NHS
Lincolnshire Community and Hospitals NHS Group

# Clinical Services Strategy
2026 - 2030



Caring and building a healthier future for all

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# Executive Summary

This Clinical Services Strategy sets out how Lincolnshire Community and Hospitals NHS Group (LCHG) will transform care delivery over the next five years, moving beyond organisational integration towards **fully integrated clinical pathways**, where patients experience care as a single, coordinated system.

The strategy responds to rising demand driven by an ageing population, increasing prevalence of long-term conditions, workforce pressures and persistent health inequalities. At its heart is a commitment to improving **quality, safety, outcomes and equity**, ensuring care is delivered in the most appropriate setting by the right team. The strategy aligns directly with the NHS 10-Year Health Plan through three fundamental shifts:

- **From treatment to prevention**, intervening earlier through population health and proactive care
- **From analogue to digital**, embedding technology, data and innovation throughout clinical pathways
- **From hospital to community**, delivering more care closer to home while focusing hospitals on specialist and complex need

These shifts are delivered through three interconnected clinical pillars:

**1. Responsive Urgent and Emergency Care**
Creating a coordinated urgent care system with a single front door, integrated triage, same-day care pathways and stronger community alternatives to hospital attendance and admission.

**2. High-Quality Acute and Specialist Care**
Focusing acute hospitals on complex, specialist and time-critical care, supported by the Acute Floor model, improved patient flow, elective hubs and centres of excellence.

**3. Integrated Out-of-Hospital Care**
Delivering coordinated care through Integrated Neighbourhood Teams (INTs), bringing together primary care, community services, mental health, social care and voluntary sector partners around population need.

A central component of the strategy is a sustained **left shift of care**, moving activity, workforce and resources out of hospital settings and into communities. This includes expanding community diagnostics, redesigning outpatient pathways, strengthening rehabilitation, increasing home-based care and growing virtual ward capacity.

Delivery will be enabled through a multi-year improvement portfolio structured around the Group's **Big Five Improvement Programmes**:

1. **Operational Improvement: Unplanned Care** – improving urgent and emergency care performance, patient flow and alternatives to admission.
2. **Operational Improvement: Planned Care** – reducing waiting times, increasing productivity and transforming elective and outpatient services.
3. **Flow and Transfer of Care** – improving discharge, rehabilitation and integration across acute, community and social care.
4. **Integrated Neighbourhood Teams Programme** – developing place-based, population-focused models of care.

5. **Left Shift Programme** – moving services closer to home through pathway redesign, community delivery and prevention-focused models.

LCHG will continue to strengthen its role in **education, research and workforce development**, supporting its ambition to progress towards **University Trust status**. The delivery of these ambitions will be articulated through the Group's **Research & Innovation Strategy** and **Workforce Plan**, ensuring clinical improvement is underpinned by innovation, learning and workforce sustainability.

**Our Future Vision**
By 2030, Lincolnshire will operate a **neighbourhood-based, digitally enabled and population-focused health and care system**, where services are organised around people, places and population need rather than organisational boundaries.

Residents will experience:
- Care delivered closer to home by default
- Earlier intervention and better prevention
- Easier navigation through a single coordinated system
- More personalised and digitally enabled care
- Reduced reliance on urgent and emergency services

Hospitals will remain focused on specialist, complex and time-critical care, while community, neighbourhood and home-based services become the primary setting for most care. This will reduce avoidable hospital activity, improve use of capacity, and ensure care is delivered in the most appropriate setting, improving outcomes, experience and sustainability.

By 2030 we will deliver:
- Better patient and resident outcomes
- Safer, higher-quality care
- Improved patient and staff experience
- Reduced unwarranted variation
- Reduced health inequalities
- More care delivered closer to home
- Improved access, flow and productivity
- A more sustainable health and care system

Ultimately, this strategy provides a clear roadmap for delivering a health and care system where:
- The system is proactive rather than reactive
- Hospitals are centres of excellence for specialist and complex care, not the default entry point
- People experience joined-up, continuous care across organisational boundaries
- Technology and data are fully embedded in care delivery
- Health inequalities are reduced through targeted, neighbourhood-based approaches
- Quality, safety, outcomes and value drive decision-making at every level

Together, these changes will create a more resilient, sustainable and equitable health and care system for Lincolnshire, improving outcomes and experience for patients while ensuring services remain fit for the future.

# 1. How have we developed this clinical service strategy?

This Clinical Services Strategy has been in development over a sustained period of time and reflects the continued evolution of our organisations as we have come together to form **a single Group**. Since the establishment of Lincolnshire Community and Hospitals NHS Group in 2024, we have been working collectively across acute and community services to deepen our understanding of the services we provide, the needs of our population, and the opportunities to deliver care differently.

This has been a deliberate and phased process, bringing together organisations with different cultures and service models to create a shared vision for **integration in delivery, not just in structure**.




The strategy has been shaped through extensive engagement with **patients, staff and wider stakeholders**, including surveys, workshops, patient panels and population health discussions. Detailed work has been undertaken with internal and external stakeholders via established forums and dedicated workshops in 2024 which included:

- Clinical Strategy Leadership Engagement Workshops
- Patient Survey
- Staff Survey
- Patient Panel Session
- Population Health Workshops

### What have we learnt from our patients?

- Out of 125 patients we engaged with, most of them are satisfied with the services.
- 20% of our patients felt that the most important area to focus on was to reduce waiting times and that our Clinical Services Strategy should be based around achieving this.
- We need to explore the integration of services and pathways and improve access to the broader range of NHS services we have the potential to offer.
- A focus needs to be placed on the improvement of the experience within our Emergency Department (A&E).
- Patients asked us to improve communication and implement innovative and effective digital solutions.
- Patients would like shared decision-making practices and personalised care.
- Patients tell us they are facing challenges when trying to access both General Practice (GP) surgeries and Dentistry, so we need to explore the opportunity to understand how we can provide wider support to various other services.

