, Paul Johnson
DDR Target	Public, LPFT, PCNs	Dr Collins Esiwe, Dr Neal Parkes
Reduction in prescribing Antipsychotic Medication	LPFT, PCNs,	Dr Collins Esiwe, Dr Neal Parkes Vlad Cucuiu, Kiran Hewitt
Memory Assessment Service	ICB, LPFT, PCNs, People with lived experience	Paula Jelly, Dr Collins Esiwe, Jackie Tyson
Dementia (Memory) Support Service	People with lived experience, LCC, LPFT, ICB, VSCE, District Councils	Paula Jelly, Jackie Tyson, Vicky Lee, Karen King
Complex Dementia – managing challenging behaviour (all settings)	ICB, LCC, ULHT, LCHS, VCSE	Dr Collins Esiwe
Palliative and End of life Care (PEOL)	ICB, LCC, ULHT, LCHS, VCSE, St Barnabas	Katie Faherty, Kerry Bareham, Tom Rose, Palliative delivery programme members

Project team

- Paula Jelly, Dr Collins Esiwe, Gina Thompson, Members of the Core team Dementia Programme Team and the Dementia Programme Board members

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

1. Future state

NHS Planning Guidance for 2023/24 sets out that further progress should be made in delivering on the NHS Long Term Plan key ambitions. This Programme Delivery Plan will align against the published priorities of the NHS Lincolnshire Joint Forward Plan 2023-28, in addition to more targeted documents such as the Model Service Specification for the Transforming Care Programme and 'Building the Right Support' and the National Service Model for Transforming Care.

Note: Learning Disabilities and Autism (LDA) are not set out in the Health and Wellbeing Strategy and Better Lives Lincolnshire Plan as a priority, however the LDA Programme will aim to link into these documents when appropriate, specifically around health inequalities. For example, the Autumn / Winter Vaccinations for People with a Learning Disability work recently produced.

The MHDLDA Alliance Vision states: 'Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities'.

The overarching aim and benefit of the LDA programme of the Lincolnshire System is;

Currently when individuals need placing in specialist hospital provision, there is an increased reliance out of area service delivery. In the future individuals with LDA service needs will be able to remain closer to home and networks, whilst accessing the right support locally. The Lincolnshire system are developing local services with a view to specialist support and delivery models and reducing the reliance on inpatient care out of county. This will help to ensure that the Lincolnshire system meets the national agenda in individuals accessing care and treatment closer to home whilst reducing the rate per m in hospital provision. This leads to person centred quality support and improved patient experience whilst meeting the national targets.

Current State - Future State – Work – Outcomes - Value

We will:

- Work so that individuals with a learning disability and/or autistic people will be able to remain closer to home and networks, whilst accessing the right support locally and in the community.
- Develop services with a view to deliver localised specialist support and reduce the reliance on inpatient care and out of county services, in line with NHSE targets of rate per million.
- Improve quantity and quality of LD Annual Health Checks to improve health outcomes.
- Develop access services for people with a Learning Disability and Neurodiverse people so that services can be accessed more easily, and their health life expectancy increases in line with the general population.
- Work so that the population can access services (physical and mental health) more easily and that their healthy life expectancy increases in-line with the general population.
- Work for a reduction in health inequalities will be supported with more LDA friendly GP practices being accredited.
- Ensure neurodiverse individuals will be supported to live well and independently where possible, but when they do require specialist mental health services, the services will be accessible and tailored to the needs of these individuals.
- Work so that people receive timely access to service (i.e., maximum 12 week wait for initial appointment) and early diagnosis across all ages.

Scope

In scope – LDA programmes of work for adults and CYP
Out of scope – Mental Health (except those with Mental Health and LDA)

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

2. What's being done to get there | Overview

MHLDA Planning

- All services have been asked to complete a planning template which details their plans for 2024/25. These update and build on the same exercise which was completed during the 2023/24 planning round, as we move towards a continual cycle of operational and strategic planning development and iteration.
- The planning templates ask services to consider their existing position and future needs in terms of performance, quality, workforce, demand, estates, digital/informatics, inequalities, finance, national drivers (i.e., policy, legislative and guidance changes), strategic alignment and impact on the wider system. This supports services to identify plans and 'gaps' needed to improve areas of existing deficit. Where services are requesting additional resourcing or investment, a second stage of planning development will take place throughout October 2023 to develop cases for change. Finally, all cases for change will be subjected to a scoring prioritisation framework to 'order' in priority any cases for change which are developed so that any future investment availability can be directed accordingly to developments in a prioritised fashion.
- Alongside this, Senior Operational Managers in LPFT have developed a list of 20+ ambitions to achieve in 5 years' time. Whilst this list is subject to further development and iteration, the long-term vision is for Learning Disability and neurodiversity service planning to be integral to system development.

Learning Disability Review:

There was an overall Learning Disability review in 2021/22 and 2022/23. The specialist Learning Disability services within LPFT are currently undergoing a service transformation review which is in 2 phases:

- Urgent care support for LDA.
- Community.

LPFT Staff Engagement

Ongoing engagement with LPFT staff across all service areas to identify gaps and opportunities in ensuring that service users with Learning Disabilities and Neurodivergent individuals receive equitable services. A case for change is being created in September 2023 and this will identify a number of improvement projects across all services. These will include:

- A case for change is in development for the Learning Disability physical health liaison pathway.
- A case for change is in development reviewing lead commissioner responsibilities to maximise existing resources.
- A case for change is currently under review for the NHSE Capital bid for LDA which commenced in August 2023. A decision will be made week commencing 25th September 2023 as to the preferred option which will lead to a business case with a view to work commencing in 2024/25.

Accommodation Strategy

A short-term plan and accommodation strategy is being developed in September 2023 to inform accommodation requirements for the LDA programme. This includes wider creative market engagement which will lead to several procurements with the market for 2024/25 to give a planned approach.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

2. What's being done to get there | Overview

LDA Roadmap

The 3-year roadmap for LDA identified several schemes which are now business as usual for the integrated care system and include:

- Purple light Epilepsy toolkit benchmarking and case for change for the specialist LDA Epilepsy pathway.
- Lincolnshire LeDeR programme including quarterly system wide webinars.
- Section 17 pilot as part of the accommodation strategy will inform future commissioning intentions and market development.
- Development of all age community support for Lincolnshire Autistic Community and family/carers.
- Sensory Environment work within the wards.
- CYP key workers.

Dynamic Support Register

Learning taken from the Dynamic Support Register (DSR) which informs all age admission avoidance where clinically appropriate to do so and continual review of the DSR and system wide process.

Neurodivergent Pathways:

As part of the LDA service review, there is a focus on neurodivergent pathways, which for ADHD and Tic's Tourette's are supported in the independent sector via the out of area treatments panel (OATs).

Currently Tics Tourette's and Functional Neurological Disorder (FND) and Acquired Brain Injury (ABI) pathways remain as OATs with services commissioned on a spot purchase basis. During 2024/25 evaluation of both the CYP and Adult OATs panels will determine whether this meets the needs of Lincolnshire citizens or whether cases for change are required.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

3. What's being done to get there | Detail

The LDA programme is working on several schemes and projects to support the overarching vision described above and to align with the NHS Lincolnshire Joint Forward Plan priorities. These schemes and projects are detailed below:

LPFT LDA Service Review. JFP Priorities 2/3/4 – Living Well and Staying Well, Improving Access, Integrated Community Care

- LPFT are carrying out a service transformation review in 2 phases. Many of the schemes and projects detailed in this section have / will come out of this review. The review will identify gaps and opportunities within LDA pathways.
- Scope of the LDS75 agreement with LCC is well established and although it is mature and with LPFT services, the pathways may not necessarily be meeting the overall needs of our citizens who are accessing mainstream LD services. E.g., People with mild LD and those who are autistic or have neurodivergent needs.
- Although both cohorts of individuals are under the umbrella of the Transforming care programme, they have very different needs, and it is a likely mainstreaming within the ICS. Where the service is now in 2024 is very different to that in 2016.

Physical Health Liaison Pathway. JPF Priority 3 - Improving Access

- The focus of this scheme is to provide hospital and community staff with training on the support needs of patients with LD and to offer advice and support to individuals and their carers during their hospital admission.
- A business case was proposed in Q2, describing 4 options to meet and exceed the commissioned physical health liaison service specification standards. The recommended option is to expand the service to meet the commissioned service requirement as detailed in the LD service specification. This will lead to reduced (Inappropriate) demand on emergency departments and acute hospital admissions and a reduction in health inequalities for LDA citizens. It will increase the quality of annual health checks. There are interdependencies through the rollout of the Oliver McGowan Training.

Care and A happy Valued workforce.

- Work is ongoing between LICB and the Local Authority (Lincolnshire County Council (LCC)) to produce the Lead Commissioner policy for complex case, of which LDA is a part. Other parts include Responsible Commissioner and Section 117 Aftercare. This policy will then stipulate process for future commissioning and procurement of complex case.
- We are currently working on a Market Position Statement for the health packages within Lincolnshire, where we have seen an increase in growth over the past 5 years, both in terms of demand and supply being created against Lincolnshire system direction of travel.
- A case for Change is in development reviewing Lead Commissioner responsibilities to maximise existing resources in line with the review of LDA services currently being conducted by LPFT and LICB. Ongoing work to meet service demands ensuring that the staffing resource is used effectively whilst ensuring staff are developed, valued and retained. The workforce within lead commissioner is our internal workforce across key partners but it forms a valuable thread in each of the main workstreams.

Accommodation Strategy including a Capital Bid for new LDA Accommodation - JFP Priorities 1/3/4 – A new relationship with the public, Improving Access and Integrated Community Care

- The Accommodation Strategy is a joint strategy across all key partners in Lincolnshire reviewing the current supply and demand of care provision across all services in Lincolnshire to meet the current level of demand. This includes developing the market to meet LICB requirements in line with our overarching commissioning plans to meet both current and expected demand. It is ensuring the market are developing services in line with both the LICB and wider system requirements. From an LICB perspective, this is growing community provision to support LDA discharges from long stay hospitals and meeting the increasing number of community services to meet our statutory responsibility in providing s117 aftercare.
- A Capital Bid will be submitted to NHSE by June 2024 with a view to work commencing in 2025/26. The Capital Bid is to develop 4/5 units of accommodation for LDA clients based on several criteria within the capital bid process. A Case for Change is currently under review which is evaluating several options which include new-build developments and development of existing buildings across Lincolnshire. Following a decision being made in early 2024, a business case will then be produced in readying us for submission in June 2024. The Capital Bid is a system bid being produced with input from key partners including LCC and LPFT.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

3. What's being done to get there | Detail

SDF – LeDeR. -JFP Priority 2 - Living Well and Staying Well

- The Lincolnshire Learning from Lives and Deaths of people with a Learning Disability and/or Autistic People (LeDeR) programme has been actively improving since its origins in 2022/23. Governance Panels occur on a bi-monthly basis and there are multiple LeDeR Reviewers stationed around the system.
- Q2 saw the successful appointment of a LeDeR Band 4 dedicated administrator and there is work ongoing to increase the reviewer cohort by bringing in external reviewers on a bank basis as it is a priority area to have LeDeR reviewers approved. This is a focus area being driven by NHSE LDA Midlands. Further webinars to be introduced on a cost neutral basis.

SDF – Epilepsy LDA Pathway ICS. - JFP Priority 3 – Improving Access

- The Epilepsy Purple Light Toolkit was produced in the FY. In early Q3 a webinar was jointly hosted between LICB and SUDEP Action charity to increase awareness of epilepsy and LDA and future commissioning plans. From this webinar, workstreams to implement the SUDEP Action checklist into Annual Health Checks has commenced and My Life in Epilepsy.
- This is a prime example of co-produced commissioning which has been extended to the wider ICS, with an enhanced offer for Expert by Experience (EBE) and looking at the Epilepsy prevalence in Learning Disabilities.
- Implementation of Commissioning Guidance was launched 14/11/2023 and there is ongoing health inequalities work. Lincolnshire is a pilot site and developing further links to the health inequalities workstreams and all age pathways.

Expansion of DSR inc. Self-Assessment. JFP Priorities 2/3 – Living Well and Staying Well, Improving Access

- The Dynamic Support Register (DSR) is going through a review process to meet developing NHSE and local requirements, including work to identify and improve on the population who should be on the DSR but are not (Self-Assessment). All age and moving of 38-to-52-week school placements avoiding inappropriate hospital admissions.

ADHD Pathway LACE Project. JFP Priority 3 – Improving Access

- The Lincolnshire Clinical Academy of Excellence (LACE) are supporting LICB with the identification of a new ADHD Pathway for the system.
- Q1 and Q2 involved gathering of the reference group and stakeholder analysis. Surveys have been sent to patients to gather evidence and data and a workshop is planned for the end of Q3 to define the issues and concerns. Another workshop will take place in Q4 for best practice evidence and then 2 further workshops in Q4 for solution generation and strategy agreements.
- Report and recommendations will then be produced by LACE in Q1/Q2 of FY 2024/25, with implementation following from that.

Virtual Autism Hub. - JFP Priority 3 – Improving Access

- In the latter part of 2023/24 LPFT are mobilising the Lincolnshire Virtual Autism Hub. This initiative aims to reduce health and societal inequalities experienced by autistic people and their families/carers by providing easily accessible community support, signposting and a level of advocacy. The Hub will also represent the voices and views of an underheard community in Lincolnshire and ensure this cohort of the population are fairly represented. Providing employment opportunities within the hub which can have positive impact on individuals' mental health.
- 2024/25 will be the first full year of operation for this new service. It is expected that the service will require at least two years of operational experience to learn and iterate before a formal evaluation. A PDSA approach will be taken within the first two years.

CYP Autism Diagnostic Pathway. JFP Priority 3 – Improving Access

- Carry over to early Qtr. 1 2024/25, as consultation ongoing in Qtr. 3/4 of 23/24.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	No.	Project	FRP	2023/24				2024/25				2025/26				2026/27			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LD – LPFT	1	LPFT LDA service review	No																
LD – LPFT	2	Physical Health Liaison Pathway	No																
LD – LPFT/LICB	3	Lead Commissioner	No																
LD - LICB	4	Accommodation strategy	No																
LD – LICB	4a	Capital Bid - LDA accommodation	No																
LD – LICB	5	SDF – LeDeR	No																
LD – LICB	6	SDF – Epilepsy LDA pathway ICS	No																
LD - LPFT	7	Expansion of DSR	No																
LD - LICB	8	LACE project ADHD	No																
LD - LPFT	9	Virtual Autism Hub	No																
LD - LICB	10	CYP Autism Pathway	No																

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

4. Projected impact on patients and system partners

Initiative	Outputs and Outcomes	
	Patients & Population	System Partners
LPFT LDA Service review	Improved patient experience	Case for Change
LPFT Physical Health Liaison pathway	Improved patient experience and access to pathway.	Expanded workforce and mobilisation
Lead Commissioner	N/A	Clearer pathway of working. Supports market development
Accommodation Strategy market development & improvement	Review of existing provision. Increased capacity in the market and greater choice for personalisation.	Market stimulation and Case for Change for Capital Bid.
SDF - LeDeR	Review and implement learning.	N/A
Epilepsy LDA Pathway ICS	Development of pathway and mobilisation of such.	Epilepsy Toolkit webinars.
Expand DSR Inc. Self notification	Improved access.	Improved access for system partners to DSR.
LACE ADHD project	Improved pathway development and access to ADHD services.	Recommendations of pathway.
Virtual Autism Hub	Improved access and experience for autistic people.	Clearer direction for primary and secondary care to signpost people with autism to appropriate pathways.

ADHD Pathway has not been included. The reason for the non-inclusion is that the LACE ADHD project aim is to scope the appropriate pathway. Until outcomes from this project are known, the ADHD pathway initiative cannot be planned or started.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

5. What's needed to make this happen

Scheme	External contributors	Requirements from enablers	Other support requirements	Resource requirements
LPFT LDA Service Review	LPFT	Client engagement/Experts by Experience		Staffing input
Physical Health Liaison Pathway	LPFT / ULHT	Workforce		Additional funding – business case produced
Lead Commissioner	LCC / LPFT	Legal agreement	Training on workforce / Educating providers	Dependant on outcome – additional finance staffing of maybe up to 2 FTEs B4/5
Capital Bid for new LDA Accommodation	NHSE / LCC / LPFT	Additional joint funding	Support at Board meetings / Project support	Additional funding to support the project. Scheme circa £2m and additional staffing support of maybe 1-2 FTE on fixed term B7
Accommodation Strategy	LCC / Districts	Embed strategy through framework/procurement	Staffing	Staffing – Will need to see an increase in contracting/procurement of maybe 2-3 FTE B6/7
SDF - LeDeR				Reviewer staffing which may result in external staff being recruited.
SDF – Epilepsy LDA Pathway ICS	Primary Care / SUDEP Action		Primary Care Network liaison for checklist distribution	
Expansion of DSR	Community LDA			
LACE Project ADHD	Primary Care	Data gathering engagement		Extra staffing as required when pathway has been identified
CYP Autism Pathway	LPFT / Primary Care	To come from action plan in development	To come from action plan in development	To come from action plan in development
Virtual Autism Hub	LPFT / Primary Care			Dependant on PDSA process

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

6. What could make or break progress

Scheme	Interdependencies	Issues and Blockers	Challenges and Risks
LPFT LDA Service Review	LPFT		Lack of LDA in key policy priorities (H&WS / BLL Plan)
Physical Health Liaison Pathway	Adult LD Service	Lack of funding	Recruitment of staff / Significantly higher patient referral numbers / High number of inappropriate referrals
Lead Commissioner	LCC / LPFT		Lead Commissioner policy cannot be agreed upon
Capital Bid for new LDA Accommodation	LCC	LCC accommodation strategy	Case for Change not accepted
Accommodation Strategy	LCC	Provider market producing provision against requirements	Provider market continue to work in silo from recommended strategy
SDF - LeDeR	LPFT / ULHT	Reviewer capacity	Unable to recruit to key posts
SDF – Epilepsy LDA Pathway ICS	SUDEP Action	Primary Care understanding	
Expansion of DSR	LPFT	ICS Interoperability	
LACE Project ADHD	LACE / Chosen provider/pathway	Workforce capacity	Unable to find appropriate pathway
CYP Autism Pathway	LCC / LPFT		Increase in demand outweighs current pathway work
Virtual Autism Hub	LPFT		PDSA uncovers issues outside of scope to be changed

General risks across all schemes

- The ability to recruit staff due to a shortage in Lincolnshire across both health and social care in both the public and private sector. If recruitment is made in one area, it is often at the detriment of another area. Both LICB and LPFT have been carrying a number of vacancies for some time.
- Changing priorities at national level in what ICBs will be doing as key priorities and lack of funding may impact on all schemes. For example, letter PRN00942_Letter Addressing the Significant Financial challenges created by industrial action in 2023/24, and immediate actions to take, dated 08/11/2023.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

7. Planning assumptions

- Demand will continue to rise in all sectors (LD, Autism, Neurodiverse), with specific increases in neurodiverse demand, such as ADHD, Tics and Tourette's Syndrome. The impact of COVID-19 is being monitored and analysed as part of the overall growth in demand seen within the MHLDA service.
  - 9 months of 23/24 a 19.2% (81) increase in MHLDA patients that are supported in core services
  - 9 months of 23/24 a 23.9% (519) increase in ADHD patients that receive an ADHD service
  - 9 months of 23/24 a 16.2% (5) increase in Tics/Tourette patients that receive a service
  - 9 months of 23/24 a 25.4% (101) increase in s.117 aftercare patients that receive a service
- Funding will remain available through SDF and other schemes to improve output in LDA.
- Assumption that funding will remain constant with this financial year and will not reduce.
- The capital scheme is subject to LICB being successful in its application for funding with NHSE and the ability to access additional national funding schemes.
- Community-based provision will continue to be seen as the most appropriate service delivery model for those with a learning disability and/or autism. However, the cost of community provision in some cases is higher and that then results in schemes being taken to the investment panel for approval.
- National and local policy will continue and will include current themes regarding LDA.
- Workforce vacancies will get filled and workforce sickness will continue in line with local trends. However, internal LICB vacancies are governed by workforce panels on a post-by-post basis and the sustainability of workforce is measured in line with the overall ICS workforce strategy
- The ICS will continue in its current makeup (ICB/LPFT/ULHT etc) and will continue to work together in an aligned way to meet the overall ICS vision.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

8. Stakeholders

Scheme	Project Team	Lead Person	Stakeholders
LPFT LDA Service Review	LPFT	LD LPFT	LICB / LPFT / LDA population
Physical Health Liaison Pathway	LPFT	LD LPFT and LD ULHT	LICB / LPFT / ULHT / UEC / LD services
Lead Commissioner	LICB / LPFT / LCC	AD LD at LCC/ MHLDA Director LICB	LICB / LPFT / LCC
Capital Bid for new LDA Accommodation	LICB / LPFT / LCC	Pooled Fund Manager LICB & Property LCC	LICB / LPFT / LCC
Accommodation Strategy	LICB / LCC	LD LCC/MHLDA LICB	LICB / LCC
SDF - LeDeR	LICB	MHLDA LICB	LICB / LPFT / Primary Care / ULHT
SDF – Epilepsy LDA Pathway ICS	LICB	MHLDA LICB	LICB / Primary Care
Expansion of DSR	LPFT	LD LFPT/MHLDA LICB	LPFT / LICB
LACE Project ADHD	LICB	Chief Commissioning Manager LICB	LICB / Primary Care / ADHD Provider market
CYP Autism Pathway	LPFT/LCC	Autism Lead LPFT/Childrens Commissioning LCC	LPFT / LICB / Primary Care / Provider Market
Virtual Autism Hub	LPFT	Autism Lead LPFT	LPFT / Primary Care / Secondary Care / Autism Charities/Providers

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

1. Future state

There are 10 separate streams within our planning. We also expect to have an eleventh plan looking at an overhaul of the Lincolnshire Joint Formulary which underpins all of our work. This is currently being scoped.

Primary care cost efficiencies

- To improve the cost-effectiveness of primary care prescribing in Lincolnshire to the point where we can justify all of the variance in prescribing spend between Lincolnshire and the national average.
- Prescribing data shows that Lincolnshire spends more per weighted patient than other areas in our region and the national average. NHSE have challenged the high prescribing in Lincolnshire compared to national average. We know that Lincolnshire has a higher-than-average ageing population, some areas of high deprivation, high rates of smoking in some areas, high levels of obesity; all of which are determining factors to higher disease/long-term condition burden. This is demonstrated as Lincolnshire have high prevalence in 7 of the 8 QOF LTCs. Lincolnshire also has one of the highest numbers of dispensing practices in England, who's priorities may not align with ours due to their business needs, so can be more challenging to affect desired change.
- Understanding how that affects prescribing in Lincolnshire is important in understanding where savings to prescribing costs can be made without detrimental effect on our patient health outcomes or increased need for secondary care inpatient services. Through promotion of self-care and education encouraging patient access to community pharmacy, reducing requests for GP appointments. Freeing up NHS resources to deliver prevention agenda and promote access to the most appropriate clinical service. This programme looks at primary care prescribing in Lincolnshire ICB for both GP and non-GP prescribers.

Community Pharmacy Integration

- To integrate community pharmacy services with primary and secondary care after the Pharmacy, Optometry and Dental delegation into Integrated Care Boards to enable cross sector collaboration and better patient experience. The aims of Community Pharmacy Clinical Services are to 'optimise patient outcomes by delivering high-quality, evidence-based clinical services that are accessible, patient-centred, and cost-effective.
- These will be delivered by collaborating with healthcare professionals within primary and secondary care, organisations, and local communities. We are striving to enhance the role of community pharmacists in delivering holistic care, improving medication safety, promoting public health, and reducing health inequalities.
- The Community Pharmacy Integration plan has the dual objective of delivering medicines optimisation services to residents of Lincolnshire and provision of clinical pharmacy services to all 14 Primary Care Networks (PCN) in Lincolnshire.
- This will be achieved through embedding work with stakeholders in Primary Care, Secondary Care, Local Pharmaceutical Committee, and other relevant stakeholders within Lincolnshire ICS by delivering the services, pilots, and projects in the Pharmacy Integration Fund (PhIF).

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

1. Future state

MO Engagement within the system

- To have optimal visibility to the system and each individual sector, organisation and contractor as the leadership for medicines optimisation and pharmacy in Lincolnshire.
- To have excellent engagement with all Lincolnshire GP practices and to engage with them on a regular basis via multiple routes.
- To have raised the profile of medicines optimisation within the Lincolnshire system with all partners and stakeholders that have any link to prescribing so that medicines optimisation is considered whenever the Lincolnshire ICS plans actions that involve medicines, and the medicines optimisation teams are fully integrated into conversations and planning that is in any way linked to medicines and prescribing.
- To build on an emerging reputation across the system as the leading team and valuable service providing advice and support with all aspects on medicines and prescribing across the Lincolnshire system. This will build and cement new and effective relationships with our GP partners and support shared decision-making with our patients.
- To fully engage with PCNs and their pharmacy staff to align priorities and maximise the impact of this workforce in achieving medicines optimisation goals.
- To have an excellent level of engagement across the interface between primary and secondary care where medicines and prescribing happens to facilitate smooth patient transitions between care settings.
- To build and grow current engagement and integration with all pharmacy partners over the next few years to achieve seamless system working and work closely with emerging services e.g. IP pathfinder sites.
- To be able to link into patient groups as an integral part of planning and delivery of MO work. This should cover the whole of the Lincolnshire system for Medicines Optimisation, medicines and prescribing. This is an essential element to enable other MO workstreams.

Secondary Care Procurement

- Timely inputting of contract implementation – proactive. Review and choose the right contract at the right time. Manage to run stocks down in the run-up to contract change. Review of non-contracted items to ensure ongoing effective purchasing.
- Start doing off-contract claims (Commercial Medicines Unit, DHSC). Potential devolvement of specialised commissioning from NHS England's Specialised Pharmacy Service
- In scope: Across 3 main hospitals, 2 OPD dispensaries, Boole aseptics unit in Lincolnshire across thousands of drug lines.

Biosimilars

- To ensure that Lincolnshire ICS supports and implements safe and cost-effective use of biosimilars where they are recommended for treatment.
- For secondary care use and prescribing of biosimilar drugs a process is in place to support identification of new biosimilars, assure supply, assess, aspects of safety, resource required (across the system), training, SOPs, homecare arrangements etc and implement safe transition for patients (and clinicians) from originator products to biosimilar products in a timely way and in line with other ICSs.
- For primary care prescriber biosimilars, an agreed scoping and implementation process is adopted to assess clinical requirements, resource needs, product supply assurance and route of supply, assess aspects of safety, training (clinician and patient) setting for switch, follow up required and any other aspects needed to be taken into account for safe and effective transition from originator brand to biosimilar products in a timely way and in line with other ICSs.
- Implement switching of originator brands to biosimilars by drug as they become available.

Medicines Optimisation

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1. Future state

Antimicrobial Stewardship

- There is an antimicrobial strategy for Lincolnshire 23-25 . The aim is to create and maintain a unified approach and service standards across the patient facing stakeholders of AMS Lincolnshire. The measures of which will be employed across the interface and partnerships to improve patient outcomes.
- These are to:
  - Encourage prudent use of antimicrobials
  - Improve understanding of antimicrobial stewardship amongst healthcare professionals
  - Optimise infection management and control elements of good antimicrobial prescribing
  - Reduce spread of infection and incidence of HCAIs
  - Limit the development of resistant organisms
  - Limit the incidence of Gram Negative blood stream infections (GNBSIs)
  - In line with the Strategic Aims of Antimicrobial Prescribing and Medicines Optimisation (APMO): To improve patient outcomes, safely reduce human exposure to antimicrobials, reduce antimicrobial resistance and reduce environmental impact and waste. Through reducing demand, reducing exposure, and optimising infection management.
- Strategic Objective A: National directives to reduce inappropriate antimicrobial prescribing across Lincolnshire, require work towards targets:
  - Primary care:
    - Total number of antimicrobials per STAR-PU per year to be < 0.871
    - Broad-spectrum antimicrobials (co-amoxiclav, cephalosporins and fluoroquinolones) to make up < 10% of the total number of antibacterial items prescribed in primary care
    - National target – 75% or more of total amoxicillin prescriptions to be 5-day courses.
  - Secondary care
    - Achieving target of <40% patients receiving IV antimicrobials past the point at which they meet oral switch criteria. This target has already been reached. The aspiration now is to reduce further to <15% Annual consumption of Antimicrobials from the watch and reserve categories to reduce by 10% compared to a baseline year of 2017.
- Strategic Objective B: Surveillance and measuring:
  - To share antimicrobial prescribing data at least every 6 months, with healthcare staff and patient facing settings (primary and secondary care), in order to highlight prescribing habits and trends.
  - Data highlights to include antimicrobial consumption levels, as well as other national priorities such as antimicrobial management of UTI, IV to oral switch, length of antimicrobial courses, as well as position against national targets.
- Strategic Objective C: Facilitate and promote means of improving Antimicrobial Stewardship across Lincolnshire, through:
  - Correct application of diagnostics in infection management
  - Documentation of indication for antimicrobial prescriptions (Primary care SNOMED or read codes, Secondary care Electronic Prescribing and Medicines Administration or prescription charts)
  - Antimicrobial prescribing practices and Key Performance indicators
  - Timely and effective review of antimicrobial prescriptions, recurrent infections, and AMR risk
- Strategic Objective D: Awareness and utilisation across all stakeholders, of local and national antimicrobial stewardship tools/resources, highlighted, developed or procured via AMS Lincolnshire, to help achieve these objectives.

Medicines Optimisation

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1. Future state

Quality and Safety in medicines and prescribing

- A functional medicines safety network which will bring together Medication Safety leads from across the Lincolnshire System with the aim to improve medication safety, discuss local incidents and events, discuss system wide medication risks, share learning and good practice, work towards the National Patient Safety Strategy & the NHS Medication Safety Improvement Plan together providing support for each other.
- To provide a cross sector platform for ongoing improvement in medication safety, encouraging collaborative working to reduce harm to patients and service users. The network will influence the way Medication Safety incidents are managed with the new National Patient Safety Strategy. How they are reported on and how we can improve them in line with the Patient Safety Incident Response Framework (PSIRF).
- Have a rolling programme of quality & safety activities that promote the highest standards of medicines safety & quality prescribing, having identified issues relating to medicines safety that require action and have plans in place. A comprehensive process to monitor ICB controlled drug use to ensure they are being prescribed in line with safety guidance to minimise harm
- National Medicines Safety Priorities 2021-24 – Reduce severe, avoidable medication related harm by 50% by 2024 through: Optimise Leadership in Medicines Safety, Optimise Safer Systems, Safer use of High-risk Medicines. 'It is vitally important for NHS England and the wider health community to continue to learn the lessons from the Shipman Inquiry especially with its many parallels to the Francis Inquiry in terms of patient safety and ensuring local intelligence is used effectively to safeguard patients and the public.' (NHSE). More than 237 million medication errors are made every year which costs the NHS upwards of £98 million and more than 1700 lives lost. 38% of the errors are from Primary Care with 42% from Care Homes. Errors are made at every stage of the process: 54% being made at point of administration, 21% during prescribing & 16% from dispensing errors
- The most common medications causing hospital admissions were NSAIDs, anti-platelets, Diuretics, epilepsy medications, cardiac glycosides and beta blockers. 80% of the resulting deaths were caused by GI bleeds from NSAIDs, aspirin or warfarin. It is estimated that 66 million potentially clinically significant errors occur per year, 71.0% of these in primary care. This is where most medicines in the NHS are prescribed and dispensed. Prescribing in primary care accounts for 33.9% of all potentially clinically significant errors. Fulfilling our statutory responsibilities to improve safety for our population in line with our responsibilities as stated by NHS England's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England. NHS England » The NHS Patient Safety Strategy

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

1. Future state

Aseptic production

- For the purpose of this document, Aseptic Preparation is defined as reconstitution of an injectable medicine or any other aseptic manipulation when undertaken within aseptic facilities to product a labelled ready-to-administer (RtA) presentation of a medicine, in accordance with a prescription provided by a practitioner, for a specific patient. Typically, aseptic preparations are personalised or low volume products that large pharmaceutical companies would not be able to provide such as chemotherapy, monoclonal antibodies, injectable nutrition and clinical trials medicines.
- The Pharmacy Aseptic Services project described in this document aims to create a Lincolnshire Pharmacy Hub facility to prepare large scale injectable aseptic medicines in line with the recommendation on “Transforming NHS Pharmacy Aseptic Services in England” document. This will create a collaborative regional hub for aseptic services to have the ability to support spoke facilities across the region to ensure safe, high quality and resilient supplies by 2026/2027 in line with NHSE vision and recommendations.
- This will also free up significant nursing staff for care enabling and enable more care closer to home.
- Opportunity number 5 “Standardising Product Formulations of Aseptically Compounded Medicines” of the National Medicines Optimisation Opportunities 2023/2024 released recently by NHSE also request that NHS Trusts collaborate to develop regional aseptic hubs. The document states that systems should: 1. Prioritise purchase of licensed RtA products where available. 2. Maximise the use of nationally standardised aseptic products. 3. Increase batch production and ordering and reduce patient-specific production and ordering. 4. Collaborate to develop a strategy and business case(s) for the development of MHRA authorised regional aseptic hubs to produce aseptically compounded RtA injectable medicines, and for local hospital pharmacy aseptic units to maintain high quality services for ultra-short shelf-life products, clinical trials and complex innovative and bespoke treatments. Associated workforce plans will be required.
- Prioritise purchase of licensed RtA products where available. The department already purchases licensed RtA aseptic products where available at all times and will continue to do so. (out of scope)
- Maximise the use of nationally standardised aseptic products. The department also use nationally standardised aseptic products when possible. All the chemotherapy products are standard aseptic products and follow the national chemotherapy dose banding tables. (out of scope)
- Increase batch production and ordering and reduce patient-specific production and ordering. The department outsources aseptically prepared batch products when possible. The current pharmacy aseptic unit does not hold a MHRA licence and therefore cannot prepare batch products. (In scope).
- Collaborate to develop a strategy and business case(s) for the development of MHRA authorised regional aseptic hubs to produce aseptically compounded RtA injectable medicines, and for local hospital pharmacy aseptic units to maintain high quality services for ultra-short shelf-life products, clinical trials and complex innovative and bespoke treatments. Associated workforce plans will be required. ULHT in collaboration with the system, aims to develop a strategy and a business case for the development of a Lincolnshire MHRA aseptic hub as described in this document. (In scope).
- Scope: This document covers the preparation and supply of aseptic preparations only. Non-aseptic products are outside of the scope of this project. Currently, the ULHT Pharmacy Aseptic Unit only prepare and supply aseptic medicines to ULHT. However, the development of the Lincolnshire aseptic services hub aims to manufacture and supply aseptic medicines for the system and outside of Lincolnshire.

Medicines Optimisation

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1. Future state

Antidepressant reduction

- Addressing inappropriate antidepressant prescribing as per MOO - NHS England » National medicines optimisation opportunities 2023/24
- To continue efforts to deliver the objectives as defined by the Mental Health CRG (shared with the Opioid and polypharmacy CRGs) whilst under the directions of the SDP. Prescribing in line with NICE, system and MH Trust guidelines. Reduction/discontinuing long term unnecessary antidepressants.

Pharmacy Workforce

- The Integrated Pharmacy and Medicines Optimisation (IPMO) Programme is an NHSE/I mandated requirement for integrated care systems (ICS) and will define how the use of medicines will be used optimally to deliver best outcomes for patients, in a number of priority therapeutics areas.
- This structural evolution brings significant changes within the world of pharmacy and for pharmacy healthcare professionals, both great opportunities and challenges. Therefore, it is imperative that Lincolnshire has a pharmacy workforce that is competent, skilled, adaptive, able and inclusive to deliver the best quality patient care it can.
- The Pharmacy Workforce Programme is aims to meet the workforce challenges that the changing pharmacy landscape presents, as well as increasing recruitment and retention into Pharmacy roles across Lincolnshire
- The national programme is in response to the needs of the population and being able to deliver effective, high-quality services in a cost-effective way. At a local level, Lincolnshire has difficulties recruiting and retaining Pharmacy staff due to a number of factors such as: attracting new people to Lincolnshire as a coastal and rural region, career development and progression, lifestyle and diversity of roles. The Pharmacy faculty is producing a plan to help address these barriers.
- In scope: All Pharmacy workforce transformation; Out of Scope: Medicines Optimisation.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

2. What's being done to get there | Overview

Primary care cost efficiencies

- We are planning several workstreams to establish what our variation in prescribing is. We will analyse the data to understand how much is driven by volume of prescribing and how much is cost/price driven.
- We then plan to link to other data sets through PHM to understand how much of our prescribing variance can be explained through population, prevalence and outcome data; how much is driven by the national prevention directives. Compiling a case for warranted variation.
- We are also investigating where cost is the driver and what actions can be taken to change prescribing behaviours to mitigate cost-driven prescribing variation. Prioritising areas to tackle with tailored plans over the coming years.
- Additionally ensuring the ICB has assessed and signed up to industry-offered rebates where they fulfil the terms of our policy, continued use of Optimise Rx messages to influence prescribing at the point of initiation and review to generate new prescribing savings, understanding when patents expire on drugs that are widely used in Lincolnshire to ensure we optimise the use of generic prescribing where clinically appropriate.

Community Pharmacy Integration

- The Community Pharmacy Programme plans to integrate Community Pharmacy Services into the NHS Lincolnshire ICB through the delivery of the clinical services including, Discharge Medicine Service, Community Pharmacy oral contraception Pilot, Community Pharmacy oral contraception advanced Tier 1 service- Ongoing supply, Community Pharmacy oral contraception Tier 2 pilot- Initiation of oral contraception, Community Pharmacy Consultation skills (CPCS), NHS Community Pharmacy Blood Pressure Check Service (formally known as Hypertension Case finding Service), Smoking Cessation Advanced service, Community Pharmacy- Independent Prescribing Pathfinder program, Palliative care drug stockist scheme, Community Pharmacy Extended Care Service.
- The role of the Community Pharmacy Clinical Lead (CPCL) post was implemented to establish community pharmacies as integral healthcare providers, driving the transformation of primary care services. The CPCL role involves the implementation, assurance, and clinical governance of community pharmacy clinical services across Lincolnshire ICS. The CPCL role is funded until 31/03/2024 and business case is needed to make this role substantive to continue implementation of the Primary access and recovery plans, NHS community Independent Prescribing pathfinder program and ensure improved outcomes and delivery of the Pharmacy First service.