- A&E, Cancer, Frailty, and other long-term conditions need to be listed as clinical improvement priorities.
- There needs to be timely access to diagnostics, and we need to continue implementing Community Diagnostic Centres (CDC) across the County whilst aiming to provide 7-day services, 24 hours per day.
- We need to continue in the development and improvement of our Estates to make them more suitable for the provision of services

### What have we learnt from our staff?

We received 344 responses from our staff, detailing what they felt are the key areas of development. The improvement opportunities identified are listed below.

| | |
|---|---|
| Workforce | ❖ Safer levels of staffing.<br>❖ Better wellbeing and culture of staff through having a 'Just Culture', competitive rates of pay, clinical education, improved career development pathways and closer working relationships with the Organisation Development team. |
| Digital Transformation | ❖ This came out repeatedly in the staff survey and speciality reviews and has been recognised as a common trend.<br>❖ Too many different systems that don't work interoperate with each other and have poor connectivity, so there is a need to streamline and standardise digital systems across the organisation. For example: there is no standard Electronic Patient Record (EPR) across the Trusts that communicates with external partners too.<br>❖ Too many systems cause Clinicians to have multiple log ins across a range of systems – a single log in across systems and programmes would reduce wasted time. |
| Quality Improvement | ❖ As highlighted in patient feedback, staff see the need to urgently reduce waiting times.<br>❖ The experience within A&E needs to be improved and will be aided by improving the patient flow and transitional care for medically optimised patients.<br>❖ There is a need to work more closely with system partners in Lincolnshire to support care closer to home. This will require a focus from all NHS providers on admission avoidance, in line with the NHS Long-Term Plan.<br>❖ To improve effectiveness by ensuring all services operate 7 days per week (Pharmacies, Therapies, and weekend discharge & flow).<br>❖ Address fragile services. (For example: Haematology, Oncology) |
| Outpatient Improvement | ❖ This links back to the feedback from patients regarding the requirement to have better communication as they have often been misinformed leading to missed appointments or had late letters meaning an increased number of 'Did Not Attend' (DNA) issues.<br>❖ Improving this would improve the rates of cancellation and DNAs and would require a standard set of clinic templates and related paperwork. |
| Estates | ❖ The estates and facilities were appropriate at the time they were built but as time has gone on, there has become a need to modernise facilities across the estates. |

| | |
|---|---|
| | ❖ There is a need to complete a clinical adjacencies programme to align specialities and a strong supporting capital development plan for outdated estate. |
| Service Gaps | ❖ There needs to be service developments to allow referrals into Physiotherapy, Frailty, Pre-habilitation and Pain Management. |

## How has this influenced our Clinical Services Strategy?

Feedback from patients and staff has shown that, while overall experience is positive, there are clear opportunities to improve over the next five years. This has shaped the Clinical Services Strategy's key priorities: reducing waiting times, organising care around population needs, strengthening partnership working and integrated pathways, investing in digital and innovation (including EPR), and ensuring estates enable more coordinated and effective service delivery across the system.

## How are we going to continue our engagement?

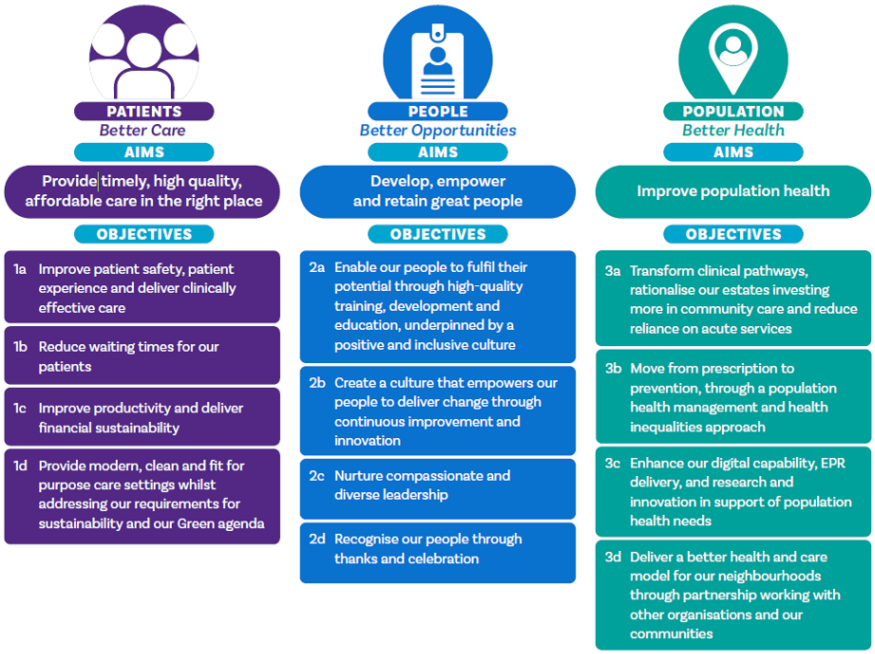
Engagement is key and we know that this is just the start of a journey to continue "**caring and building a healthier future for all**" across Lincolnshire. We will continue engaging and co-producing with our patients and staff and work with wider partners and stakeholders across the health system, utilising current forums such as our Patient Panel to gather feedback as we move through the delivery of new models of care. We will develop an LCHG Co-production strategy to support the embedding of Personalisation within LCHG. This will include working with patients, carers and local communities as partners in pathway redesign, recognising that people who use services are often best placed to identify duplication, waste, delays and unnecessary complexity in current pathways.

This also means communicating in ways that are clear, accessible and meaningful to residents, recognising differences in health literacy, language, digital confidence and personal circumstances. As pathways change, communication will need to explain not only what is changing, but why it is changing, what it means for people using services, and how residents can influence the design and delivery of care.

As delivery progresses, detailed pathway models and service changes will continue to be tested with operational teams, clinical leaders, patients and system partners. Where changes require formal engagement, consultation or decision-making, these processes will be followed to ensure that the strategy sets direction without predetermining specific outcomes.

## How does it all fit?

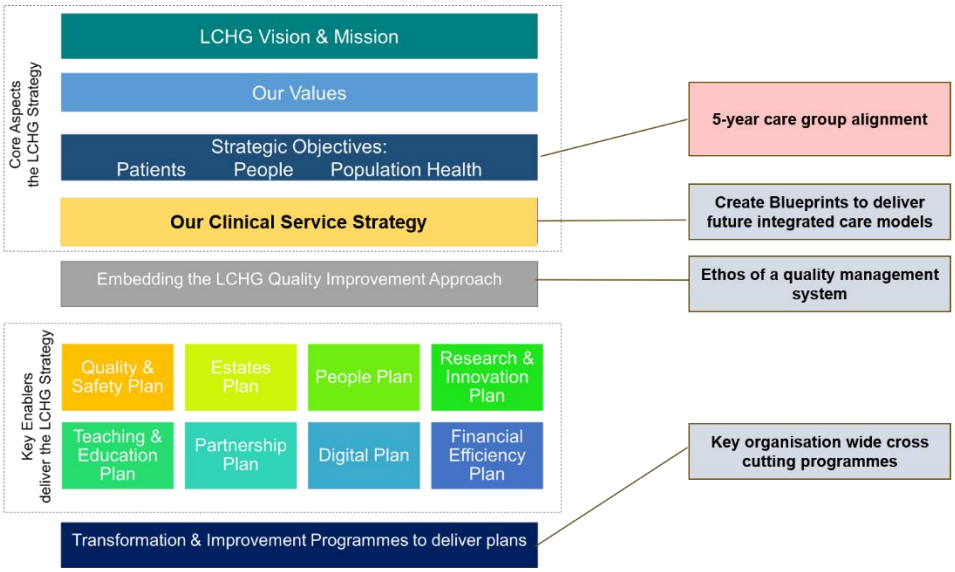
The **Trust Strategy 2025–2030** is the Group's overarching strategic framework, setting out the vision, values, strategic objectives and intended outcomes for patients, people and population health. It defines the long-term ambitions of LCHG and provides the overall direction for the organisation.




*LCHG 2025-2030 Strategy*

The **Clinical Services Strategy 2026–2030** sits beneath the Trust Strategy and describes how those ambitions will be achieved through the future clinical operating model. In essence:

- The **Trust Strategy** defines **what we want to achieve**
- The **Clinical Services Strategy** defines **how care will evolve to achieve it**




The Clinical Services Strategy provides the blueprint for future models of care, describing how services will be organised across urgent care, acute care and neighbourhood delivery. It establishes the common clinical direction for the Group and provides a shared framework for service transformation.

Importantly, the purpose of the Clinical Services Strategy is **not to describe every aspect of delivery**. The detailed actions, investments, workforce requirements, digital

developments, infrastructure plans and improvement programmes sit within a series of supporting enabling strategies.

The **breadth of delivery sits within these enabling plans, not within the Clinical Services Strategy itself**. Their role is to provide the capabilities, resources and infrastructure required to deliver the future clinical model. The role of the Clinical Services Strategy is to ensure those plans are aligned behind a single vision for how care should be delivered.

These enabling plans provide the capability required to deliver the future clinical model (see table below).

| Enabling Plan | Contribution to Delivery |
|---|---|
| **Workforce** | Future workforce models, skills and leadership |
| **Digital** | Information sharing, digital access and coordinated care |
| **Estates** | Estates and facilities aligned to the future care model |
| **Quality & Safety** | Improvement, assurance and reduction in variation |
| **Research & Innovation** | Evidence-based care and adoption of innovation |
| **Partnership** | Delivery across organisational boundaries |

Running throughout the strategy is the **LCHG Quality Improvement Approach**, which provides the organisational philosophy for how change is delivered. Rather than improvement being a series of isolated projects, the strategy adopts an ethos of continuous improvement, reducing variation and embedding a quality management system across the Group.

Finally, the strategy is delivered through a portfolio of **Improvement Programmes**, which translate strategic ambition into operational change. These organisation-wide programmes provide the practical mechanism for implementing new pathways, improving services and delivering measurable benefits for patients, staff and populations.

Together, this creates a clear line of sight from the Group's vision and strategic objectives, through the Clinical Services Strategy, to the enabling plans and transformation programmes that will deliver change in practice. This ensures that every programme, investment decision and enabling strategy is aligned to a single clinical ambition: delivering high-quality, sustainable and integrated care for the people of Lincolnshire.

# 2. Driving Principles

This Clinical Services Strategy is underpinned by a small number of core principles.



# 3. Health Inequalities and our Population Need

Lincolnshire is a large, predominantly rural county with a population of around 780,000, increasing to over **825,000 registered patients** due to seasonal variation. Health need varies significantly across the county, shaped by differences in **deprivation, access, demographics and outcomes.**

The population is spread across **urban, coastal and rural communities**, with population density around a third of the national average. While overall deprivation aligns with England, this masks marked local inequalities. Coastal communities such as **Skegness and Mablethorpe are among the most deprived in England**, while areas such as Lincoln are relatively more affluent. Rurality adds further challenge, with limited transport and access to services, in some areas **only around one third of residents can reach a GP within 15 minutes**.

Lincolnshire's population profile contributes to increasing demand:

- **23% of residents are aged over 65 (vs 18% nationally)**
- Over **50% live with high need or long-term conditions**
- Higher rates of **smoking (15.4%), obesity (67.6%) and physical inactivity (58%)**

These factors are leading to rising levels of **frailty, multimorbidity and complex need**, placing sustained pressure on services. Health inequalities in Lincolnshire are strongly **place-based**, with around **15% of the population living in the most deprived quintile**, predominantly in coastal and some urban areas where outcomes are poorer and reliance on urgent and emergency care is higher.

In contrast, rural and market town communities often have different challenges, with inequalities driven by **distance from services, transport limitations and digital exclusion**. Together, this creates a **distinctive pattern of coastal deprivation and rural access inequality**, shaping demand, access and outcomes across the system.

Population Health Management data reinforces this, showing that a **disproportionate share of resource is consumed by a relatively small, high-need population**, largely through reactive care models.