MO Engagement within the system

- The MO Team have been building relationships with GP practices since the pandemic. We now need to build on this and learn what works and what doesn't work as well. Engagement and working relationships across the primary/secondary care interface are growing and this will be one of the benefits of establishing IPMO and APC transformation.
- Continued work to raise awareness of MO within ICB Teams so that service/pathway development, contracting and other work takes account of medicines optimisation and includes resource from the MO Team wherever decisions are made concerning medicines and prescribing.
- Get involved in existing patient forum groups to encourage 2-way engagement on MO issues.

Medicines Optimisation

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2. What's being done to get there | Overview

Secondary Care Procurement

- Lenalidomide: This was a complex change due to the pregnancy prevention aspect that required setting all Pharmacies and consultants up on the Pathfinder system. Now complete.
- Deferasirox – Switch has been implemented
- Etanercept – Legacy usage of originator brand – patients who were not appropriate or switched back due to clinical reasons
- Pemetrexed – Planned
- Bortezomib – Planned
- Lanreotide – Planned
- Thalidomide – Planned
- Tacrolimus – Planned
- Botulinum Toxin – buying a mix of products based on clinician direction (not in scope for this workstream)
- Infliximab - Legacy usage of originator brand – patients who were not appropriate or switched back due to clinical reasons.
- Human Immunoglobulin - buying a mix of products based on clinician direction (very influenced by national supplies and allocations). Other lines where savings could be achieved by changing purchasing patterns. Summary of work – overview of the approach, plans or strategies that are/will be delivering this change.

Biosimilars

- Development of a biosimilar switch policy/protocol for ULHT to initiate and implement safe use of biosimilars (stronger governance).
- Identify and highlight what resource is needed to support and implement work as per this policy.
- Ongoing and support appropriate use of biosimilars in the clinical setting – (this has been initiated but more work needed
- Benchmarking Lincolnshire with other ICBs to understand where there is variance in biosimilar uptake and investigate the reasons for this. NHSE are directing the optimisation of biosimilar uptake work through their national MO priorities list.
- Current insulin biosimilar work being scoped and will link with the newly formed system diabetes CRG. Keep track of our out of area providers intentions and implementation.

Antimicrobial Stewardship

- Strategic objectives are supported by 4 strategic objectives including work on Antimicrobial Prescribing Guidelines, audit, monitoring, reporting and benchmarking, education, training and development, system wide engagement with antimicrobial stewardship initiatives and campaigns, engaging with partner organisations to develop collaborative approaches.

Medicines Optimisation

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2. What's being done to get there | Overview

Quality and Safety in medicines and prescribing

- *Medicines Safety:* We are setting up a medicine's safety network encompassing all partners – this group will dictate the future strategy and plan. Working towards recruiting a primary care quality and safety pharmacy lead post. Reviewing medicines related data entries on Datix, monitoring type of incidents and creating learning from incidents. Liaison with NHSE POD Team around drug incidents reported by community pharmacies.
- *Controlled Drugs:* Strengthen Local Intelligence Network around the management and use of controlled drugs in Lincolnshire. Engaging as a healthcare commissioner and member organisation to ensure that arrangements to provide services that involve, or may involve, the management or use of controlled drugs by relevant individuals or designated bodies comply with the regulations. Engaging as a healthcare commissioner and member organisation to ensure all reasonable steps are taken to improve patient and public safety with regards to the safe and secure handling, management and use of controlled drugs.
- *Opioids:* The mission is to provide education and support for all those living with persistent pain in Lincolnshire, whilst promoting safe and rationale prescribing and deprescribing of opioid medication in line with the National Medication Safety Improvement Plan.
- *Valproate – Safe Prescribing:* New guidelines for prescribing of valproates coming into effect January 2024, cross system working required to implement the changes and develop local guidance to ensure the safe prescribing of valproates for women of child-bearing potential and men under 65 years old.

Aseptic production

- The build of a pharmacy aseptic unit in January 2023 in partnership with LSIP (Phase 1), with close proximity to the University of Lincoln School of Pharmacy and the University's own partnership with ULHT, has been identified as an exemplar of collaborative aseptic delivery. A case study has been published by NHSE and the project team.
- This project aims to develop a business case for Phase 2, in which the service aims to develop a pharmacy aseptic hub to supply aseptic medicines beyond ULHT into the wider ICS and region, contributing to the NHS England's Infusions and Special Medicines Programme aspirations of a hub and spoke mode. Phase 2 provides the opportunity to expand to an income generation model thereby facilitating a commercial opportunity through collaborative working. This shall ensure future demand for aseptic products can be met and provide opportunities for patients to receive care closer to home.
- Final plans for the hub will be based on the business case development but will include: Batch production of aseptic products to supply outside of ULHT, Scope for chemotherapy, antibiotics (CIVAs) and Advanced Therapeutically Medicinal Products (ATMPs). The phase 2 project is currently in the scoping and planning phase. A Phase 2 Steering Group has been established to investigate the opportunities that NHSE investment in Lincolnshire would bring.

Antidepressant reduction

- Ensure new prescriptions in line with good practise standards and system guidelines.
- Provide education and training opportunities to upskill prescribers in treatment of depression.
- Identify patients in primary care for reduction, stopping if long term and ineffective.
- Discussion as to how the previous work carried out within the CRG under the SDP will be continued.

Medicines Optimisation

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2. What's being done to get there | Overview

Pharmacy Workforce

- A pharmacy faculty group has been meeting for 12 months with project management since February 2023. The Pharmacy Faculty has achieved the following: Clarity of purpose and plan for the group. Successful engagement with senior people in key organisations from across Lincolnshire and the region including Health & Social Care providers, NHSE, Education Institutes, ICB. Regular reporting now in place from all key partners that has enabled a strategic understanding of the challenges, opportunities, risks and issues.
- Pharmacy workforce numbers are being flowed to the ICB, and this process is being strengthened to ensure accuracy and efficiency. Following a Faculty away day in September 2023, a number of workstreams and milestones have been identified with a strategy and plan being produced.
- The areas of focus through the workstreams are: Marketing and Attraction, Recruitment, Training and Placements, Career Mapping. The evidence-base for prioritising the above work streams is the faculty dashboard that has been in place since May 2023, capturing provider activity, risks, challenges and local improvement programmes. The priorities have evolved from the ongoing challenges that were discussed at the Faculty Away Day. In this instance issues have been identified in a risk register, mitigations of which have informed our Workforce plan.

Medicines Optimisation

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3. What's being done to get there | Detail

Primary care cost efficiencies

- *Prescribing Data Deep Dive:* continue and complete this work that investigates where variation in prescribing is cost-driven. Working group from MO Team to risk-assess the findings and RAG rate them for priority. Plans to be developed for individual areas of prioritised prescribing, working with system partners and stakeholders. Plans will include foundation/infrastructure actions (understanding pathway and source of initiation, making formulary changes, reviewing and updating local guidance)
- *Enhanced Scheme for primary care prescribers:* Compiling a list of all the switches we are aware of that may reduce prescribing spend. Asking practices who sign up to our planned Enhanced Scheme to choose a percentage of these switches to make to achieve a percentage of the total potential opportunity. Year 1 = 24/25 to replace part-year prescribing incentive scheme (23/24) The scheme will have engagement and quality elements in additional to cost-savings elements. (links to Engagement Plan and Quality and Safety Plan) (branded generic prescribing is not condoned at a national level as it adversely affect generic drug tariff prices)
- *Rebates:* Research available rebates for 24/25, review against policy and sign up for those that meet criteria. Monitor and claim rebates at the end of each quarter.
- *Patent expiries:* track drug patent expiries. Develop an action plan review dependant on the drug - make any changes to formulary, local guidance etc. through APC/PACEF identify additional opportunity made through switching brand to generic prescribing, promote this generic prescribing with GP practice prescribers.
- *Optimise Rx:* Continue to use and promote Optimise Rx with primary care prescribers. This may be part of the planned Enhance Scheme. Identify non-GP practice prescribing centres and implement use of Optimise Rx for these centres where appropriate (needs digital clinical system in place). BAU work rolling to review messages and adapt to local use, stand down messages to avoid message fatigue, re-introduce and develop new messages to support other areas of the MO primary care workplan.
- *Stoma review scheme:* Continue with current offer in 24/25, promoting this service with GP practices through engagement activities. Also in 24/25, scope to upgrade this service to offer annual review for every stoma patient being managed in primary care. Implementation timetable dependant on scoping and planning exercise.
- *ONS:* Build on scoping exercise due to complete in 23/24. Develop plan to source dietitian resource to review patients on ONS in care homes, primary care after discharge from hospital on ONS and if successful, roll out to the general patient population on ONS. Also link to ONS use in LPFT. 25/26 planning to scope gastrointestinal projects.
- *OTC/Self care:* Scoping in the remainder of 23/24. This is a large transformational piece of work planned for the next 4-5 years. Previous work in this area has not always been sustained and COVID and the recent cost-of-living issues have caused progress to reverse. 24/25 plans to assess this in 'topics' and select a fixed number of topics to concentrate on each year. There are foundation actions and enablers to put in place including a comms campaign for both prescribers and patients. A restrictive formulary for all self-care items so that necessary prescribing of these areas is most cost-effective products only. Plan for each topic individually with support from MO team, resources, monitoring and may be included in planned Enhanced Scheme

Medicines Optimisation

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3. What's being done to get there | Detail

Community Pharmacy Integration

- *Discharge Medicines Service (DMS):* The NHS Discharge Medicines Service aims to integrate care between secondary care and community pharmacy and enhance relationships between general practice and community pharmacy. DMS links to 2 of the 5 systems priorities - Living well and Staying well and Improving Access as it optimises the use of medicines while facilitating shared decision making and reduce harm from medicines over transfers of care. The NHS Discharge Medicines Service became a new Essential service within the Community Pharmacy Contractual Framework (CPCF) on 15th February 2021. As an essential service, all community pharmacy contractors in Lincolnshire ICS must provide the service. Within the LICS, the Lincolnshire Partnership Foundation Trust (LPFT) is currently the only trust referring into DMS. Lincolnshire Community Hospital trust (LCHS) has begun a pilot referring into DMS and the acute trust, that should roll-out over time. United Lincolnshire Hospital Trust is yet to implement the digital tools needed to allow DMS referrals into community pharmacies. IPMO needs to address the barriers to DMS at ULHT, that include radical change to current service and significant investment to implement the changes needed to support DMS implementation. The CPCL is currently working with ULHT and the digital team to facilitate implementation of DMS and escalating the risks in appropriate risk registers within ICB and ULHT.
- *Community Pharmacy Contraception Service:* Following the 2021 NHS England a pilot involving pharmacies offering repeat supplies of oral contraception to people who had previously had the medicine prescribed, where 16 community pharmacies located within Lincolnshire signed up. Building on this, from April 2023, community pharmacy started to manage oral contraception for women through the NHS Pharmacy Contraception Advanced Service Tier 1 - ongoing supply of oral contraception and the NHS Pharmacy Contraception Advanced Service Tier 2 - initiation of oral contraception (PILOT). The CPCL and LPC are working with relevant stakeholders such as GPs, Pharmacy contractors and universities increasing engagement around the service using Comms such as posters to encourage more uptake of this Tier 1 service. Additionally, work has being done to increase more Tier 1 community pharmacies sign up to deliver Tier 2 initiation of oral contraception as the service progresses from pilot phase to an advanced service. From 1st December this service will transition into the Pharmacy Contraception Service (advanced service). From this date the service incorporates initiation and repeat supplies of oral contraception. The NHS pharmacy contraception service forms an integral part of improving access, a fundamental part of Lincolnshire system priorities. Any pharmacy registering to provide the service from that date onwards must provide the full service, i.e. both initiation and repeat supplies. As part of service changes within the community pharmacy contractual negotiations, a 'bundling approach' is being phased in, and by March 2025 it is anticipated that most pharmacies will be providing this advanced service.
- *Community Pharmacy Consultation skills (CPCS):* Originally launched 29th October 2019, the NHS Community Pharmacist Consultation Service enables general practices to refer patients for a minor illness consultation via CPCS. The service connects patients who have a minor illness or need an urgent supply of medicine with a community pharmacy. CPCS is a key part of the Lincolnshire system priority improving access by integrating community pharmacy into the wider self-care agenda (interdependent with Primary Care Prescribing Cost Efficiencies) and improving relationships between community pharmacy and general practice. Work is currently being done through the CPCL, ICB staff working with relevant stakeholders such as LPC and LMC to improve relationships between practices and general practice. The target is to increase GP CPCS to an average of 500 a month from 40 practices from the current level of 384 consultations from 26 practices. In addition, working with ICB digital teams to fix streamer tool and start referrals from all UECs in Lincs to CPCS. From 31st January 2024 (subject to IT systems being in place, CPCS will be integrated into the new Pharmacy First advanced service.
- *Pharmacy First:* The three elements to the Pharmacy First service, which is expected to launch 31st January 2024 *(subject to appropriate digital systems being in place to launch the service). The Pharmacy First service in its entirety forms an integral part of system priorities Improving access and living well and staying well.

Medicines Optimisation

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3. What's being done to get there | Detail

Community Pharmacy Integration (cont.)

- *Blood pressure Check service:* The NHS Community Pharmacy Blood Pressure Check Service supports risk identification and prevention of cardiovascular disease (CVD). Lincolnshire ICB is working to expand the BP check service, through utilisation of PCARP funding to support contractors who have signed up but not delivering the service to address any concerns/barriers. The CPCL and LPC are working with to work with contractors with low BP check figures to increase output. CPCL will work with 4 identified pathfinder sites to expand BP check service as all pathfinder sites will be providing CVD prevention model, which links in with the BP check service. Finally, we aim to expand BP check service innovatively by cross sector working with other HCP such as Optometrists who can refer patients with HTN changes in the eye to community pharmacy BP check service
- *NHS community pharmacy smoking cessation service:* The NHS Long Term Plan focuses on the importance of preventing avoidable illness and more active management of the health of the population. It suggests that, as smoking cessation is specifically identified as a key service that can improve the prevention of avoidable illness, existing services can be expanded to further support patients who are looking to quit smoking, as well as those affected by second-hand smoke. The NHS community pharmacy service links into system priority, living well and staying well, in addition it links in system ambition of reducing harm in patients and reduction in smoking in pregnancy if household members of an expectant mother takes up the service. This programme is working with tobacco dependency group within the ICB, acute and mental health sector to achieve a referral route for smoking cessation referrals from hospitals and other secondary care settings into community pharmacy, improving integration of community pharmacy and providing patients with better health outcomes closer to home.
- *NHS Community Pharmacy Independent Prescribing Pathfinder Programme:* NHS England is developing a programme of pilot sites, across integrated care systems enabling a community pharmacist prescriber to support primary care clinical services. The Community Pharmacy independent prescribing pathfinder programme forms an integral part of Improving access and Integrated Community care which are fundamental parts of system priority. In addition, the Cardiovascular Disease (CVD) prevention model aligns with system ambition of CVD prevention in relation to lipid management.. 1. Minor illnesses associated with acute Ear, Nose and Throat conditions - The LICB intend to utilise the skills of community pharmacist IPs working in collaboration with local general practices to address urgent patient need for help, advice and possible intervention relating to acute ENT conditions. 2. Cardiovascular disease (CVD) prevention- identifying more people with undetected risk factors of CVD such as high blood pressure, raised cholesterol and atrial fibrillation. This clinical model aims to prescribe statins for patients with raised cholesterol, identify any undiagnosed hypertension utilising existing BP check service and identify patients with undiagnosed irregular heart rates/rhythms. 3. Acute Conditions (CPCS+) - Utilise pharmacist IP qualification to clinically assess, diagnose and prescribe for minor illness conditions such as skin conditions.
- *Palliative Care Drugs Stockist Scheme:* We are working to ensure there continues to be a good geographical coverage of this service, which provides increased access to palliative care medicines through a network of community pharmacies who keep an agreed list of drugs in stock. We currently have 20 pharmacies signed up to the scheme. The palliative care drug stockist scheme forms an integral part of integrated community care- one of the 5 JFP priorities
- *Community Pharmacy Extended Care Service: The* service aims to provide patients access to self-care advice and treatment of a range of conditions, and, where appropriate, can be supplied with antibiotics or other prescription-only medicines (POMs) to treat their condition. A working group is addressing gaps in the provision of extended care services, its effect on the 'Pharmaceutical need assessment' and if any similar services can be commissioned.
- *Primary Care Access and Recovery Plans (PCARP):* The delivery plan for recovering access to primary care was launched in May 2023, which forms an integral part of the Improving access system priority. Many of the above schemes feed into this e.g.:1. Launch of Common condition service (CCS) otherwise referred to as Pharmacy First. 2. Expand pharmacy oral contraception (OC) advanced service and Blood Pressure (BP) check services. 3.Utilise existing community Pharmacy services- GP CPCS and Midlands Extended Care Service. 4.Improve digital connectivity between pharmacies and practices. NHS England is currently working to provide interoperable digital solutions to improve digital connectivity between pharmacies and general practice. This will improve safety and quality and unable to determine specific financial savings.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

3. What's being done to get there | Detail

MO Engagement within the system

- APC transformation and establishment as part of the medicines governance framework. Provision of focused medicines optimisation meetings for individual practices to talk about medicines optimisation and how our team might support them with their priorities in this area, sharing information, resources and data, listening to issues and providing advice on specific medicines and prescribing issues.
- Establishing an annual or biannual visit pattern offer to improve contact and dialogue. Support GP practice engagement in a variety of ways through a planned enhanced scheme. Engage more regularly with our GP Clinical Leads, Medical Directors, Deputy Medical Directors, sharing our MO strategy and plans and welcoming their input and advice on engagement with GP practices in their localities.
- Continuation and development of Prescribing Forum meetings for primary care prescribers and primary care practice and PCN pharmacy staff, with renumeration.
- Continuation and development of support for prescribing queries from healthcare professional in Lincolnshire through MO inbox.
- Review of some other engagement and communication activities e.g. medicines optimisation newsletter. Initiate an escalation process where practices are very resistant to MO engagement. The initial stages will be internal within the MO Team but will allow information on non-engagement to be shared with the ICB where there are specific identified examples and issues. Work on engagement with other ICBs has commenced but will be built on. MO team members allocated to support pathway design, contracting and any development work that involves medicines and prescribing. Work on engagement through interface between primary and secondary care through further development of IPMO group and increased transparency that comes with working closer together. Exploring best options for patient engagement to ensure regular involvement of patients with medicines optimisation decision-making.

Secondary Care Procurement

- For each drug individually, understand where there are the most potential savings – Exend+ system. Work through understanding what needs to be done to put the change in place (e.g. injectable chemo is complex due to stability and worksheet changes, tacrolimus as brand specific, inhalers as branded needing formulary changes and local adoptions to support new prescribing).