Lincolnshire is uniquely positioned to respond, with one of the **first fully linked, person-level datasets covering 100% of the population**, integrating primary care, hospital and social care data. This enables a clearer understanding of need, earlier identification of risk and more targeted intervention.

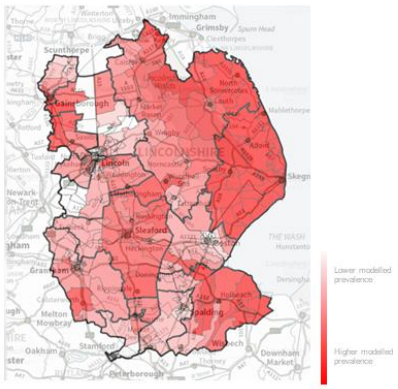
**How Health Inequalities Shape Demand and Service Use**

Health inequalities in Lincolnshire are not evenly distributed and are a key driver of variation in demand, access and outcomes across the system. This is reflected

clearly in patterns of service use, where a relatively small proportion of the population accounts for a disproportionate level of activity.

Respiratory disease provides a clear example of how these inequalities translate into clinical activity and system pressure in the figure:

- **114,000 people living with respiratory conditions**
- **~285,000 outpatient appointments annually**
- **34% attend A&E each year**, including **4,500 frequent attenders**

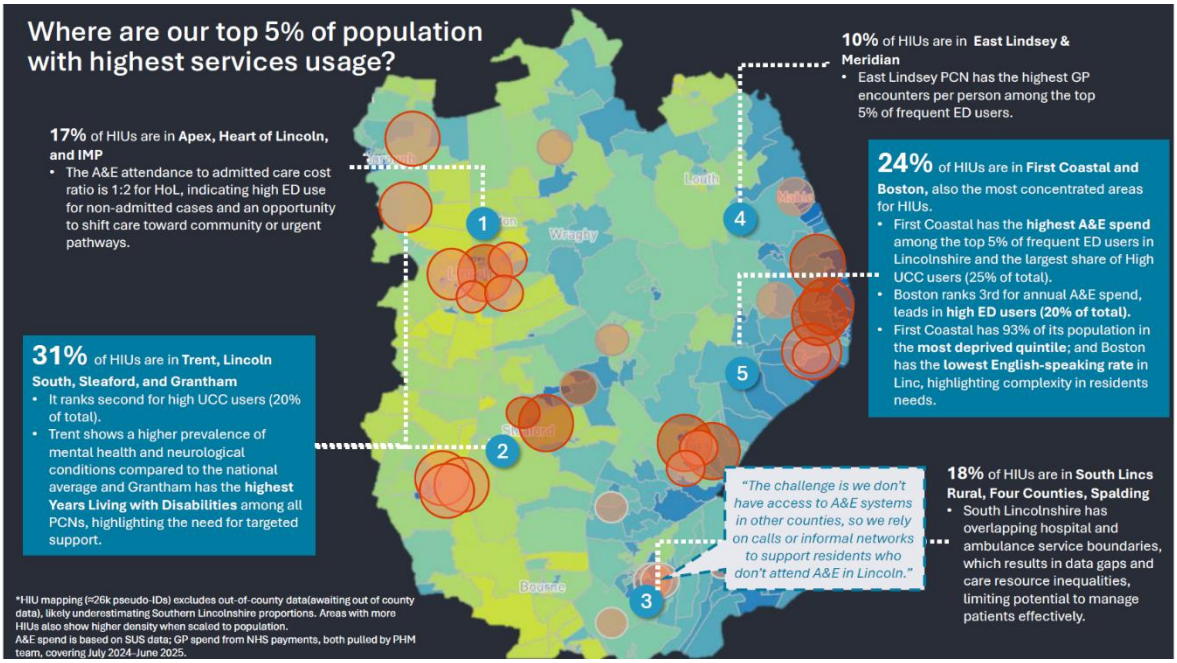


The following map shows the prevalence of COPD in Lincolnshire at lower super output area (LSOA) across Lincolnshire for 2022/23 modelled by the dominant registered GP practice prevalence for each LSOA.

Higher prevalence and service use are concentrated in more deprived coastal communities. This reflects a system that is often responding to **advanced disease and deterioration**, rather than preventing it earlier in the pathway. As a result, avoidable demand flows into urgent and emergency care.

A similar pattern is seen in **high-intensity users**, who represent a growing cohort of people with complex and often unmet needs. This group:

- drives a significant proportion of acute demand
- includes many patients not consistently supported by community services
- has seen **high-frequency ED use more than double in recent years**




Source: Lincolnshire System Flow Diagnostic, Newton, August 2025

- **75% of acute demand is generated by just 5% of the population (high intensity users)**
- These same people account for **36% of Emergency Department attendances**

- **70% of the population don't use acute services.**

This highlights that need is concentrated, and a uniform model of care cannot effectively respond to the complexity and scale of demand seen across the county.

At an individual level, this results in repeated and uncoordinated system contact. For example:

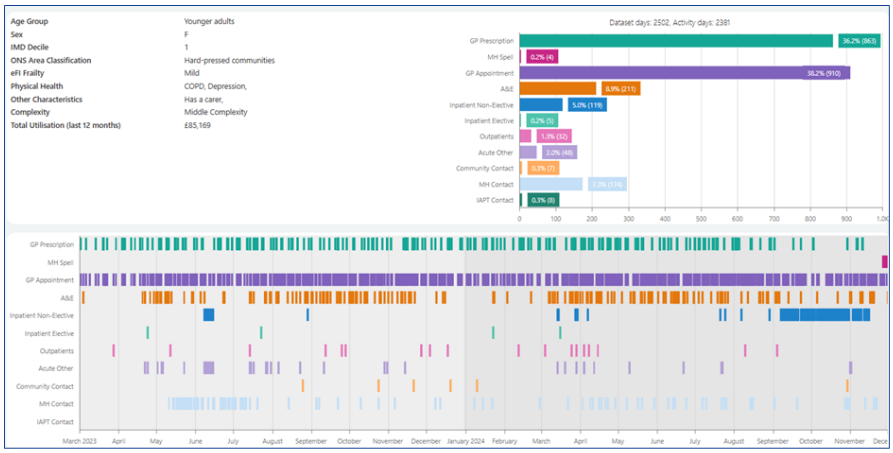
- One patient attended **A&E 211 times in a year**
- Generated **~£85,000 in system cost**
- Had multiple interactions across primary care, mental health and acute services

A patient theographic from the PHM linked dataset can show us the interactions an individual is having with health and care settings.

The patient shown is a young female adult, living in the most deprived areas of Lincolnshire. She has COPD and Depression as well as having a carer.

**Total system spend in the last 12 months is £85k**

She has high level of Primary Care Prescriptions, GP Encounters, MH Contacts and has accessed **A&E 211 times**




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Evidence shows that much of this demand is avoidable with the right model of care:

- **83% of high-intensity users could have reduce their ED and UTC attendance with coordinated care**
- **50% could have seen their admissions reduce**

**What This Means for Our Clinical Model**

Current models are not consistently reaching those most in need. Many high-intensity users have **no contact with community services**; identification remains **reactive rather than proactive**. As a result, care is often delivered **too late and in crisis**, reflecting gaps in coordination and pathway design.

This evidence shows that health inequalities are not only a population health issue, but a **primary driver of demand and variation** across the system. The current model, largely reactive and hospital-focused, is not aligned to need, with our population, particularly those with complex conditions, not receiving coordinated, preventative care.

Addressing this requires a **fundamental shift in the clinical model** to one that is:

- **Neighbourhood-based and population-focused**
- **Proactive in identifying and managing high-risk and high intensity use cohorts**
- **Integrated across acute and community services**
- **Rebalanced toward care closer to home**

This represents a **system-wide redesign**, delivered through Integrated Neighbourhood Teams, underpinned by left shift principles, co-created with our population and enabled by population health data to better target need, coordinate care and improve outcomes.

It should be recognised that delivering this scale of change will depend on shared understanding and commitment across system partners. Many of the pathways described in this strategy, including discharge, neighbourhood coordination, care home support, prevention and step-down care, cannot be delivered by LCHG alone. They require continued alignment with primary care, local authorities, voluntary sector partners and wider system providers, with a collective understanding of both the case for change and the model of care required to respond to it.

| Shift | What We Will Do | What This Means in Practice |
|---|---|---|
| **Reactive to Proactive Care** | • Identify high-risk patients before crisis<br>• Use population health data to manage key cohorts:<br>– High-intensity users<br>– Frailty and end-of-life patients<br>– Children and young people with high ED use | Population segmentation and risk stratification<br><br>Care will be **planned and anticipatory**, not triggered only at the point of crisis<br><br>Prevention/more activity upstream to intervene earlier |
| **Fragmented to Coordinated Care** | • Deliver care through multidisciplinary teams<br>• Ensure patients in priority cohorts have:<br>– Named coordinator<br>– Shared care plan<br>– Clear system oversight | Care will be **organised around the patient**, with fewer handoffs and duplication<br><br>**Data sharing** will be the norm to ensure better coordination and more effective response |
| **Hospital-Centric to Neighbourhood-Based Care** | • Shift most care into Integrated Neighbourhood Teams<br>• Focus hospitals on specialist and complex care<br>• Better understand and utilise our collective neighbourhood assets | More care delivered **closer to home** through coordinated through INTs community, mental health, health and social care and primary care teams |
| **Access by Default to Access by Design** | • Create pathways easier to access than ED<br>• Improve same-day access, especially for:<br>– Children aged 0–4<br>– Low-acuity urgent care | Patients will use community services because they are **simpler, faster and more effective** |
| **One-Size-Fits-All to Targeted Intervention** | • Focus resources on:<br>– High-need neighbourhoods<br>– High-intensity cohorts | Services will be **tailored to need**, not delivered uniformly |
| **Activity Based to Outcomes and Value** | • Reduce avoidable acute activity<br>• Scale only interventions that:<br>– Reduce hospital demand | Success measured by **reduced ED use/bed days, LOS reduction, admission avoidance, attendance** |

| | | |
|---|---|---|
| | – Improve outcomes and experience | **avoidance and improved continuity with better outcomes** |
| **Pilots to System-Wide Delivery** | • Move from fragmented pilots to consistent models<br>• Build delivery infrastructure to:<br>– Mobilise and scale change<br>– Track benefits<br>– Sustain transformation | Change will be **implemented at scale and embedded**, not isolated or short-term<br><br>**What doesn't work will be stopped** and something else started in its place |

# 4. The Lincolnshire Clinical Operating Model

The most significant transformation set out in this strategy is the shift toward a system where care is delivered predominantly in **community and neighbourhood settings**, supported by more focused and specialised acute provision. This represents a move away from fragmented, reactive models toward a **coordinated, population-based system designed around our population need**.

The purpose of this model is to improve quality, safety, outcomes and sustainability by reducing unwarranted variation, supporting earlier intervention and delivering more consistent, coordinated care

We are already building this model through programmes such as the **Acute Floor, ED triage, Patient Services Hub**, **Hospital @ Home, virtual wards, Care Coordination Hubs and Integrated Neighbourhood Teams**. **Supported by Electronic Patient Records and other digital enablers/innovations that allow our patients to access and our teams to deliver care in more convenient and accessible ways.**

Over the next five years, this will evolve into a system where residents are supported continuously and proactively, where risk is visible in real time, intervention happens earlier, unplanned care is turned back into planned care, and reliance on acute hospital care is significantly reduced.