Biosimilars

- Current policy/protocol development for biosimilar implementation at ULHT has been written and had first round of internal feedback– expected ratification in April 2024. Resource plan/business case to support resource needed for biosimilar implementation
- Identifying biologic patent expiry and biosimilar expected launch dates through SPS – horizon scanning. For each individual drug - Identify expected access, available drug levels and required actions to secure local supply (sometimes this information comes in with little notice and NHSE allocations – may be resource dependant). Implement the expected biosimilar implementation policy/protocol. Expected Future biosimilar drugs – Ustekinumab (2024/25), Tocilizumab (2024/25), Aflibercept (2025/26), Vedolizumab (2026 anticipated).

Medicines Optimisation

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3. What's being done to get there | Detail

Antimicrobial Stewardship

- Strategic Objective A: ONGOING timeline
  - **Primary care** - Data being shared 3 monthly with GP practices, highlighting trends and engaging prescribers. Positive results being noted in practices being visited. - Training and newsletters facilitating with insight to evidence base, tools/resources available and progress. Guidelines reviewed to reflect evidence base and local microbiology trends to support his. Optimise Rx and formulary updated in accordance with guidelines. Microguide navigation edited to make it more user friendly. Looking into development of clinical decision tools for primary care. e.g. Helicobacter pylori as complex decision-making and exploring other useful indications/initiatives that could be supported with clinical decision tools on Microguide.
  - **Secondary care** - IVOS CQUIN efforts and introduction of evidence based clinical decision tools, annual audit plans, addition to prescribing standards to include IVOS. - Sharing divisional data on antimicrobial use at top level for accountability to ASSG. Pilot evidenced effectiveness of approach. Guidelines reviewed to reflect evidence base and local microbiology trends to support his. Microguide awareness reminders sent regularly. All specialties invited to input on quality and prescribing improvement projects to tackle inappropriate antimicrobial use. Multiple QIPs overseeing clinical teams throughout Trust, led by Antimicrobial Pharmacy Team. Ongoing developments to training packs/sessions accessible for all levels of prescriber or healthcare staff.
- Strategic Objective B: ONGOING timeline Sharing consumption data and IVOS CQUIN findings via ASSG with divisional leads on board for secondary care, bespoke divisional surveillance shared at top level in divisions to cascade to specialties and feedback initiatives being taken. Effect of implementation being noted in the top-level reports to close the loop. Example Positive effect noted from efforts so far. Primary care surveillance distributed to GPs every 3 months, breaking down prescribing habits and trends. Position against national standards highlighted in all primary care reports.
- Strategic Objective C: Facilitate and promote means of improving Antimicrobial Stewardship across Lincolnshire, through: Secondary care implemented ePMA with mandating of indication from a specific dropdown list to ensure correct level of detail, regular reminders and teaching sessions, educational messages re correct diagnostics around UTI, chest infection, C.diff infection and various others. Advising on correct sampling, plans for incorporating information into clinical decision tools re diagnostics and sampling. Exploring with regional NHSE AMR links about how to implement further improvements and resources in primary care, potential for introducing coding to primary care prescriptions, etc to enable clinical checks in community pharmacies and auditing of local data. Secondary care prescribing practices picked up from audit plans and presentations, captured via Clinical Governance mechanisms and meetings. Encouraging individual specialties to set up own independently, with support from Antimicrobial Consultant. Mapping out plans for AMR Clinics for timely and effective review of antimicrobial prescriptions, recurrent infections, and AMR risk based on specific criteria and evidence base. Will look to cover Penicillin allergy de-labelling and testing in this. - Reviewing resource and provision from Antimicrobial or Clinical microbiology teams in Lincolnshire. AMR SRO to look at whether alternative models of delivery can be implemented. Examples put forward include advertising for Lincolnshire specific consultant microbiologists (outside of Pathlinks contract as this is a key challenge in stretching the resource available to Lincolnshire ICB), or creating antimicrobial Pharmacist, Technician, Nurse and support roles to lessen the gap in resource and increase stewardship. Also explore a system set up or Antimicrobial Stewards in each practice or healthcare facility.
- Strategic Objective D: Regular microguide reminders and developments. Increasing awareness, engagement and stakeholder representation and accountability via AMS Lincolnshire. Ensuring local resources such as formulary status, Optimise Rx and Ardens etc. The latter is not aligned with local guidance and is creating variation in practice. Timely review of national updates and guidelines and implementation into local guidelines, policies and training within an appropriate timeframe. This will improve safety and quality and unable to determine specific financial savings.

Medicines Optimisation

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3. What's being done to get there | Detail

Quality and Safety in medicines and prescribing

- *Medicines Safety:* We are awaiting monies to be released from ULHT disinvested MOCH service to fund agreed Pharmacy Quality and Safety Lead within the ICB to lead much of this work. This has been escalated and we plan to have this post filled during 24/25 – Job description agreed and banded, permission to recruit given pending release of monies. Detailed planning underway between Chief Pharmacist ICB (YS) and Chief Pharmacist LCHS (SB) to agree agenda items and areas for discussion – most pertinent quality and safety issues. Incident review and management in individual providers as normal. Weekly/2-weekly review of primary care related medicines incidents. Working closely with the patient safety team. Including Quality and safety elements in the planned primary care prescribing enhance scheme. Implementation of the Discharge Medicine Service across ULHT to feed into Community Pharmacy, build working relations & improve patient outcomes
- *Controlled Drugs:* Liaison with NHSE CDAO office regarding controlled drug prescribing and monitoring in Lincolnshire. Plan for robust Controlled Drug monitoring process within the LICB MO team 6 monthly reporting. Improving patient outcomes and reducing harm by picking out irregular prescribing of controlled drugs, excessive quantities and inappropriate high doses. Support NHSE with their routine monitoring. Support practices with the safe storage and prescribing of controlled drugs.

Aseptic production

- Feasibility and scoping of the project is currently being undertaken by the project steering group. Project deliverables, milestones, FRP plans, and phasing will be shared once agreed. This will improve safety and quality and unable to determine specific financial savings.

Antidepressant reduction

- Needs planning/discussion at IPMO.

Pharmacy Workforce

- *Work Stream One: Marketing and Attraction:* All Pharmacy marketing and attraction work centralised. Annual careers events calendar in place with input and participation from all providers. Standardised Pharmacy promotion material across all medium in place. 'Be Lincolnshire campaign fully utilised and adapted to include Pharmacy roles, in place.
- *Work Stream Two: Career Development Pathways:* Lincolnshire wide professional journey maps including produced including: Entry and progression points clearly defined for each role. Training and skills needed for each role clearly articulated. Creative career development opportunities outlined i.e. split posts. Mentoring/Coaching, teaching, leadership and management development offers clearly defined. Standardisation of entry requirements and Job descriptions. Define entry points for older workforce and emphasise equality in recruitment process.
- *Work Stream Three: Training and Placements*: Establish baseline data including number of placements available across the system, and conversion rate for people who train locally and stay. Strengthen placement activity across whole system by implementing processes enable university and placement providers to plan, prepare, and provide good quality placements. Processes in places including SOP to capture placement activity undertaken and core competencies gained for everyone. Explore introducing central team of assessors with standardised assessments. Develop student passports aligned to harmonise competencies i.e. JD's, T & C's.
- *Work Stream Four: Recruitment:* System wide collaboration on common vacancies established. Cross-sector posts introduced and advertised. Recruitment programme linked to marketing and attraction work stream outlining key activity i.e. roadshows with same day application / interview. Programme in place for welcoming national and international recruits to Lincolnshire. System level incentive scheme introduced highlighting incentives offered by each provider i.e. golden handshake, relocation package, pay General Pharmaceutical Council fees, leadership course offer.
- *Additional Work Stream: Workforce Modelling:* Work with providers and ICB to establish workforce baseline, cross reference with population need, over next five years and produce year on year expansion trajectory.

Medicines Optimisation

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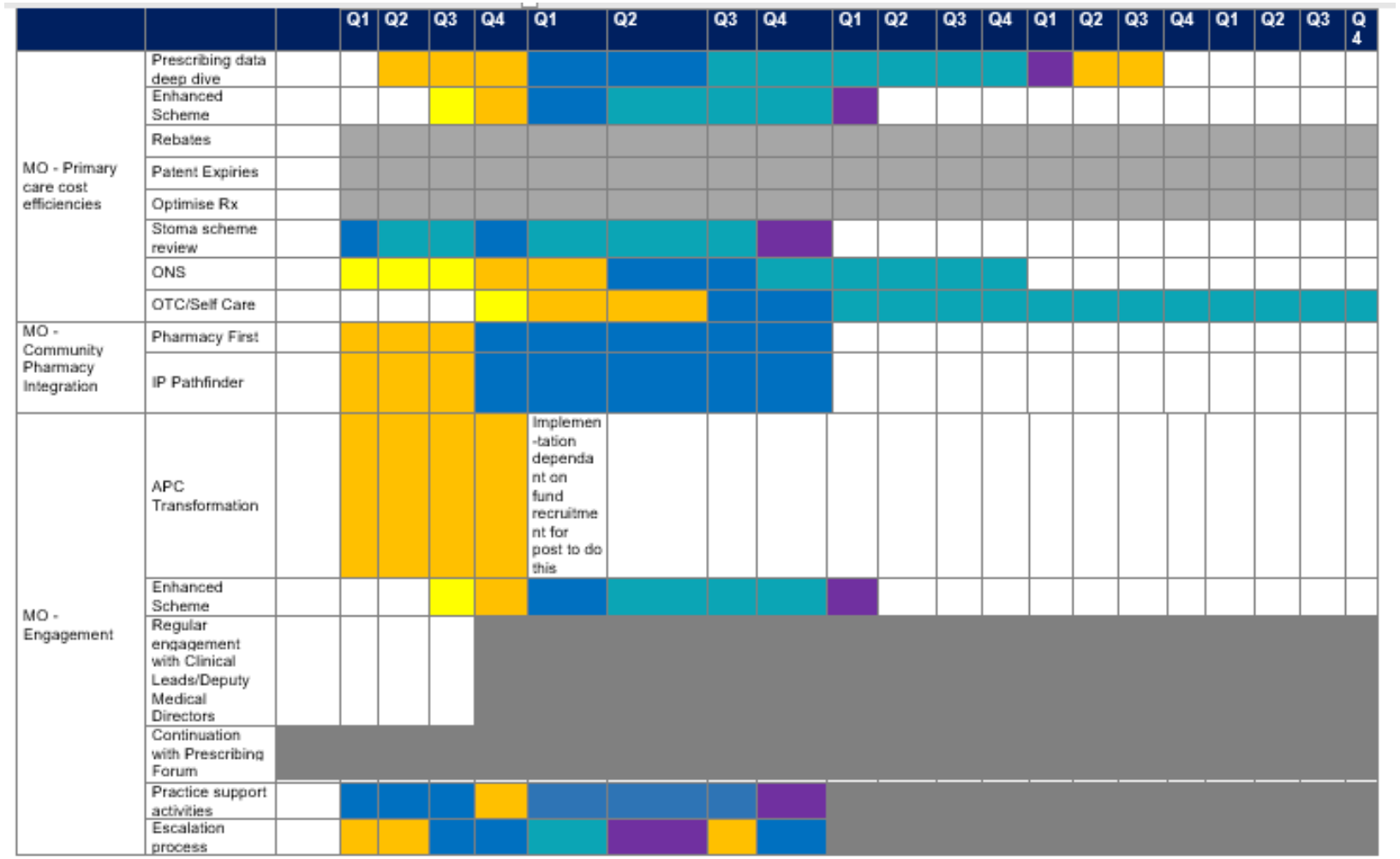
Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU



Medicines Optimisation

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Medicines Optimisation	Procurement – Secondary care																					
	Biosimilars																					
MO – AMS	Objective A Primary																					
	Objective A Secondary																					
	ePMA surveillance function																					
	ePMA indications																					
	Coding primary										Local pilot?											
	AMR clinics									2pilot												
	Micro/Abx staff																					
	Ardens template corrections																					
MO – Quality and safety	*Cannot commit to detailed phasing until Lead Pharmacist is in place*																					
Medicines Optimisation	Aseptic production																					
	Antidepressant reduction																					
	Pharmacy Workforce																					

Medicines Optimisation

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4. Projected impact on patients and system partners

All schemes will benefits patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

Primary care cost efficiencies

- Patients: reducing harm from medicines through offering safe and cost-effective alternatives. Measured through acceptance rates on Optimise Rx, reduction in medicines-related incidents, reduction in admissions with primary coding as medicines-related and improvement in practice response/actioning of red Eclipse Live alerts. Reduction in cost to the system, freeing up resources and capacity to improve patient services and patient. Savings measured as reduction in prescribing spend (specified areas) – caveat is underlying increase in drug prices and volume.
- Prescribing Data Deep Dive – Benefits will be potentially financial for primary care prescribing spend if areas are identified that are unwarranted variation and can be changed. This will be measures by ePACT2 data to show decrease in spend in these areas compared to baseline.
- Enhance Scheme switch savings – Benefits will be qualitative and financial for primary care prescribing spend on successful completion of work in line with planned Enhanced Scheme by GP practices who sign up. Measured by ePACT2 data/activity reporting from practices as decrease in spend or evidence of change to demonstrate resulting prescribing savings
- Rebates – benefits will be financial only for primary care prescribing spend (provider rebates – unclear where they are reported in currently)
- Patent Expiries – benefits will be financial only across the system prescribing spends. Primary care measured as reduction in spend through ePACT2 reporting. Unclear how reporting on hospital/provider use will be reported.
- Stoma Review Service – Quality benefits to patients will be improving their care by regular reviews of their stoma needs and ensure they receive the correct products to support ongoing stoma management. Financial benefits through limiting ordering to correct quantities and essential products. Reporting will be from the stoma nurse on completion of reviews in each practice who signs up, changes made and resulting monthly savings. Primary care only. ICS
- ONS – This work will be in collaboration with ULHT dietitians but is not expected to impact on ULHT prescribing or services. Quality benefits to patients will be review of ONS products and deprescribing is no longer needed. Financial savings will be reported by activity and changes to prescribing made at reviews to calculate prescribing savings delivered.
- OTC/Self-care – Benefits will be mainly financial. This is a difficult area to measure using ePACT2 as areas of prescribing are very large and many variables. Still working up how to measure financial savings if this is part of the panned Enhanced Scheme. Impact on patients may be negative if they are asked to buy medicines that they have previously been obtaining on prescription and if they live a distance away from a community pharmacy and have extra travel to obtain self-care medicines (most of this prescribing is expected to be for patient who do not usually pay for their prescriptions). This will have a negative impact for patient who may not be able to afford these medicines in areas of high deprivation. Will impact Community Pharmacy contractors – higher workload/demand for already struggling community pharmacies, but increased income through medicines sales.

ICS Aim to deliver transformational change in order to improve health and wellbeing.

Medicines Optimisation

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Community Pharmacy Integration

Improved patient outcomes measured as number of consultations within community Pharmacy (PharmOutcomes) Impact on system partners will be reduction in GP appointments. Improved communication of changes made to a patient's medicines in hospital and its aims to improve patients' understanding of their medicines and how to take them following discharge from hospital.

- DMS also aims to reduce hospital readmission by reducing risk of medication related harm and hospital readmissions.
- Every 10 community pharmacy consultations undertaken following a DMS referral from secondary care will prevent one readmission. Even if readmitted it will reduce the length of stay by six days (data by NHSE).
- Offer people greater choice where they can access contraception services and create extra capacity in primary care and sexual health clinics (or equivalent) to support meeting the demand for more complex assessments.
- CPCS - relieve pressure on the wider NHS by providing patients with accessible and swift consultation with an appropriate HCP a Community Pharmacist via Telephone or face to face consultation at the local community pharmacy, re-enforcing the message of 'Right Clinician, Right Time and Right place'.
- Increase identification of hypertension and to refer those with suspected hypertension for appropriate management.
- Promote healthy behaviours to service users.
- IP pathfinder presents a unique opportunity for community pharmacy to redesign current pathways and play an increasing role in delivering clinical services in primary care.
- Develop and utilise clinical skills and capabilities of community pharmacists to facilitate quicker and more convenient access to safe and high-quality healthcare, including the prescription of appropriate medicines for minor illness, addressing health issues before they get worse, providing monitoring of long-term health conditions and preventing ill-health.
- Community pharmacy Extended Care Service provides increased accessibility for patients to seek advice and treatment, and act as an alternative to seeking treatment via a prescription from their GP or Out of Hours (OHH) provider, walk in centre or accident and emergency department.
- Digital connectivity aims to improve the following: Access Record-Improve access of CP to view medical history in GP patient record to support the consultation (very vital for IP pathfinder and common conditions service); Consultation Template- Capture details of Pharmacist consultation (e.g., notes, outcomes, meds issued) particularly useful for oral contraception, IP Pathfinder and BP check service. Reduces duplication of sending clinical details via emails for practice to action. Update Record- Send post consultation reports back to GP systems to update the record.
- Payment & Data API- Dataflows to enable renumeration and national reporting on meds

Medicines Optimisation

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4. Projected impact on patients and system partners

All schemes will benefit patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

MO Engagement within the system

- Impact on patients – Open up a channel of direct communication with our patients, where patients feel able to share their stories and contribute to developing services which are tailored to individual communities and influence decisions made about their medicines, taking into account the health inequalities agenda. This will contribute to improved patient outcomes through increased service user participation. Measured with patient surveys and participation in decision-making agendas with medicines optimisation.
- Benefits of improved engagement with GP practice will benefit primary care prescribers in support with their prescribing and medicines optimisation questions and concerns, which can be either resolved within the MO Team or directed to the relevant part of the system that can support. Measurement of success will be tracked through satisfaction survey and feedback. Impact can also be measured through the number of practices participating in annual practice visit.
- Benefits to primary care providers in organising system specialist speaker education for prescribers through Prescribing Forums and other organised events.
- Mutual sharing of plans through IPMO will benefit all partners through core joined up collaborative working success will be measured through the shared strategy and workplan and its successful delivery. Escalation process should allow the right level of intervention is given where practices are very reluctant to engage. Success will be measures in the number of escalations that are satisfactorily resolved.
- Benefits to ICB teams through MO Team involvement in service/pathway design/development and contracting will be that potential issues and difficulties that may lead to barriers or difficulties in prescribing provision can be identified and mitigated at the initial stages. Reduction of non-formulary prescribing that may result in higher/unwanted prescribing spend may also be minimised. Managing the expectations of patients and improving understanding of medicines optimisation.
  ICS aim – Tackle inequalities and inequity of service provision to meet the population needs. ICS aim – Take collective action on health and wellbeing across a range of organisations. ICP Strategy Priority Enabler 4.

Secondary Care Procurement

- Financial savings for Lincolnshire ICS, (Potential contracted drug as per CMU should guarantee a certain level of supply), more robust supply for patients, possibility of impact to primary care, but depends on formulary amendments e.g. brand to generic

Biosimilars

- The benefits of this work are financial to the system as biosimilars are less expensive than originator brand biologics. Opportunity to review the patient and optimise their medication and access pathway. With any biosimilar switch, there is an impact on resource initially for clinical teams to perform the switch in addition to the supporting resource within the (ULHT) pharmacy team. Strengthen system approach to implementation and ongoing management of biosimilars through collaborative working, including out of area acute providers.

Medicines Optimisation

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4. Projected impact on patients and system partners

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Antimicrobial Stewardship

- Reduced likelihood of infection-related hospital admissions – measurement through hospitals information systems – quarterly surveillance,
- Reduced likelihood of antimicrobial resistance – measurement through microbiology data – quarterly surveillance
- Reduced consumption of high-risk antimicrobials – measurement pharmacy prescriptions quarterly surveillance,
- Expected reductions in GP presentations for recurrent infection – to be explored then aim to tie in to quarterly surveillance. First need to set up a process of capturing and measure SNOMED codes as one potential on prescriptions. Also measure volume of antibacterials via ePACT2, EMAS and UTCs should see reduction in pressured due to deteriorating patients and sepsis – explore EMAS and UTC/LCHS surveillance data – quarterly,
- Reduced pressure on social care services with reduced length of stay in hospital (deconditioning) – explore LCC data – quarterly,
- Better patient engagement with AMR and selfcare/self-reporting – Measurement in demonstrating improved equality in care and seeing ePACT2 data showing less variation in prescribing practices across areas of deprivation vs less deprived – quarterly. As get new initiatives up and running, such as AMR clinics, would do patient experience surveys and follow up of primary and secondary outcomes on impact (TBC)

Quality and Safety in medicines and prescribing

- This will support patients to live well and stay well by reducing the risk of harm from medications. This will be measured by monitoring medicines-related incidents and admission coding within the hospital. Sharing system learning and creating a safer environment for patients & reduced admissions due to medicines-related complications. The Medicines Safety Network will function as a group working together to identify and make recommendations on how to reduce preventable medication-related harm within the organisations and across the integrated care system. Influencing the way medicines safety incidents are managed within the National Patient Safety Strategy. Sharing and learning from safety events across the Lincolnshire health economy.
- Reduce secondary care admissions due to medicines related harm. Opioid work benefits - Reducing secondary care admissions due to opioid overdose or increased anticholinergic burden,
- Reducing the number of falls due to opioid side effects or increased anticholinergic burden (links to system ambitions and the Lincolnshire Older People's 5-year Strategy),
- Reducing the harm to patients from medicines by reducing polypharmacy, increased risk of addiction, overdose, Improving patient outcomes by optimising their pain management techniques increasing their quality of life

Medicines Optimisation

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4. Projected impact on patients and system partners

All schemes will benefits patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

Aseptic production

- Improved chemotherapy capacity: Improved chemotherapy capacity and delivery in line with cancer strategy.
- Improved patient clinical outcomes through improved availability and distribution of aseptic products.
- Improved patient experience by enabling care closer to home. The manufacture of Outpatient Intravenous Antimicrobial Therapy (OPAT) will reduce the length of patient stay in hospital and increase capacity within the system. Patients will also be free from the risk of hospital acquired infections, leading to faster recovery, overall improving the quality of care. Ability to meet current gaps in Central IV Additive Service (CIVAs) and monoclonal antibodies for non-cancer. These products are currently being prepared by nurses. Investing in pharmacy aseptic facilities to make CIVA's reduces the risk for patient associated with errors and frees up nursing time for direct patient care.
- Improved productivity and efficiency within the service through batch manufacturing and automation. Removes the need for all products to be patient specific, leading to efficiencies in supply and cost reductions for the system through batch production. Improved employment opportunities across Lincolnshire (pharmacy, scientific etc.).
- Increased of flow of revenue funding to Lincolnshire ICS, as there is a significant gap in the market for selling aseptic medicines. Development of a centre of excellence for pharmacy aseptic services: application for an IMP licence, may attract workforce to Lincolnshire, giving the opportunity for collaborative working with other organisations, for instance University of Lincoln.

Antidepressant reduction

- Prescribing in line with NICE for depression. No prescribing for mild depression. Reduction for long term ineffective Rx – need services to support de-prescribing.

Pharmacy Workforce

- Successful implementation of the programme will result in a workforce that meets the needs of the local population, by reducing vacancy rates, increasing retention, and improving staff satisfaction across all Providers. Results will be measured by establishing an annual trajectory to increase Pharmacy roles and measuring against achievement of targets.
- Other measures will include workforce data such as recruitment, retention and promotion figures. This programme is enabling system partners to work in collaboration on challenges faced by all providers by centralising activity and working together where appropriate i.e. cross sector posts, central recruitment.

Medicines Optimisation

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5. What's needed to make this happen

Primary care cost efficiencies

- Internal MO resource to run reports, data analysis, expert review and narrative, planning actions and project management.
- Input from providers as specialist input into formulary can guidance changes via APC/PACEF.
- Support for programme management from IPMO and clinical support/peer representation from our primary care prescribers.
- PHM and BI support to build up context through complimentary data sets.
- Support from F&BP to work up the financial elements of the scheme and assist reporting. Clinical/peer support in developing the scheme to represent primary care prescribers.
- Contracting and procurement teams and F&BP to support ongoing use of software.
- MO resource to update and review messaging and other maintenance requirements.
- Input from digital team in review of market products, developments, and opportunities in 25/26-26/27 to ensure best use of digital medicines optimisation tools.
- ULHT Stoma Nurse input into providing current service and capacity to build/extend.
- PCN dietitian for current pilot, workforce for further dietitian resource to fulfil project plan.
- May require Contract Team input if using any 3rd party provider.
- Input from ULHT dietitian team for clinical advice and support, input into formulary and guidance changes
- Comms and engagement support needed for projects over the lifespan of this work with regular information and campaigns to raise awareness of self-care.
- Health inequalities support to ensure our planned work has no detrimental effect on health inequalities in Lincolnshire.
- Community Pharmacy engagement, understanding their role and what impact it will have on their workload/resource and link into Primary Care Directorate to align priorities.
- Investment to pay for this scheme would come from identified savings.

Community Pharmacy Integration

- Financial Investment and business case will be needed to ensure the role continues for the remainder of the pathfinder program. 1WTE B8c and 1WTE B7.
- Support from NHSE midlands and national team
- Support from East midlands POD team- to investigate any contractual issues/breach. Need more Implementation support hours on top of NHSE funded hours- to facilitate implanting GP-CPCS, Contraception, BP checks.
- Additional project management support to deliver NHS Community Clinical services
- B.I to create a PCARP dashboard focusing on clinical pharmacy services data.
- Comms team launching of the GP facing website advising of which CP is delivering which advanced service. Add details for community pharmacies delivering advanced services onto the ICB webpage.

MO Engagement within the system

- Awareness of the MO Team offer to other ICB Teams and willingness from them to engage.
- IPMO cohesion as a leadership group to direct and support collaborative working across the system.
- Support from ICB and GP clinical leads with engagement strategies and ideas. Support from ICB where specific engagement issues are identified. Support from ICB/system Comms, Engagement Teams and patient experience teams.

Secondary Care Procurement

- Identified need for more staff resource to sure up the current team (recruitment in progress). Additional staff resource needed to release more senior staff to proactively manage contracts and other identified procurement gaps.
- Need good supply chain and available drug stocks within the UK.
- Quality assurance process/specialist to ensure safe drug supplies (quality and safety).
- Specific resource dedicated to off-contract claims.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

5. What's needed to make this happen

Biosimilars

- Input from providers, requirements from enablers (e.g. digital, estates, workforce, PHM, personalisation and health inequalities), other support requirements, resource requirements: investment and non-financial.

Antimicrobial Stewardship

- AMS system leader, Wider and more focussed engagement and surveillance from AMS Lincolnshire stakeholders. Patient Safety Partner of AMS Lincolnshire Group,
- Digital support and contractual support for Ardens, SystmOne and EMIS to develop indication and allergy status on prescriptions (SNOMED) and updating Ardens templates,
- Financial/business case for initiating antimicrobial clinics across Lincolnshire, which will also enable penicillin allergy reviews (with future aspiration for sensitivity testing).
- Increase in Antimicrobial/Microbiology staffing resource and support across Lincolnshire ICS (not yet scoped) [ICS planning require a business case and need to know when this is expected]
- System-wide Comms and Primary Care support for public campaigns including information in CPs, GP practices, public areas etc. Successful recruitment of 1WTE B8b quality and safety pharmacy lead for the ICB

Quality and Safety in medicines and prescribing

- Financial Investment - ICB Medicines Optimisation Quality and Safety Lead Pharmacist, Band 8b – Release of funding from MOCH disinvestment from ULHT agreed in Feb 2023,
- IPMO engagement and collaboration on medicines quality and safety.
- Digital needs.
- PHM data on safety and quality consequence (If available)
- ICB to continue commissioning Eclipse Live
- Engagement from GP practices to use the new Learning from Patient Safety Events (LFPSE) incident reporting tool. Inclusion of quality prescribing elements in the planned Enhance Scheme

Aseptic production

- Financial investment for ICS – Aseptics Workforce (TBC). Financial Investment: Business case to be developed to bid for the 2024/2025 NHSE Aseptic Services Capital: Build and workforce. Workforce plan to be developed. System and NHSE support.

Antidepressant reduction

- Need for antidepressant reduction to be prioritised and GP practice pharmacists to be allocated time for this work
- MH expertise, education and training for GP's and prescribers, PCN pharmacists, practice pharmacists, healthcare professionals resource and other mental health workers.
- Patient information resources as available in MH Services to also be available to primary care (choice and medication and MH Trust medicines information support/expertise).
- Financial resource to enable hyperbolic prescribing for de-prescribing – liquid preparations can be very expensive.

Pharmacy Workforce

- Continued engagement with activity taking place in the faculty meeting and work stream groups
- ICB People Team – Support needed on workforce modelling to produce annual trajectory of growth based on population need, and provider capacity to recruit and train
- Long term Programme Management support as funding from NHS England is on a temporary basis.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

6. What could make or break progress

Primary care cost efficiencies

- Low level/lack of engagement from GP practices and primary care prescribers with the MO Team will affect the success of the planned Enhanced Scheme, Stoma, Optimise Rx, ONS and self-care work. If we cannot improve the level of Practice engagement, delivery of potential savings will be profoundly reduced. This lack of engagement may be due to conflicting priorities, no allocated practice resource to carry out the necessary work, historic and underlying reputation and engagement issues.
- MO Team staff vacancies will reduce the resource available to progress some of these work areas and may lead to slipped timelines. There are two essential agreed posts that are not currently filled (Quality and Safety and APC development) (refer to 2/23/24 planning templates) that are needed to lead and put in place essential framework required to deliver on MO programmes. This will also release current staff who are covering some of these crucial duties to work on these schemes, particularly engagement. The monies for these posts are currently not released from an agreed disinvestment with ULHT for a MOCH service no longer provided or delivering.
- Resource and management arrangements for Lincolnshire Joint Formulary need to be bolstered as the current arrangement does not support the reviews, changes and updates needed to underpin many of the above schemes.
- No renewal of Optimise Rx Contract in short-term (Feb 2024) and review of market products in longer-term.
- The LICB position on rebates need to be agreed at an Exec level before this can go ahead.

Community Pharmacy Integration

- Current ongoing issues facing community pharmacy with staffing/workforce are likely to mean that they are unable to offer some of these services; advanced services are optional but are likely to be ‘bundled’ in the future, meaning pharmacies will be required to provide Pharmacy First (including CPCS), the Pharmacy Contraception Service **and** Hypertension Case Finding together if they wish to offer any of these.
- Lack of funding to pay for Community Pharmacy Clinical Lead Post – without this post, further development with this programme will cease. Lack of funding for the Community Pharmacy Project Manager, also funding for this post needs to be full time and permanent. Strong engagement from LPC is needed – this is delicate as community pharmacies face unsurpassed challenges in providing services in current times, and the LPCs are representative organisations (not providers)
- Unplanned pharmacy closures due to workforce pressures and permanent community pharmacy closures. Geographical area(s) without a community pharmacy would be unable to deliver any of the clinical services to those patient populations.
- Not enough independent prescribers in Community Pharmacy at the current time, and challenges in undertaking this training (time, finding supportive Designated Prescribing Practitioners, cost)
- Continued steer needed at a national / NHS England level. Workstreams involving or continuing to be led by the Health Innovation Networks Diversification of Community Pharmacy workforce- technicians taking up more advanced roles, working with PGDs.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

7. Planning assumptions

Primary care cost efficiencies

- OTC/Self-care will direct patient from GP practice to community pharmacy – will need to establish whether workload will be manageable for community pharmacy, ONS and Stoma schemes rely on specialist dietitian and stoma nurse workforce.
- Savings on prescribing spend will be factored into primary care prescribing budget calculations.
- Cross-organisation joint working: Current Staff vacancies within MO Team will be filled as monies from ULHT disinvestment will be released to fund these.

Community Pharmacy Integration

- No more significant pharmacy closures, common condition
- Service will be launched early 2024, digital connectivity (GP connect) between general practice and Community pharmacy is launched and maintained.
- Community Pharmacy Workforce within Lincolnshire doesn't significantly deplete.
- Working relationship exists between general practice and Community Pharmacies.

MO Engagement within the system

- Assumes ICB MO Team are able to recruit to current vacancies.
- Workforce shortages in provider trusts are addressed with robust mitigation
- Assumes IPMO group continue to develop shared workplan and strategy.

Secondary Care Procurement

- Demand for drugs will remain stable.
- Current staffing resource remain stable – including sickness levels
- No major changes with drug suppliers
- Availability of workspace needed to accommodate any new staff.

Biosimilars

- Stable patient population using these drugs
- Stable workforce (recruitment, retention and sickness)
- Homecare companies have capacity and workforce
- Products come to market with similar arrangements to originator brands
- Price reductions on all emerging biosimilars, which may not materialise when they confirm the biosimilar prices
- Availability of workplace for any new staff needed as per business case

Medicines Optimisation

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7. Planning assumptions

Antimicrobial Stewardship

- Population/patient-driven demand: Existing demand or need in primary care will be ongoing and increasing as awareness of AMS and resources increase. Prime example in AMR clinics, and function of such clinics will evolve as demand does. Development of AMR: assuming no viral pandemics, but that AMR will continue to develop. Even if we manage to stall development locally, travel and relocation, and microbial evolution make this a confident assumption. Hence, we need to take mitigating actions knowing the situation will get worse, in order to contain harm to patients and the health economy.
- System-driven demand: National policy and focus sustained for last few years and increasing. Hence increases demand with additional performance targets; expectation of embedded practice requires sustained focus and resource for those workstreams due to nature of healthcare staff turnaround, patient movement, life-span of efforts. Service improvements of currently sub-standard set-up requires building to baseline before can build beyond. Areas of deprivation in Lincolnshire require additional effort as access to healthcare and patient health beliefs are impacted. Move to electronic and virtual settings impacts on implementation and progress (some positive, some negative). New infections arising from change in environmental circumstances will drive demand (epidemics, climate change, polluted waters, refugee camps) changes in care settings (secondary to primary, virtual wards, etc).
- Digital: Embedding & spreading existing initiatives (such as ePMA in secondary care); Deploying new solutions (such as SNOMED codes on primary care prescriptions to allow clinical checks in community pharmacy settings). Ability to tap into existing digital platforms at point of care or patient access.
- Finance: allocation & position – CIP targets are unlikely to be realised in this workstream, as patient improved outcomes, or reducing financial burden of Antimicrobial Resistance cannot be captured as a preventative measure, or by avoided hospital stays, interventions such as surgical procedures, etc. set up of additional digital features will require some short-term funding for set up and potential increase in subscription fees for digital solutions and packages that enable this.
- Need for centralised resource including Antimicrobial Specialists or Microbiologists will be most cost efficient but require funding. Need for AMR clinics will need finance lead support and contract lead support in business case, set up of service, tariffs, etc.
- Assuming (calculating) tariffs to cover cost of running the clinics in most cost-efficient manner. Inflation on all the above. ERF, SDF and capital assumptions
- Shortage of healthcare staffing is also increasing need for alternative and cost/workforce efficient initiatives that enable strategic planning for system benefit in reducing need for acute and emergency healthcare presentations.
- Estates will be required to house additional staffs and initiatives such as clinics. Exploration of existing estates such as healthcare centres would still need to be scoped and reimbursed.
- Assuming system set up will address challenges such as information governance, improved synchronisation of communications systems and workforces.

Medicines Optimisation

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7. Planning assumptions

Quality and Safety in medicines and prescribing

- ICB Meds safety resource. Patient safety events number stable. Robust process for reviewing medicines related incident reporting.
- Resource available from LCHS and LPFT.
- Financial resource available for recruiting to the LICB post.
- All partners fully engaging with the Medicines Safety Network.

Aseptic production

- Increasing demand- cancer demand in the Trust is increasing by 10% annually and demand in aseptic preparation is predicted to increase as a proportion of global drug spend and injectable medicines sales are growing at 7.3%. Alongside the growth of core chemotherapy and parenteral nutrition, there is a need to anticipate future demand for advanced therapy medicinal products (ATMPs), such as gene therapy, growth in clinical trials, and potential to address the sizeable unmet need for central intravenous additives (CIVAs) and monoclonal antibodies (MAbs).
- Workforce: the service delivery relies on reliable and sustainable workforce. Digital: relevant digital and IT systems such as robotics for batch manufacturing required.
- Finance: successful business case.
- Estates: location to build and build of the facility.

Antidepressant reduction

- Not yet discussed

Pharmacy Workforce

- None stated

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

8. Stakeholders

Primary care cost efficiencies

- *Prescribing Data Deep Dive:* Project Team – MO resource. Stakeholders – GP prescribers, clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, PHM, F&BP, IPMO
- *Enhance Scheme savings:* – Project Team – MO resource. Stakeholders – GP prescribers, ICB primary care team, clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, PHM, F&BP, Community Pharmacy, IPMO.
- *Rebates:* Project Team – MO resource. Stakeholders – APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, F&BP, PrescQIPP, IPMO
- *Patent Expiries:* – Project Team – MO resource. Stakeholders – APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, F&BP, IPMO.
- *Optimise Rx:* Project Team – MO resource. Stakeholders – ICB contract Team, F&BP. Digital Team, IPMO.
- *Stoma Review Service*: Project Team – MO resource. Stakeholders – GP practices, ULHT stoma nurses, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, wider MO Team for practice engagement and support.
- *ONS:* Project Team – MO resource. Stakeholders – clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, F&BP (Contract Team) input if using any 3rd party provider.
- *OTC/Self-care:* Project Team – MO resource. Stakeholders – GP prescribers, clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, PHM, F&BP Comms and engagement team Health inequalities partner, Community Pharmacy (LPC).

Community Pharmacy Integration

- Project team are – CPCL and Project Manager
- Stakeholders – NHSE/I, NHSE Midlands Region Team, Community Pharmacy Lincolnshire (LPC), GP practices, PCNs, Community Pharmacy contractors, AHSN, Secondary Care colleagues, community care colleagues, Lincolnshire IPMO, Patients/carers, pharmaceutical industry, pharmacy suppliers/wholesalers.

MO Engagement within the system

- Project Team are MO Team,
- Stakeholders – GP practices, PCNs Primary Care Prescribers, Pharmacy Leadership colleagues from partner organisations, community pharmacy, LMC, LPC, ICB teams involved in developing services/pathways and contracting, Comms Team, Engagement Team, Patients.