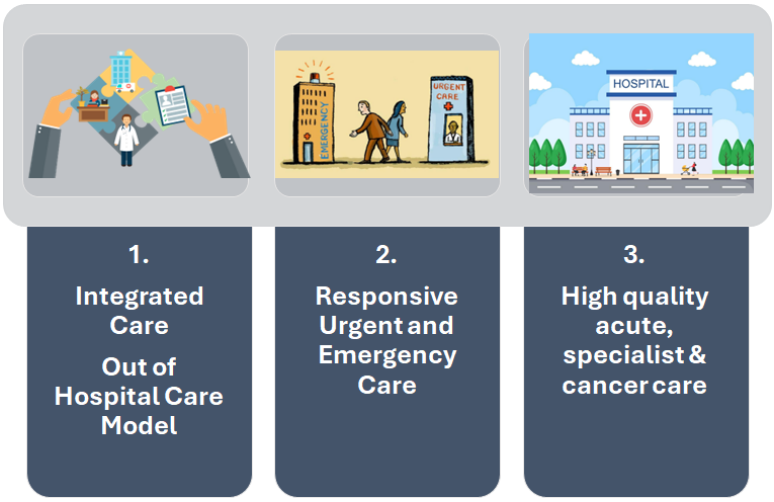
**A Life-Course Model of Care**

The Lincolnshire Clinical Operating Model is intended to support people across the life course, from maternity and neonatal care through childhood, adulthood and older age. Maternity, neonatal, children and young people's services will therefore be part of the wider shift toward more coordinated, preventative and neighbourhood-based care, while maintaining access to specialist and acute services where clinically required.

This means strengthening links between maternity, neonatal, paediatric, community, primary care, therapy, education and wider partner services, so that families receive more coordinated support and pathways are less fragmented. Detailed pathway development will continue through care group plans and operational delivery plans,

but the strategic direction is clear: these services must be part of the future integrated model, not separate from it.

**Three Pillars of the Future Model**
Our future model of care operate as **one integrated system**, connected through shared pathways, real-time data and multidisciplinary teams.




**Our clinical operating model**

### a. Integrated Out of Hospital Care – The Engine of Transformation (2030 State)

By 2030, the majority of care in Lincolnshire is delivered through a **neighbourhood-based, integrated model**, which forms the foundation of the entire health and care system. Integrated Neighbourhood Teams (INTs) are the **default unit of care delivery**, bringing together primary care, community services, mental health, social care and the voluntary sector. These teams provide **proactive, coordinated and continuous care** for defined populations.

This includes support for children, young people and families, where integrated community, primary care, therapy, health visiting, maternity, neonatal and wider partner services will play an important role in prevention, early intervention and coordinated care. The intention is to strengthen support around families and local communities, while ensuring timely access to specialist advice, assessment and escalation when required.

The model described here improves quality by supporting earlier identification of risk, reducing fragmentation, improving continuity and enabling people with complex needs to receive more coordinated care before crisis occurs.

#### *Neighbourhood-Based Delivery*

**Integrated Neighbourhood Teams (INTs)** aligned to Primary Care Networks and serving populations of approximately 30,000 to 70,000 people. These teams bring together:

- General practice
- District Nursing, community nursing, therapies and wider community services
- Mental health services
- Social care

- Voluntary and community sector partners

Care delivery is characterised by:

- Proactive management of long-term conditions
- Early intervention to prevent deterioration
- Coordinated care for complex patients
- Greater use of diagnostics and outpatient activity in community settings

This reduces reliance on hospital services while improving outcomes and patient experience.

### *Local Population Priorities and Workforce Alignment*

The Out of Hospital Care model is operationalised through clearly defined neighbourhood footprints, each aligned to **Primary Care Networks (PCNs), mental health hubs and population health priorities**, with tailored workforce models to meet local need.

Across Lincolnshire:

- **INT-1 Gainsborough** focuses on cardiovascular risk and obesity, supported by pharmacists, health coaches and social prescribing
- **INT-2 Lincoln** addresses complex multimorbidity including Chronic Kidney Disease, diabetes and mental health, with integrated nursing, pharmacy and mental health practitioners
- **INT-3 Louth and Wolds** prioritises respiratory, MSK and diabetes, supported by specialist nurses and rehabilitation teams
- **INT-4 Skegness and Mablethorpe** focuses on cardiovascular disease, diabetes and hypertension in a high-deprivation coastal population
- **INT-5 Sleaford** targets cardiovascular risk and long-term conditions through integrated primary and community workforce
- **INT-6 Grantham** focuses on frailty, dementia and mental health alongside long-term conditions
- **INT-7 Boston** addresses high levels of multimorbidity, cancer and deprivation through a broad multidisciplinary workforce
- **INT-8 Spalding** focuses on cardiovascular disease and stroke prevention with strong LTC management and care coordination

Each INT aligns its workforce, such as pharmacists, advanced practitioners, therapists, health coaches and social prescribing teams to meet these needs, ensuring **resources are targeted where they have the greatest clinical and population impact**. We will work with system partners to strengthen INT teams with the right skills mix for the needs of the population, and we will work closely with the population within these neighbourhoods to ensure that services meet their needs and support equitable access and outcomes.

These locality priorities are intended to illustrate how population health intelligence can guide targeted intervention. They do not imply that access to services is restricted by geography or by single conditions; rather, they support a more tailored approach to improving outcomes based on the needs of local populations.

### *Population Health and Targeted Interventions*

Population Health Management underpins delivery, with a clear focus on **measurable outcomes and targeted interventions** for key population groups.

Priority areas include:

- **Falls and frailty**
- **Cardiovascular disease (CVD)**
- **Diabetes and obesity**
- **Dementia**
- **Musculoskeletal (MSK) conditions**
- **Respiratory disease (COPD and asthma)**

Each priority is supported by:

- Defined **metrics** (e.g. admission rates, disease control, screening uptake)
- Linked **data sources** (e.g. primary care, hospital and community data)
- Specific **INT-led interventions**, such as:
    - Falls prevention and frailty MDTs
    - Cardiovascular screening and lifestyle interventions
    - Structured diabetes education and weight management
    - Dementia support and advance care planning
    - Community MSK and rehabilitation pathways
    - Pulmonary rehabilitation and inhaler optimisation

This transformation will reduce inequalities, improve outcomes and ensure that care is delivered **in the right place, at the right time, by the right team**, supporting a more resilient and sustainable health system for Lincolnshire.

## b. Responsive Urgent and Emergency Care- 2030 Future State

By 2030, urgent and emergency care across Lincolnshire operates as a **coordinated, system-wide response**, where hospital attendance is no longer the default for urgent need.