Secondary Care Procurement

- Project team – ULHT Pharmacy Procurement Team.
- Stakeholders – wider ULHT Pharmacy Team, ULHT wards, departments, clinics and theatres, ULHT Finance Team, Lincolnshire ICB, Drugs suppliers and wholesales, East Midlands Procurement Collaborative, Patients, NHSE/I, CMU.

Biosimilars

Project team – High-Cost Drugs and Homecare Team ULHT
Stakeholders, HCD Contract Monitoring Group, Clinical Teams (ULHT), Senior Pharmacy Management Team ULHT, DTC, PACEF/APC, IPMO, Finance Teams, Patients.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

8. Stakeholders

Antimicrobial Stewardship

- Project team – AMS Lincolnshire*, with expert 'guidance' from ULHT Consultant Antimicrobial Pharmacist and Antimicrobial Team, ICB Antimicrobial lead, Programme leads, and AMR SRO for Lincolnshire.
- Stakeholders - BMI Healthcare, East Midlands Ambulance Service, Lincolnshire Community Health Services, Lincolnshire County Council, Lincolnshire ICB Medicines Optimisation Team, Lincolnshire LMC Ltd, Lincolnshire Partnership NHS Trust, Lincolnshire Local Pharmaceutical Committee, LIVES, NHS England, NHS Lincolnshire ICS/ICB, Office for Health Improvement and Disparities, PathLinks Microbiology, St Barnabas, UK Health Security Agency, United Lincolnshire Hospitals NHS Trust.

Quality and Safety in medicines and prescribing

- Project team – LCHS Chief Pharmacist LICB Chief Pharmacist, Quality and Safety Pharmacists/Technicians, ICB, ULHT, LPFT, LCHS.
- Stakeholders – ULHT, LCHS, LPFT NHSE Midlands Central, We are With You, Notts Healthcare, EMAS, Lincs Police, CQC, GPhC, LCC, LPC, Lincs Air Ambulance, Private providers

Aseptic production

- Project team: ULHT: ULHT executive sponsor, CSS, Pharmacy, R&I, Cancer, Strategic projects, IID, Finance, Digital, HR, Procurement, CDH programme director, Lincolnshire Science and Innovation Park (LSIP), Local Enterprise Partnership, LICB, LCHS, LPFT, Lincoln University, Lincolnshire County Council, Health Innovation Network, NHSE, Pharmacy representation from other NHSE organisations outside of ULHT
- Stakeholders: ULHT, IPMO, LICB, NHSE, University of Lincoln.
- Project team – lead = GP; MH pharmacist' consultant psychiatrist senior PCN pharmacist.
- Stakeholders - patients prescribed antidepressants, all prescribers, IPMO.

Pharmacy Workforce

- Project team: Lincolnshire Pharmacy Workforce Faculty Group
- Stakeholders TBC

People & Workforce

People & Workforce	SRO: Claire Low	Programme lead: Saumya Hebbar	Clinical/Technical Lead:

People Board

System partners meet quarterly

Oversees delivery and seeks assurance against the People plan

Oversees and signs off on Workforce Development Fund

Receives highlight report for information from Workforce Board so that a single People report can be submitted to SDPC

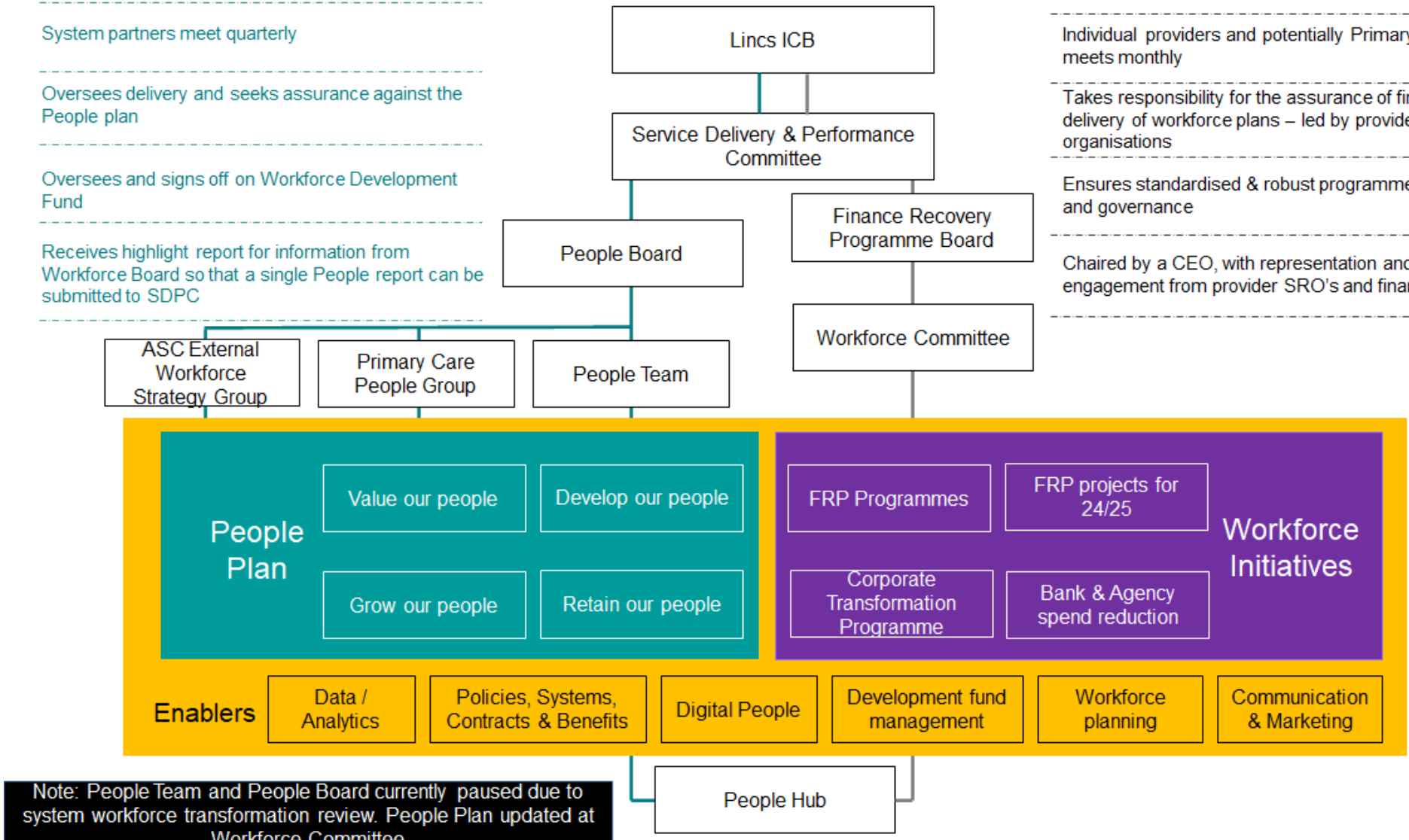
Workforce Committee

Individual providers and potentially Primary Care – meets monthly

Takes responsibility for the assurance of financial delivery of workforce plans – led by provider organisations

Ensures standardised & robust programmes of work and governance

Chaired by a CEO, with representation and engagement from provider SRO's and finance



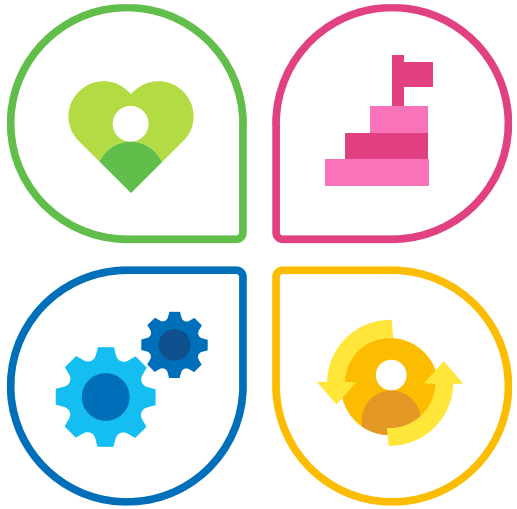
Note: People Team and People Board currently paused due to system workforce transformation review. People Plan updated at Workforce Committee

People & Workforce

People & Workforce	SRO: Claire Low	Programme lead: Saumya Hebbar	Clinical/Technical Lead:

Value our People

- Work together across the system to deliver against the **six high impact actions** set out in the equality, diversity and inclusion improvement plan for the NHS
- Embed a **compassionate culture** built on civility, respect and equal opportunity through inclusive recruitment, Just Culture, Allyship and system-level networks
- Develop and launch system-wide consistent **health and wellbeing services**



Grow our People

- **Widen access** of opportunities to people from all backgrounds and in underserved areas to join the NHS through apprenticeships.
- Engage with higher education institutions to support students, **placement capacity** and maximise accreditation of recognition of prior learning (RPL)
- Adopt **new recruitment practices** and systems in line with the outcomes of the national programme to overhaul NHS recruitment.
- Embed strategic workforce planning through enhanced systems and processes

Develop our People

- **Increase placement capacity and experience** to support increased training places in the NHS.
- Develop multi-professional, system-based **rotational clinical placement** models to increase capacity.
- Agree the system level **Leadership Development & Talent framework**
- Fully embed **digital technology in training pathways**, to support more efficient and effective ways of learning and improved learner experience
- Offer **blended learning programmes** to which integrates technology and digital media with traditional classroom-based learning

Retain our People

- Continue to embed the **People Promise** elements to enhance staff experience
- Agree and publish a consistent system-wide offer of **benefits offer** for our people
- Continue to focus on **flexible working** as a means of retaining our staff
- Work with specific staff groups/network through pilot **projects** (stay conversations, flexible working etc)
- Continue to strengthen our **pastoral care for International Recruits** across the system

People & Workforce

People & Workforce	SRO: Claire Low	Programme lead: Saumya Hebbar	Clinical/Technical Lead:

Financial Recovery Programme initiatives

- Identify and **agree further opportunities** for bank and agency reduction across providers - both medical and non-medical staff
- **Progress identified projects** already part of the plan
- **Negotiate rates with agencies** to better comply with the NHS cap and framework guidance

Bank & Agency Spend reduction schemes

- Focus on improving **off-framework** usage and **cap compliance** across provider organisations
- **Identify avenues of saving** based on submitted weekly returns

Financial Recovery projects for 24/25

- Reduce sickness management spend by up – to 1% across providers
- Continue to enhance **medical productivity** through a focus on effective rostering & job planning
- Scope income generating opportunities through apprenticeships
- Review apprenticeship spend across providers/partners to see how much can be retained within the system
- Expand the **Refugee Doctor Programme** initiative to maximize benefits

Corporate Transformation Programme

- Agree scope of the project – **identify processes** across individual provider organisations
- Agree **operating model** for each process and obtain sign off
- **Implement new operating model**

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

1. Future state

Across the system, digital and information are enablers that aim to

- Ensure strong foundations for technology-enabled care
- Drive digital readiness and digital inclusion
- Use intelligence to empower decision making and improve outcomes
- Enable improved health and care delivery and outcomes
- Provide public facing digital services

Out of scope

Any digital change that requires funding or digital/information team resources that is not accounted for in the portfolio described below will require prioritisation against existing schemes and changes to the described portfolio to reallocate resources or funding to areas of most need

System Review February – May 2024

A system-wide digital review was initiated in February 2024 and is scheduled to conclude in May 2024. This aims to determine our level of ambition and what good looks like for digital enablement. The review will help inform how we prioritise and determine the digital initiatives that support us achieving our wider priorities and objectives for the Integrated Care Partnership. This may need us to revisit our governance, our current work programme and our operating model as we consider any recommendations in support of best practice and getting the most out of our resources to improve digital maturity and support transformation using digital solutions

2. What's being done to get there | Overview

A portfolio of work will meet those objectives:

- Digital Social Care Records
- Improve cybersecurity
- Improve technical infrastructure
- Improve technical capabilities for collaboration
- Technology enabled care (remote monitoring, virtual wards, etc)
- Robotic Process Automation
- Handover of maintenance and support of the reporting platform from external arrangements
- Determine requirements for social prescribing digital solution
- Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services

Proposed but currently unfunded

- Development of the Lincolnshire Care Record
- Scope an online go-to resource for the population to navigate health, care and wellbeing
- Integration of digital systems
- Develop framework to assess and address digital skills readiness (staff or population)
- Support areas with digital solutions that enable business change (such as People and Workforce)
- Introduce shared system intranet
- Use operational data to provide intelligence at a system level
- Replacement of the reporting platform
- Access for clinicians to LACE evidence base

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

2. What's being done to get there | Overview

Other work influencing system capabilities

ULHT	• Delivery of Electronic Patient Record • Electronic Document Management System • Change of Maternity System • Digital Outpatient appointment management • Community Diagnostic Centres
LCHS	• Single Point of Access
LPFT	• Rio EPR review • Cloud Data Warehouse Procurement and Implementation
Primary Care	• Online consultations • Digital telephony • Accelerated access to records
Cancer Team	• Chatbot integration to Lincolnshire Cancer Support Website

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Digital Social Care Records																						
Development of the Lincolnshire Care Record	• In context launch from clinical systems • Add LCHS inpatient and UTC activity • Add LPFT medicines • Add pathology and radiology results from NWAFT • Add pathology and radiology results from NLAG • Add GP and walk-in radiology from ULHT • Include Somerset cancer data • Include social prescribing data • Include Child Health data from LCC • Use national record locator to find records in other ICS Care Records		**Tasks will be scheduled when funding is identified**																			

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Scope an online go-to resource for the population to navigate health, care and wellbeing	• Provide population login and view of health record in Lincs Care Record • Provide gastro patient facing online capability							Recruit post to facilitate work														
Improve cybersecurity	• Network Access Control • Proxy Server implementation • Replace network firewalls																					
Improve technical infrastructure	• Cloud strategy • Cloud implementation • Network upgrades • Wi-Fi improvements • Telephony switch to digital • Storage area network (files and email storage)																					
Integration of digital systems																						
Improve technical capabilities for collaboration							Investigation and improvement															

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop framework to assess and address digital skills readiness																						
Technology enabled care	• Remote monitoring in care homes • Virtual Wards		Care home delivery				Pilot in virtual wards		Business case for wider adoption		Further rollout											
Robotic Process Automation							Initial use cases ULH															
Support areas with digital solutions that enable business change (such as People and Workforce)																						
Introduce shared system intranet			No funding identified																			
Use operational data to provide intelligence at a system level	• Dashboard for UEC • Dashboard for end of life																					
Handover of maintenance and support of the reporting platform from external arrangements							Business case															

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Replacement of the reporting platform																						
Determine requirements for social prescribing digital solution																						
Access for clinicians to LACE evidence		No funding identified																				
Delivery of Customer Relationship Management system in LCVS																						

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

4. Projected impact on patients and system partners

.

Digital Social Care Records	Digital systems will support electronic transfers of data which are faster and more secure to speed up discharge and improve decision making across pathways of care. Care Homes without digital systems are unlikely to be rated Good or Outstanding
Development of the Lincolnshire Care Record	Those delivering direct patient care will have the information they need when and where they need it to make decision that improve patient outcomes and reduce risk for our workforce.
Scope an online go-to resource for the population to navigate health, care and wellbeing	The population will be supported in keeping well, avoiding admissions, accessing health and care services only when needed making best use of resources and supporting choice and access and reducing health inequalities.
Improve cybersecurity	Protect our services from cyber-attack, without which patients would come to harm and avoid breaches of information including patient information, recovery costs and reputational damage.
Improve technical infrastructure	Provide the infrastructure that enables a modern, mobile workforce and patients to access online services.
Integration of digital systems	Joining up information enables better decision making for best use of resources and better patient outcomes.
Improve technical capabilities for collaboration	Provide the digital solutions for staff to collaborate and operate as a system.
Develop framework to assess and address digital skills readiness (staff or population)	Having the digital skills required to use digital health solutions will capitalise on opportunities for efficiency and effectiveness, improve staff morale and patient satisfaction.
Technology enabled care (remote monitoring, virtual wards, etc)	Will reduce the need for travel and make most efficient use of resource and expertise across geographical areas in the context of rising demand on services.

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

4. Projected impact on patients and system partners

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Robotic Process Automation	Improve processes through speed and efficiency, freeing up staff to deal with more complexity
Support areas with digital solutions that enable business change (such as People and Workforce)	To maximise the opportunities that digital has to support business change, improved process and efficiencies.
Introduce shared system intranet	Join up information across teams making it searchable, joining up address books, sharing knowledge, sharing learning
Use operational data to provide intelligence at a system level	Decision making can take into account system level benefits, supports service transformation and planning
Handover of maintenance and support of the reporting platform from external arrangements	Ensures that at the end of the Optum contract the maintenance and ongoing development of the joined intelligence dataset does not cease
Replacement of the reporting platform	Ensures that at the end of the Optum contract access to the joined intelligence dataset is still possible
Determine requirements for social prescribing digital solution	Informs a system level decision on where information needs to be captured, how it is shared to support PHM, health and care delivery, and reporting
Access for clinicians to LACE evidence base	Putting research and evidence into practice to achieve best outcomes for patients
Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services	Ability to manage information that supports third sector support into health and care and social prescribing

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

5. What's needed to make this happen

	Funding source to be identified	Comments on resource	Engagement and sponsorship
Digital Social Care Records	£490k if years 1 and 2 remain outstanding		ICP
Development of the Lincolnshire Care Record	£240k		ICP
Scope an online go-to resource for the population to navigate health, care and wellbeing	£100k		All ICS organisations
Improve cybersecurity	£500k		NHS organisations
Improve technical infrastructure	£300k		NHS organisations
Integration of digital systems	£100k		NHS organisations
Improve technical capabilities for collaboration		To be undertaken by existing digital teams	NHS organisations
Develop framework to assess and address digital skills readiness (staff or population)	£80k		All ICS organisations
Technology enabled care (remote monitoring, virtual wards, etc)	£500k		ICP
Robotic Process Automation	£200k		NHS organisations
Support areas with digital solutions that enable business change (such as People and Workforce)	£60k		NHS organisations
Introduce shared system intranet	£100k		NHS organisations
Use operational data to provide intelligence at a system level	To be scoped		NHS organisations
Handover of maintenance and support of the reporting platform from external arrangements	To be scoped		ICP
Replacement of the reporting platform	To be scoped		ICP
Determine requirements for social prescribing digital solution		Workshops needed	ICP
Access for clinicians to LACE evidence base	To be scoped		NHS organisations
Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services	Already funded		All ICS organisations

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

6. What could make or break progress

- Lack of funding
  - Nationally digital transformation funding becomes available in year and has little protection and so may be subject to review at any time, which we have seen occur with connected care record funding, for example. This means that forward planning is hampered as there is little certainty and the reliance then is predominantly on local business cases to be made.
- Lack of resources
  - There are currently limited resources with roles dedicated to system digital work – a Chief Digital Information Officer, a Programme Manager for the Lincolnshire Care Record, a business partner who supports Primary Care and a project manager who supports Shared Care Plans. This leaves significant areas of opportunity without sufficient capacity to undertake business partnering, needs assessment, business case creation and solution design and business analysis that would support improvements through technology, as well as the delivery, coordination and programme management of wider digital transformation opportunities such as remote monitoring for which there is no dedicated resource.
- Insufficient capacity for business change
  - It is well evidenced that the resources required to deliver digital initiatives, support change adoption and work through business change associated with new initiatives is often underestimated. We do not have dedicated business change support for digital transformation at a system level and need to ensure this is built into all relevant business cases. Coordination of digital transformation needs dedicated resource at a system level to ensure that business change is realistic, safe and controlled. Without this, an operational area could attempt to adopt multiple changes at the same time risking delivery, causing stress for staff, increasing risk for patients, and incurring unnecessary cost – undertaking change in a coordinated and controlled way ensures that planned benefits are delivered.
- Political change
  - A change in government may introduce policy changes and affect funding opportunities.

7. Planning assumptions

- External funding awarded continues to be available (e.g. Frontline Digitisation, cyber allocation)

Estates

Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

1. The **Lincolnshire Strategic Infrastructure and Investment Group** (LSIIG) is now well established and provides the forum for discussions regarding the Strategic Infrastructure Plans and capital schemes that are being developed.
   a) There is an Operational Estates Group, chaired by the LPFT/LCHS Associate Director for Estates & Facilities which meets monthly and, by exception reports into LSIIG
   b) The Financial Recovery Estates and Facilities workstream sits within the remit of the Operational Group and reports into LSIIG.
   c) Whilst capital allocations across the system are siting with the Financial Leaders Group there are strong links between the two Groups with several representatives sitting on both. LSIIG receives a monthly report from the System Finance Lead **Building for Health.** Taken as a whole the NHS is one of the largest landowners in England. Through its role as an anchor institution, the NHS has an opportunity to intentionally manage its land and buildings in a way that has a positive social, economic and environmental impact. The effects of good management can improve the health and wellbeing of communities and reduce health inequalities.

2. NHSE (NHS England) has summarised the key-ways estates and facilities can play their role in reducing health inequalities in their 10 building blocks for building for health. NHS England » Building for health. The building blocks can be applied to all aspects of estates management including in the:
   a) delivery of new healthcare buildings, for example through the New Hospital Programme or the development of community diagnostic centres
   b) modernisation of NHS facilities
   c) prioritisation of investment
   d) management of the use of NHS buildings and spaces
   e) disposal' or repurposing of facilities the NHS no longer needs – the NHS Estates and facilities workforce action plan (2022) sets out ways to address estates workforce needs
   f) The NHS Net Zero Building Standard, published on 22nd February 2023, provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future. Developed together with healthcare, industry, and sustainability partners, the Standard will support the NHS to get ready for and align with UK Government building requirements, as well as meet its commitments to deliver a net zero health service by 2045. The NHS became the world's first health service to commit to becoming net zero in response to the profound threat to health presented by climate change.

3. **Lincolnshire Infrastructure and Investment Framework**
   a) Lincolnshire ICS (Integrated Care System) has significant issues with the current estate, and this is impacting on our ability to deliver and transform patient care and provide the best possible environment for our patients and staff. Collectively we recognise that a "do nothing/do minimum" approach is not sustainable and therefore we need to attract significant capital investment over the next 15 years.
   b) The infrastructure plans we are developing set out our ambitions to modernise our NHS infrastructure; providing care in the right way, in the right place to meet need. This takes account of the need to transform and integrate services and ensuring that we have a population, place-based needs approach aligning to our digital strategies and the rural and coastal challenges that we have across Lincolnshire.
   c) This work estimates the capital cost ask of £1.94bn (at today's prices). Without Lincolnshire being recognised as a national priority, it is unlikely to attract significant funding and enable the transformation required to enable a healthier population supported by high-quality health and care services that benefit everyone. We were not successful in any of our expressions of interest for the New Hospital Programme, submitted in 2021.

Estates

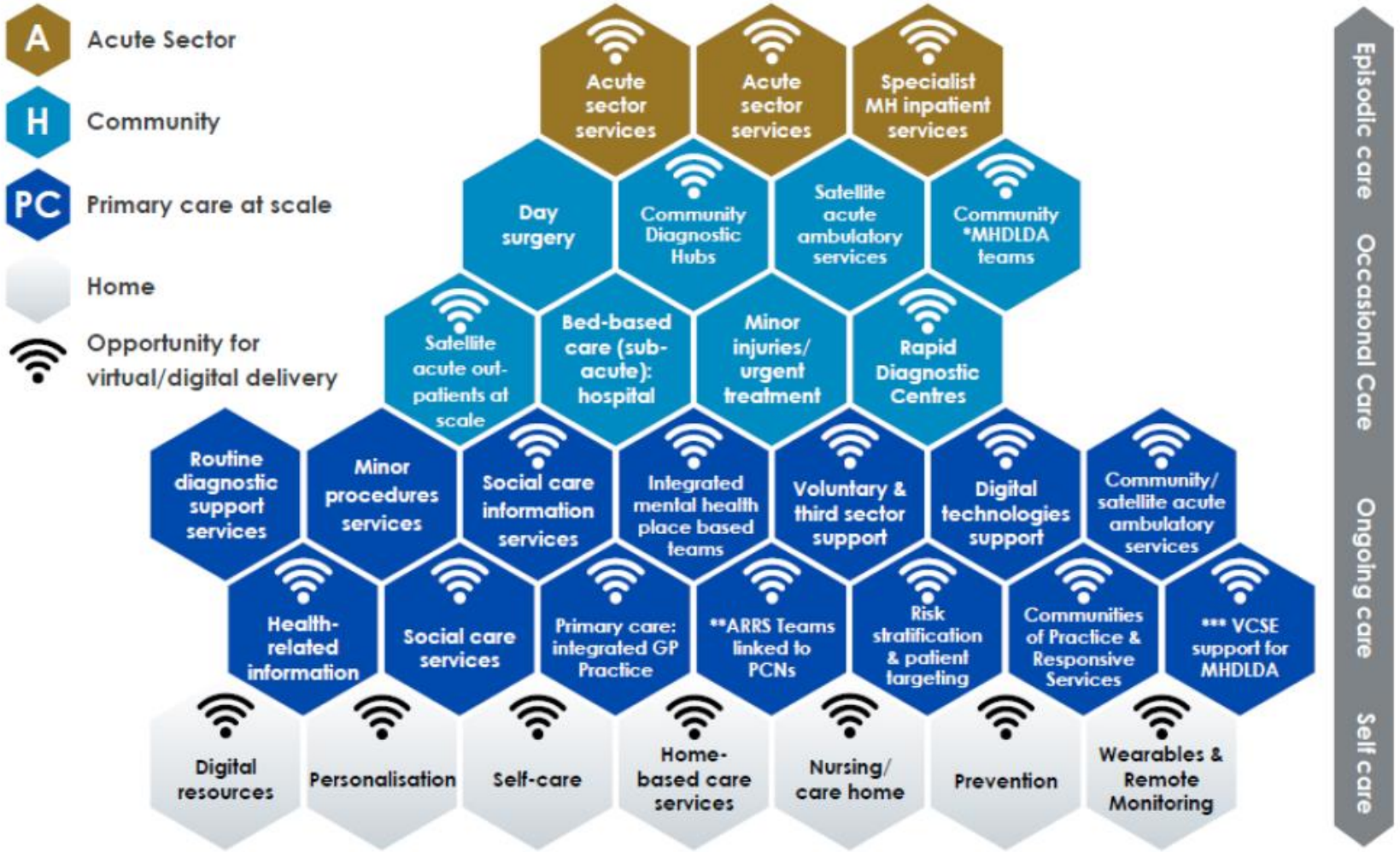
Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

d) Lincolnshire ICS has developed a strategic framework which articulates the high-level programme case for the significant investment that is needed and without which our clinical vision and strategies will not be delivered.

e) It is an iterative framework that will enable each Trust and Primary Care to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs across Lincolnshire.

f) It is supported by a suite of technical documents that are saved on the System NHS Futures Page.

g) It helps the ICSs (Integrated Care Systems) to aggregate and prioritise requirements against other system demands for capital. We are working to agree the key priorities for the next 5 to 10 years using a scenario model to ensure that we focus on developing those business cases that can be “oven-ready” for funding as it becomes available



Estates

Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

4. Current and recent Capital Developments

a) In December 2022 **Grantham Hospital** opened a new £5.3million modular building which includes two operating theatres, along with their associated preparation rooms, utility facilities and a six-bed recovery.

b) Lincoln County Hospital. The £5.6m expansion of the Emergency Department Resuscitation area opened in January 2023. It contains eight treatment cubicles, all fitted with patient hoists and the latest equipment needed to provide life-saving support for patients.

c) Pilgrim Hospital Boston. The work has started on the Boston Urgent and Emergency Care. The £37.9m development includes the demolition of the existing H-block building and the erection of a two-storey extension with a full refurbishment. It will more than double in size and include state of the art innovations and infection prevention control measures, have more cubicles to treat patients and a bigger resuscitation zone for the sickest patients. It will also include a separate area dedicated to providing emergency care for the hospital's youngest patients and their families and have more training rooms for staff.

d) Mental Health Wards

- In June 2023 LPFT opened two new mental health inpatient 19 bed wards - Ellis and Castle on the Lincoln County Hospital site. All patients have separate ensuite accommodation for our patients. They all have ground floor access to a courtyard area for peace and quiet. The £25m development includes outdoor environment which offers major benefits to our patients helping to support their recovery. The design of the new wards has been shaped using feedback from patients, carers and staff as part of our 'Building Together' programme
- In December 2023 LPFT received NHSE full business case approval for a new 19-bed mixed-gender inpatient ward at the Norton Lea site in Boston

e) Community Diagnostic Centres (CDCs). The first opened in Grantham in 2022 and business cases have been approved for two further sites in Lincoln and Skegness. These modular builds will open in 2024.

f) PE21 Boston. Since 2015, Boston Borough Council (BBC) and the NHS have driven forward a passionate partnership vision for health/wellbeing regeneration. BBC has successfully secured £14.8m from the Government Levelling Up Fund to kick-start regeneration and secure further investment to the heart of the town centre.

- The Levelling Up Fund is specifically designed to secure capital investment in infrastructure that has the potential to improve lives and give people pride in their communities. Boston's Rosegarth Square masterplan, forming part of PE21, seeks to revitalise and repurpose the area between the river Witham and the bus station - particularly focusing on the area of the former Dunelm/B&M building and the vacant Crown House building.
- The ICB (Integrated Care Board) has secured £650,000 to fund the business case for an integrated health and care centre, potentially on the PE21 site. The work is underway with the business case due to be completed summer 2024.

Estates

Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

5. Primary Care Network Estates Strategies

a. There has been a programme to support Primary Care Network Estates strategies. Community Health Partnerships (CHP) worked with the National Association of Primary Care (NAPC) on behalf of NHS England, to produce a Primary Care Network (PCN) Estates Toolkit to provide PCNs (primary care networks) with a flexible framework and support process for producing robust primary care investment plans with clear priorities that align to wider ICS strategies.

b. The toolkit had two objectives:
   - To enable each PCN to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs.
   - To support the production of capital investment plans for PCNs and places and help ICSs to aggregate and prioritise local primary care investment requirements against other system demands for capital.

c. CHP commissioned advisors to work with the Lincolnshire PCNs.

d. The work has been finalised and is being socialised within the system to confirm the Primary Care priorities.

Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

On 1 July 2022, the NHS became the first health system to **embed** net zero into legislation, through the Health and Care Act 2022.

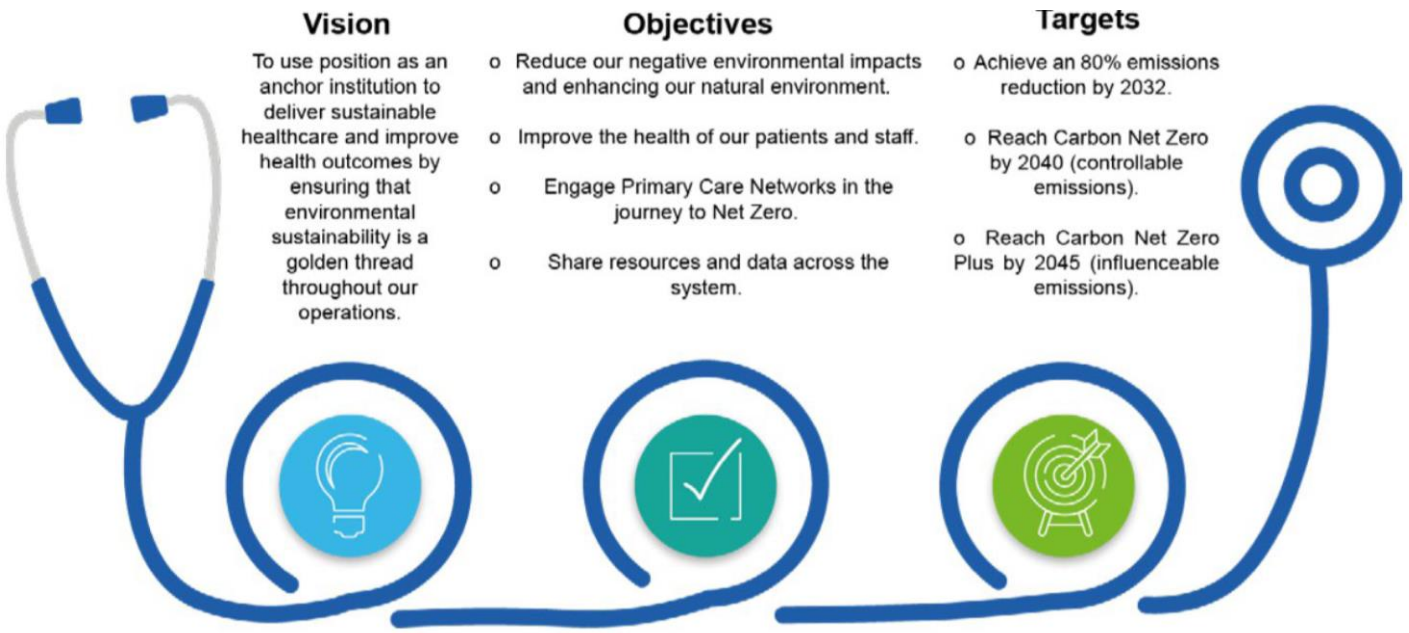
- This places **duties** on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets.
- The Act **requires** commissioners and providers of NHS services specifically to address the net zero emissions targets.
- It also **covers** measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

The UKHSA published their first Health Effects of Climate Change report, with the apt acronym of HECC. It is an important overview of exactly how climate change is affecting health, and the extent to which it will do so in the future.
To support this net zero ambition, each trust and integrated care system should have a Green Plan which sets out their aims, objectives, and delivery plans for carbon reduction. ICB plan approved November 2022

The Greener NHS programme is arranged in a number of workstreams:

- Models of care -
- Workforce -
- Medicines -
- Estates and facilities -
- Travel and transport -
- Supply chain -
- Adaptation -
- Research and innovation -
- Digital -
- Data and analytics

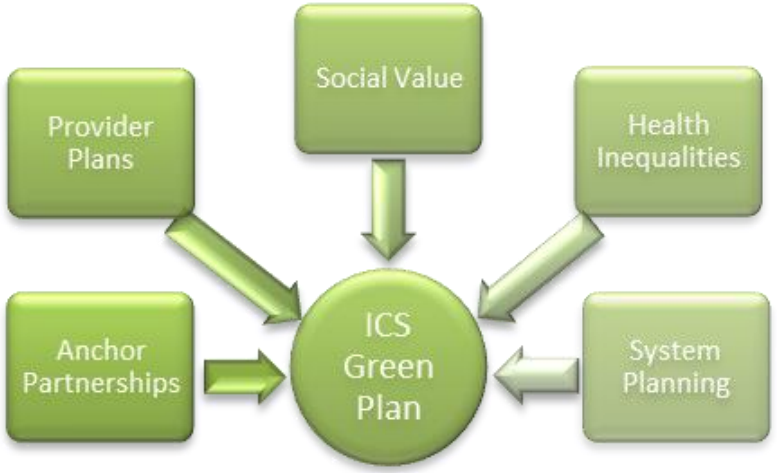
The Lincolnshire System Greener NHS Plan's vision, objectives and targets:



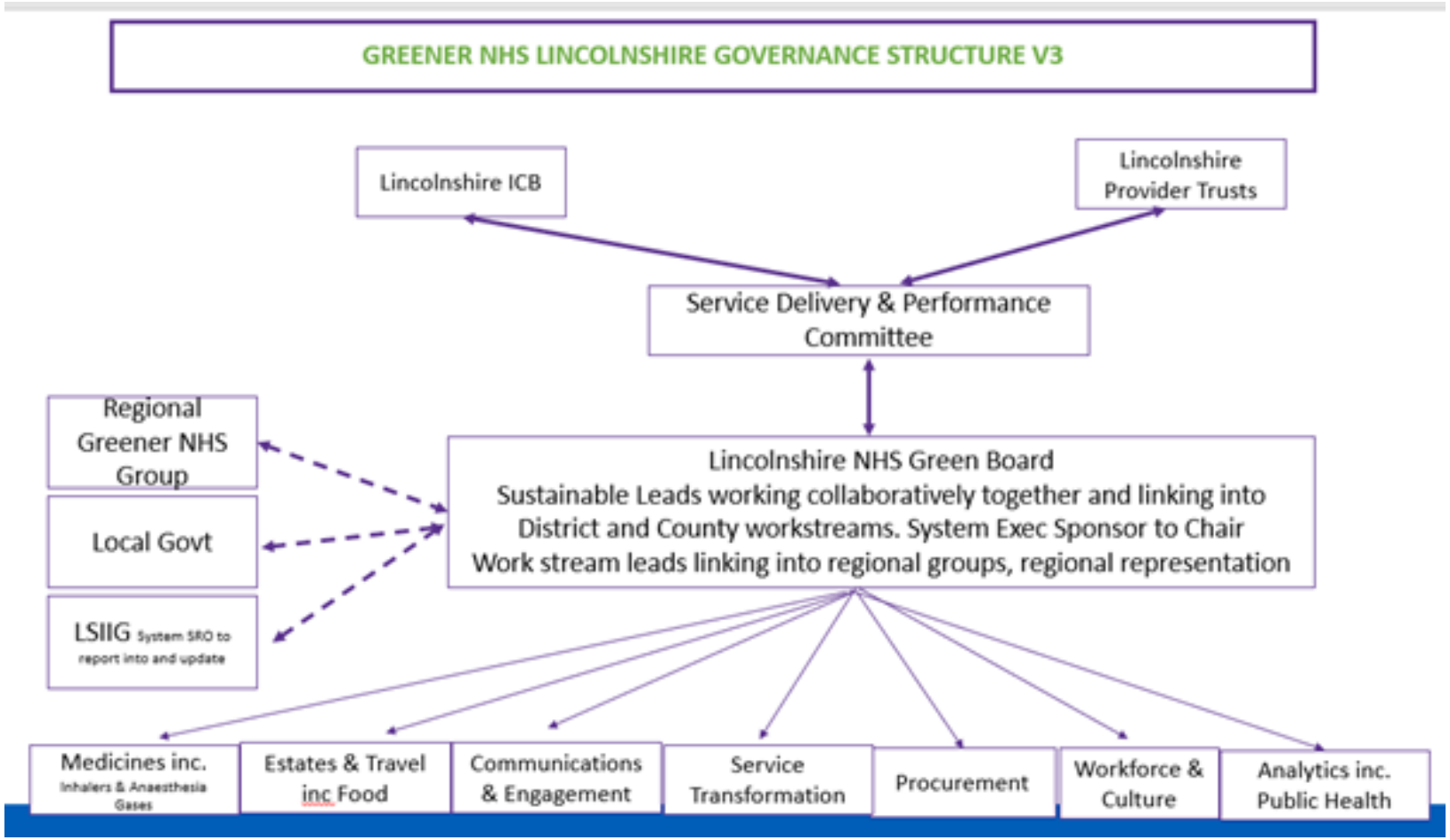
Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

The Lincolnshire NHS approach is as follows:



The Governance structure for the Lincolnshire Greener NHS is as follows:



Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

Areas of work include:

	• Work to deliver the NHSE Travel & Transport Strategy recognising the challenges in a rural and coastal county • NHS England » Net Zero travel and transport strategy • Working with District and County Council colleagues on EV charging
	• We have reduced the proportion of desflurane anaesthesia gas used in surgery to less than 5% of overall volatile anaesthetic gases with the aim to eradicate this completely. • Reducing the emissions associated with nitrous oxide waste, in line with the Standard Contract. • Reducing the CO2e impact of inhalers -this is part of the Primary Care Green Plan
	• Ensure plans are in place to phase out fuel oil as a primary heat source [in NHS Secondary Care sites], • Ensure all new builds and retrofits over £15m are compliant with the Net Zero Hospital Buildings Standards • ULHT and LPFT have bid for Public Sector Decarbonisation Scheme (PSDS) funding to improve the estate and reduce the Trusts carbon footprints
	• Ensuring that the Green Agenda is incorporated into all staff inductions across the system. • Work towards all staff complete the ESR training. • As the system leadership changes are embedded and the Group Model Established agree the Board leadership for the Green Agenda and appropriate awareness and training for Boards
	• All new NHS procurements include a minimum 10% net zero and social value weighting as per the PPN06/20 and PPN06/21 Greener NHS » Applying net zero and social value in the procurement of NHS goods and services (england.nhs.uk) • Achieving a 50% reduction in use of office paper by 2025 compared to baseline, and ensuring ICSs and NHS trusts only purchase 100% recycled content paper for all office and non-office-based functions by 2025.