People access care through a **single, integrated front door**, combining digital access, NHS 111 and local coordination hubs. Every contact results in **rapid clinical triage**, supported by real-time system data, ensuring individuals are directed immediately to the most appropriate service.

This integrated front door will combine digital access, telephone triage, care coordination and local operational oversight into a single, coherent model of entry to services. Over time, this will provide residents and professionals with a clearer and more consistent route into urgent care, reducing duplication, avoiding unnecessary hand-offs and ensuring that people are directed to the right service first time. It will also support a more proactive use of system capacity, with digital triage and real-time coordination helping to match demand to the most appropriate community, neighbourhood or hospital-based response.

Where clinically appropriate, this will include booked urgent care and scheduled same-day access, helping to create more order in urgent pathways and reducing the need for patients to default to walk-in hospital-based services.

The quality and safety aim is to reduce avoidable delays, hand-offs and unnecessary attendance, while ensuring that people with urgent need receive timely assessment, senior decision-making and the right response first time.

Urgent care is delivered predominantly **outside hospital settings**, with same-day responses available through:

- Integrated neighbourhood teams
- Urgent community response services
- Home visiting and virtual care models

As a result, the majority of urgent needs are **assessed and managed without hospital attendance**.

Hospitals now focus on **time-critical and life-threatening conditions**, with Emergency Departments reserved for patients requiring immediate specialist intervention. The wider urgent care system provides **equivalent or faster alternatives** for lower-acuity need, making hospital attendance the exception rather than the norm.

Care coordination hubs provide **real-time visibility of demand and capacity across the system**, enabling dynamic deployment of clinicians and services. Services such as Urgent Community Response (UCR), CEMS, LIVES, virtual wards and Hospital at Home are integrated. This ensures that:

- The **right professional responds first time**
- Patients are **not redirected between services**
- Care is delivered **quickly, locally and effectively**

This model has reduced avoidable Emergency Department attendances and ambulance conveyances, while improving patient experience and system flow. Urgent care is now **proactive, coordinated and community-based**, rather than reactive and hospital-centric.

### c. High-Quality Acute and Specialist Care- 2030 Future State

By 2030, acute hospitals across Lincolnshire operate as **centres of excellence for complex, specialist and time-critical care**, within a broader integrated system. Hospital activity is **highly focused**, with the majority of routine and lower-complexity care delivered outside acute settings. Hospitals no longer act as default locations for assessment, monitoring or follow-up.

Acute services concentrate on:

- **Complex and high-acuity care**
- **Specialist and tertiary services**
- **High-volume planned care through elective hubs**
- **Centres of excellence** such as cancer, stroke and cardiology

Concentrating specialist expertise and improving clinical adjacencies will support safer, more reliable care, reduce unwarranted variation and improve outcomes for patients requiring complex, specialist or time-critical intervention.

This will be delivered through consolidation of expertise, improved clinical adjacencies, expansion of day-case and short-stay pathways, and improved elective productivity. We will work closely with other acute trusts across the region to ensure the Lincolnshire population receive equitable specialist and tertiary services as close to home as possible.

### *Site Configuration and Pathway Redesign*

A core enabler of this model is the development of a **"hot and cold" site configuration**:

- **Lincoln and Pilgrim hospitals** will operate as "hot" sites, delivering urgent, emergency and complex care with co-located EDs and UTCs.
- **Grantham Hospital** will operate as a "cold" site, focused on planned elective care, supported by an Urgent Treatment Centre and step-down beds.
- **Louth, Skegness, Johnson and John Coupland Hospitals** will operate as local cold sites, delivering planned care, diagnostics, day-case activity and rehabilitation, and Urgent Treatment Centres, alongside step-down beds and frailty pathways. They form a **distributed network of elective and recovery services**, enabling care to be provided closer to home while releasing capacity in acute hospitals for complex and emergency care.

This separation protects elective pathways from emergency pressures, reducing cancellations and improving reliability. It also enables greater productivity in planned care and supports system resilience, particularly during periods of high urgent demand.

The development of Grantham District Hospital as a dedicated elective site also creates opportunities for **regional collaboration**, including large-scale elective models such as the proposed **East Midlands Elective Orthopaedic Centre.** This approach supports delivery of **high-volume procedures at scale**, improves consistency of outcomes and reduces reliance on the independent sector.

Advances in technology, including minimally invasive techniques and digital monitoring, will support shorter lengths of stay and further reduce reliance on inpatient care.

### *The Acute Floor Model: Enabling Flow-Based Care*

At the centre of the future acute model is the **Acute Floor**, which redesigns urgent and emergency care in 'hot' sites around **flow, assessment and early decision-making**, rather than inpatient beds.

The current system is under sustained pressure, with:

- **Inpatient occupancy exceeding 95%**
- **18.6% of beds occupied by patients with no criteria to reside**
- Approximately **104 patients per night**, many remaining longer than 24 hours

At the same time, alternatives to admission are underutilised:

- Same Day Emergency Care (SDEC) manages **around 41 patients per day**
- Only **15–20% require admission**
- Approximately **50% of capacity remains unused**

Taken together, this demonstrates that pressure within the acute system is primarily driven by **flow inefficiencies, delayed discharge and underutilisation of same-day pathways**, rather than insufficient bed capacity.

### *A Shift from Beds to Flow*

The Acute Floor model addresses this by creating a **single, integrated assessment and decision-making hub**, bringing together:

- Emergency Department triage and assessment
- Same Day Emergency Care (SDEC)
- Frailty and specialty assessment units
- Medical and surgical assessment services

Within this model:

- The Emergency Department is refocused on **life- and limb-threatening presentations**
- Most patients are managed through **same-day pathways**
- Services are co-located to enable **rapid clinical decisions and escalation**

A core principle is that **admission becomes the exception**. Improving flow and discharge could:

- Release **>70 beds per night**
- Reduce occupancy by **~12.7%**

This ensures patients are seen **earlier by senior clinicians, assessed more quickly and directed to the right pathway first time**, reducing delays and duplication.