Each provider Trust has its own Green Plan and assurance process. A final draft Primary Care Green plan is being socialised. The final draft version is already on the primary care intranet.
The primary care bulletin now includes a specific 'GREEN' section. Communications are being aligned to any national 'GREEN' event so we can promote with Practices.

Work will be completed by March 2024 on a system Carbon Footprint assessment. This will show the progress that has been mad, where we are on our net zero journey. This work is needed to support the trajectory planning needed to ensure we are able to meet the national net zero targets.

The communications leads across the System meet regularly to agree campaigns and responses to national and regional green messaging opportunities.

The Programme Director for Partnerships, Planning and Strategic Estate is working with colleagues in the County Council regarding climate change and climate mitigation. There is a proposal for setting up a Lincolnshire Climate Adaptation Forum which the NHS will be part of.

There are also countywide sustainability discussions the Greater Lincolnshire Strategic Infrastructure Group and the Greater Lincolnshire One Public Estate Board, both of which the NHS is represented by the Programme Director. This work includes energy, waste and EV charging

Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

System Maturity Assessment

As systems continue to take on greater collaborative responsibility for the delivery of a Net Zero NHS, programme performance issues should be addressed as close to the system as possible. Whilst regional teams will continue to have a role in managing programme development and performance; this responsibility should shift to the system as it matures.

In order to better align the regional Greener programme assurance regime with that of other regional programmes, the Midlands Greener programme will implement a system tiering model in 2024/25.

System programmes will be assessed based on their maturity within 7 domains and 4 criteria. Each domain will be weighted and based on the assessment criteria from each domain, a score will be generated, to divide systems into overall programme maturity tiers, from 1 (Emerging) through to 4 (Thriving).

The maturity assessments will be agreed between the system and the Regional team before the end of the financial year 2023/24 and this will confirm the level of “support” for 2024/25

Section 4: Planning, delivering and evaluating our service improvement

a) Intelligence: Opportunity identification, measurement and evaluation
b) Our system improvement framework
c) System governance arrangements

Intelligence generation and opportunity identification

The Lincolnshire ICS Joined Intelligence Dataset is one of the most advanced in the country. It combines record level, pseudonymised data from across some of our largest primary, secondary and acute care services including hospital, community, mental health, general practice and adult social care data. The dataset continues to be expanded, to include more essential data sources that help our ICS and decision makers to understand the needs, causes, outcomes and disparities of our populations.

Sub-licencing processes have been established so that our ICS partners and GP practices can access joined, pseudonymised data via our Optum Reporting Suite. This expands the analytical capacity we have across our ICS to maximise the value of the dataset and to enable PCNs and practices to investigate cohorts and outcomes within their own populations and act upon the intelligence. Support to access, interpret and utilise the intelligence continues through training programmes and access to skilled analysts.

Intelligence from the Joined Dataset is being used across the ICS at local level to identify opportunities, develop interventions, target support and evaluate outcomes, and at the system level to inform strategy development and major transformation. The ICS analytics community is being supported through a programme of learning and development opportunities, including peer to peer support.

The work is closely aligned with activities across the system including the development of the ICS Digital, Data and Technology Strategy and the development of data and intelligence platforms such as the Lincolnshire Health Intelligence Hub (https://lhih.org.uk) and Athena, AGEM's imminent replacement for their GEMIMA system.

Together these activities begin to change the way that the ICS intelligence and analytics community can work together. Opportunities for collaboration are increased through shared priorities and access to a shared, joined dataset, which provides a system view of activity as well as understanding of journeys and outcomes for cohorts of the population and individuals.

The way that analysts work with decision makers is also changing. The joined dataset and technical capabilities allow analysts to directly support decision making processes and discussions, moving understanding on much more quickly than ever before. Opportunities for improvement in outcomes for cohorts of the population can be quickly identified, and understanding of the characteristics and health service behaviours of those cohorts can be provided which can be key in developing interventions and alternative provision to improve outcomes. Cohorts can then be identified in primary care for direct intervention, and the impacts of intervention evaluated.

Short- and Medium-Term Priorities

- Continued understanding of the joined data that we have, its further development and improvement, and its best use
- Appropriate widening of the ICS Joined Intelligence Dataset.
- Continued onboarding of users.
- Intelligence & analytics workforce development.
- Continued support to end users of data and intelligence to encourage best use through action learning.
- Increasing collaboration across the ICS Intelligence & Analytics capacity.
- Development of new intelligence provision through the software and tools available within Athena
- Continued joint development of the Lincolnshire Health Intelligence Hub https://lhih.org.uk

Developing our system improvement framework

1. The driving ambition

Our ability to deliver on the ICS mandate to improve health and care at scale rests to a significant degree on the success of our collaboration.

As health and care services concurrently try to focus on longer term population health ambitions while addressing immediate challenges, we are increasingly thinking of improvement through the lens of system working.

Historically, the majority of improvement efforts have been focused on organisations and the services they provide, concentrated on acute hospital services and reliant on central direction.

Our ambition is to re-balance this thinking and develop Lincolnshire into a dynamic self-improving system that:

- Aligns top-down pressures for improvement relating to strategy, accountability and resource allocation with
  - understanding what matters to people and communities: not only responding to public preferences but also how we engage with people as empowered partners – which is intrinsically linked with the 'Our Shared Agreement' work developing a new social contract with Lincolnshire citizens; not only involving individual groups who have a particular need around care, but also looking at whole populations and working with communities to address inequity
  - responsiveness to staff: generating approaches to improvement that are owned by those doing the work – understanding that real change happens in real work
  - Incorporating peer-to peer learning, challenge and support, both within our system and beyond
- Supports the delivery of our big, bold population health improvement goals as well as care delivery; collaborating across all ICS partners to tackle the wider determinants of health and wellbeing; adopting appropriate methods – learning from other sectors e.g. unlocking community power to transform public services
- Reaches the parts of the health and care system that have not previously benefited from investment in improvement capabilities and resources
- Adopts the learning health system concept, which is focused on systematic, intelligence-driven improvement and predicated on the development of high-quality measurement and analytical capability
- Knows itself inside out in terms of understanding: population health needs; capacity and capability; developing a clear understanding of the relationship between investment and outcomes
- Legitimises improvement: achieving a culture shift with the emphasis on commitment not compliance, where improvement is everyone's business
- Enables stronger collaboration across organisations and more effective scaling of innovation
- Harnesses the power of the collective: making the most of all the resources and the expertise that exists in Lincolnshire, so the sum is greater than the individual parts

Developing our system improvement framework

2. The intended end-product

The Better Lives Lincolnshire Leadership Team has agreed to and is committed to the development of a framework that provides a cohesive approach to improvement, learning and innovation. This will focus on two main elements: creating the conditions for change; delivering transformation.

The emphasis is very much on framework rather than something overly prescriptive: agreeing common language and principles; incorporating a suite of resources and tools that can be best matched to the people involved and the problem that is being tackled; ensuring visibility of all the various support offers.

Creating the conditions for effective, sustainable improvement

- Creating collective understanding, vision and leadership
  - Co-creating a vision and narrative for change – considering the legacy and learning of previous improvement efforts; Assigning responsibility and building shared ownership for improvement; Building leadership support; Engaging all partners & communities – building relationships
- Aligning operating models to direct and enable improvement
  - Building consensus on what is best done at system level; Aligning resources and priorities; Balancing demand for rapid results & systemic transformation; developing goals and ability to measure progress; redesigning management systems to enable improvement
- Fostering the capability, connections and culture needed to learn and improve
  - Understanding current expertise and assets; Building skills and space; creating collaborative learning structures, networks and communities; ensuring learning is systematic

.

Enabling the planning and delivery of changes across the system, to transform care and improve outcomes

- System-wide diagnosis and redesign of pathways
  - Taking a whole population view of needs, inequities & assets; managing system shifts in infrastructure; diagnosing and redesigning end-to-end pathways and service models
- Continuously improving quality and service performance
  - Supporting work by service level teams; Understanding and optimising performance of the system as a whole; adapting roles, ways of working, metrics and linked systems
- Identifying and embedding innovations to meet future needs of the system
  - Understanding the current situation and desired futures; Identifying priority gaps and innovations; testing, experimenting, scaling and embedding innovations

This framework would encompass all assets, support offers and improvement methodologies e.g. Clinical & Care Directorate (leadership, pathway redesign & research & innovation), population health management; health inequalities; personalisation; provider improvement resource

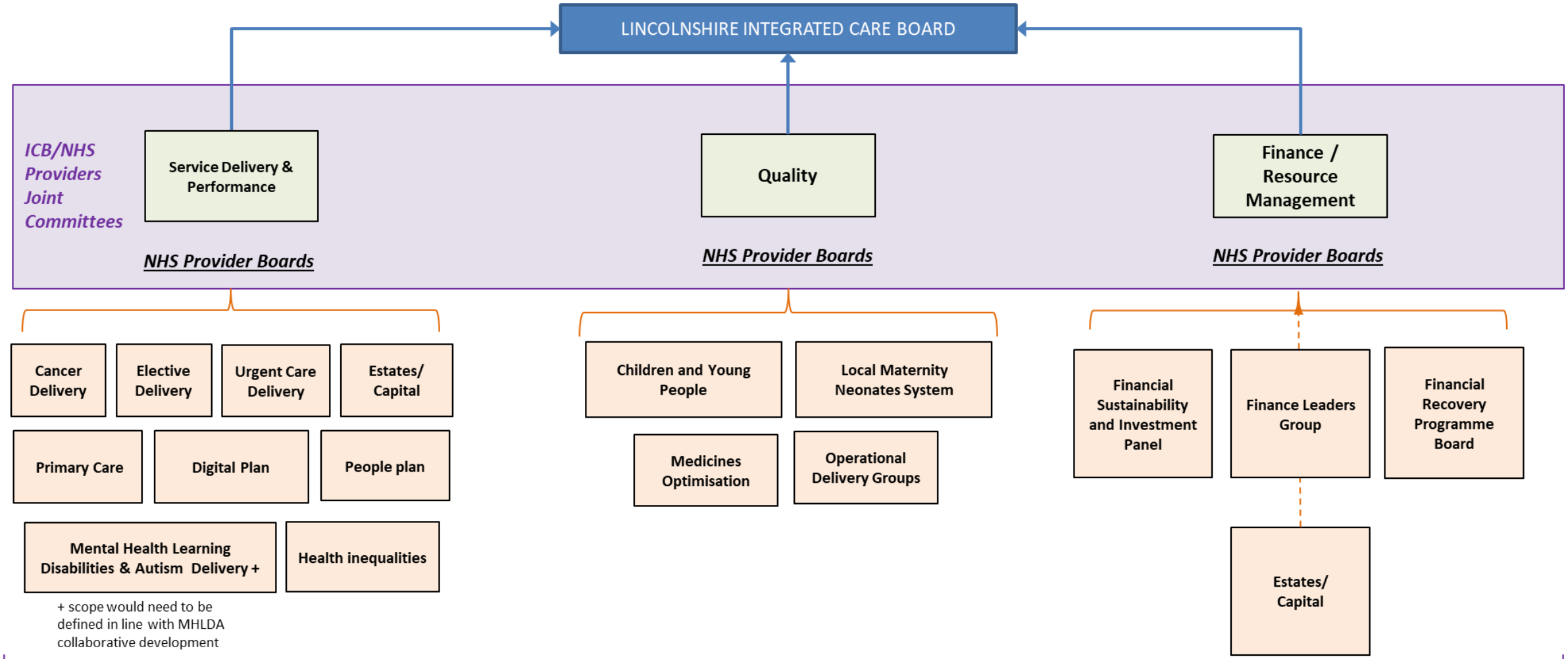
Developing our system improvement framework

3. The approach to making this happen

The headline plan for progressing this work is:

1a) Set up a working group Building on the QI Strategy working group membership, with representatives from: Lincolnshire County Council – Adult Social Care and Children's Services; Lincolnshire Integrated Care Board; United Lincolnshire Hospitals NHS Trust; Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership NHS Foundation Trust; Lincolnshire Primary Care Network Alliance; Lincolnshire Voluntary Executive Team; Lincolnshire Care Association; University of Lincoln 1b) Link in with the national support offers i.e. The Health Foundation and the NHS Confederation	March – April 2024
2) Draft up the framework - Building on and incorporating our work to date (e.g. QI and research Strategy development work; Integrating the LACE/PHM/Personalisation/Health inequalities offers; ADHD project) - Reflecting the outcomes of the NHS IMPACT self-assessment completed by the Lincolnshire NHS Trusts and Lincolnshire County Council (both Adult Social Care and Children's Services) - Using the Q framework, incorporating Lincolnshire's improvement assets & capabilities	April – May 2024
3) Test the framework on two system transformation initiatives Selection criteria: - Involvement of as many ICS partners as possible - Strategic fit: system priority; potential to improve outcomes for key population segments - Likelihood of success; requisite capacity in place - Helpful timescales – still yet to start but scheduled for Q1 2024/25 Proposed initiatives: - Children & Young People asthma (Children & Young People programme) - Respiratory (Integrating Specialist Care programme in the Primary Care, Community & Social Value portfolio)	June 2024 onwards

Overall system governance & oversight



Monthly reports covering

- Activity & Performance: delivery against the national objectives and other national metrics/LTP commitments (P132-136)
- Workforce: actual v planned trajectories for substantive, bank and agency
- Finance: existing FRP delivery against plan headlines; other key financial headlines: run rate; projected March 2024 position

Financial Programme Recovery Board meetings: Phase 2

Week 1	Week 2	Week 3	Week 4	[Week 5]

ICB FRP oversight meetings

ICB Finance and Resource Committee (FRC)

Core data and reporting

Pipeline full update report

Finance & CIP data available working day 8

Pipeline summary update

Fins/CIP & H2 reset update report

Financial Recovery Board (FRB) meetings

Wk1 FRB: 24/25 pipeline

Wk3 FRB: 23/24 FRP & H2 reset delivery

Progress review meetings with SID

Pipeline area deep dives as requested by wk1 FRB

Pipeline progress catch ups with all providers and cross cutting workstreams (indicative timings)

Attendance at key provider and workstream assurance meetings as useful to provide constructive check and challenge and assurance

Key FRB agenda items

Week 1 FRB agenda and attendees

Area	Commentary
ICB (30 mins)	ICB (30m)
Providers: 1:45hrs	LPFT:30m; LCHS:30m; ULHT:45m
Cross system work streams (1 hr)	To include pipeline workforce & longer term H2 reset actions
Notes	*To include break*

Week 3 FRB agenda and attendees

Area	Commentary
ICB (30 mins)	ICB (30m)
Providers: 1:45hrs	LPFT:30m; LCHS:30m; ULHT:45m
Items	*To include H2 reset workforce delivery.*

Core FRB attendees

Area	Board attendees
ICB	CFO and/or SID; CMO/ CNO; COO or equivalent
Providers	At least two Exec Dirs: CFO, COO; CMO/CNO; CPO; & relevant CIP leads

Area	Board attendees
ICB	CFO and/or SID; CMO/ CNO; COO or equivalent
Providers	At least two Exec Dirs: CFO, COO; CMO/CNO; CPO; & relevant CIP leads

Financial Programme Recovery Board meeting approach: Phase 2

Week 1 FRB Pipeline - agenda and attendees

30 mins	ICB	• Key actions update; • Update on FRP scheme delivery; • Productivity update;
30 mins	LPFT	• Per Group agenda below
30 mins	Work-streams 1	• Updates on workstream pipeline development progress for 24/25;
	Break	
30 mins	Work-streams 2	• Workforce medium long term • Focus areas as requested by FRB
1 hour 15 mins	Group: LCHS	• Key actions update; • Pipeline progress updates/phasing; • Ideation & delivery approaches; • Key opportunity areas (deep dives); • Productivity update (key areas); • AOB • *Outcome: FRB requests for further assurance.*
	Group: ULHT	

Organization	Board attendees
• ICB	• CFO and/or SID; CMO/ CNO; COO or equivalent
• Providers	• At least two Executive Directors: CFO, COO; CMO/CNO; CPO; & relevant CIP leads

Week 3 FRB H2 reset and pipeline - agenda and attendees

30 mins	ICB	• Key actions update; • H2 reset actions and delivery update;
30 mins	LPFT	• Per Group agenda below
30 mins	Work-streams	• Workforce short term controls (H2 reset); • Exception reporting for Workstream updates with 23/24 FRP impact;
	Break	
1 hour	Group: LCHS	• Key actions update; • H2 reset actions and delivery update • Delivery progress on full year FRP CIPs • Getting to recurrent run-rate impact of 24/25 schemes • AOB • *Outcome: FRB requests for further assurance.*
	Group: ULHT	

Organization	Board attendees
• ICB	• CFO and/or SID; CMO/ CNO; COO or equivalent
• Providers	• At least two Executive Directors: CFO, COO; CMO/CNO; CPO; & relevant CIP leads