### *Enabling Delivery at Scale*

Delivering this model requires a step change in clinical delivery:

- **24/7 senior clinical decision-making** to support rapid assessment
- **Integrated multidisciplinary teams**, working across traditional boundaries
- **Standardised pathways and streaming criteria**
- **Rapid access to diagnostics and investigations**
- **Data-driven flow management and performance oversight**

**What this will look like in practice**

**A patient's perspective:**

**"Mary", 76, living with frailty and multiple long-term conditions**

*Today, Mary accesses care through multiple disconnected services and often ends up in hospital when her condition deteriorates. She repeats her story, waits for different appointments and experiences care as reactive and fragmented. In the future model, Mary is supported proactively through an Integrated Neighbourhood Team, with a named coordinator, shared care plan and access through a more integrated front door. She receives most of her care either at home or closer to home, supported by diagnostics, therapies, digital monitoring and coordinated multidisciplinary input. The only time Mary needs to visit hospital is to receive care focused on those parts of the pathway that genuinely require specialist intervention*

**A staff member's perspective:**

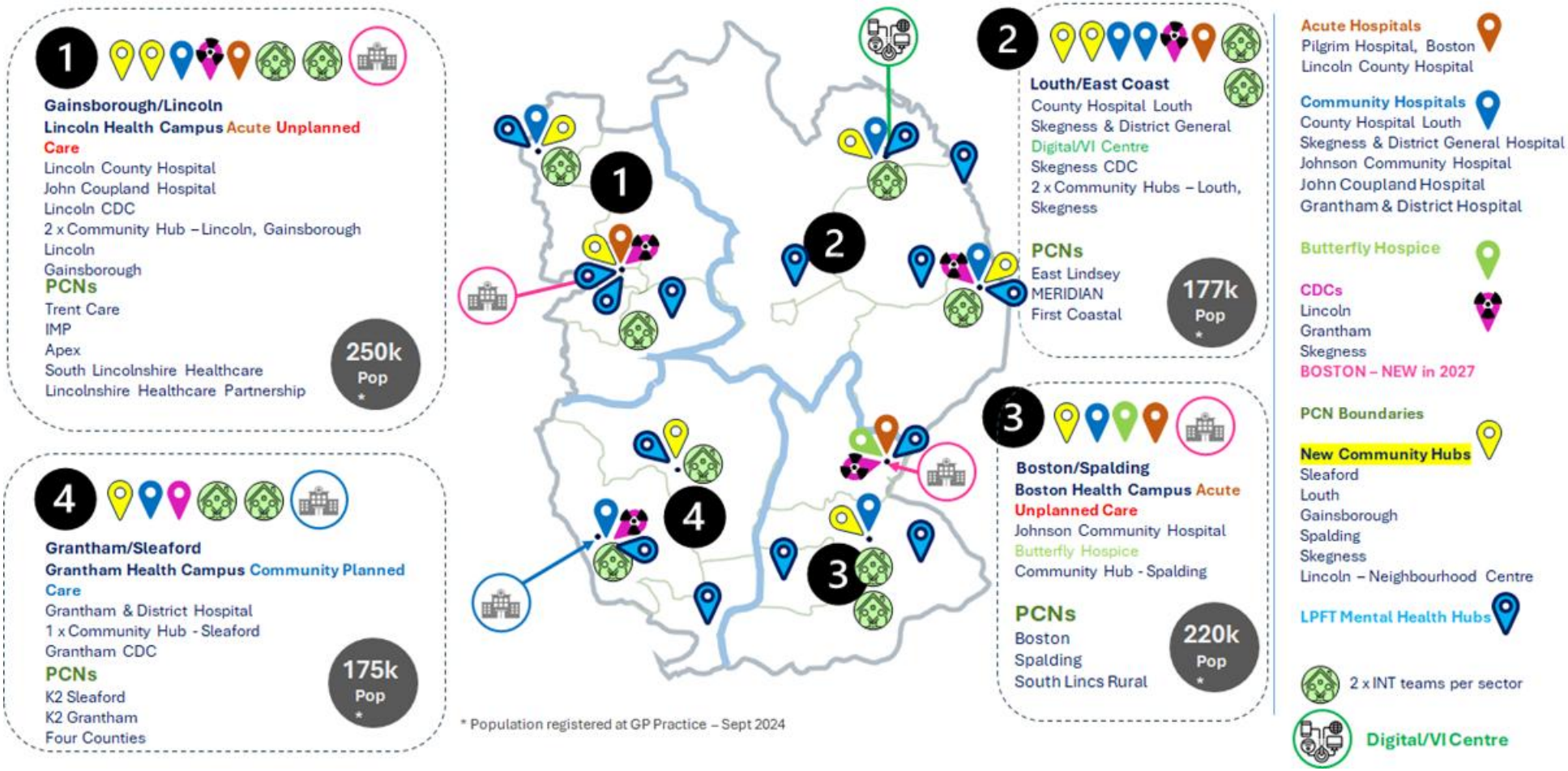
**"Sarah", Advanced Clinical Practitioner, Integrated Neighbourhood Team**

*Today, Sarah works across a system where care for people with frailty and multiple long-term conditions is often fragmented. Patients may move repeatedly between primary care, community services and hospital teams, with limited visibility of the whole pathway and too much time spent coordinating information rather than delivering care.*

*In the future model, Sarah works as part of an Integrated Neighbourhood Team aligned to local population need. She contributes to proactive case management, works alongside GPs, community nursing, therapies, mental health and social care colleagues, and uses shared information to identify people at risk of deterioration earlier. Job planning increasingly reflects delivery across pathways and settings, rather than within traditional organisational silos.*

*Digital tools, coordinated care planning and stronger links with urgent community response, virtual wards and Hospital at Home mean Sarah can help people remain well at home for longer, intervene earlier when needs escalate, and reduce avoidable attendance or admission. This gives her more time for direct clinical care, better multidisciplinary working and greater ability to improve outcomes for the people and neighbourhoods she supports.*

The physical environment will also support this shift, with an **ambulatory model of care**; using assessment spaces and chairs rather than beds wherever possible, reinforcing same-day care as the default.



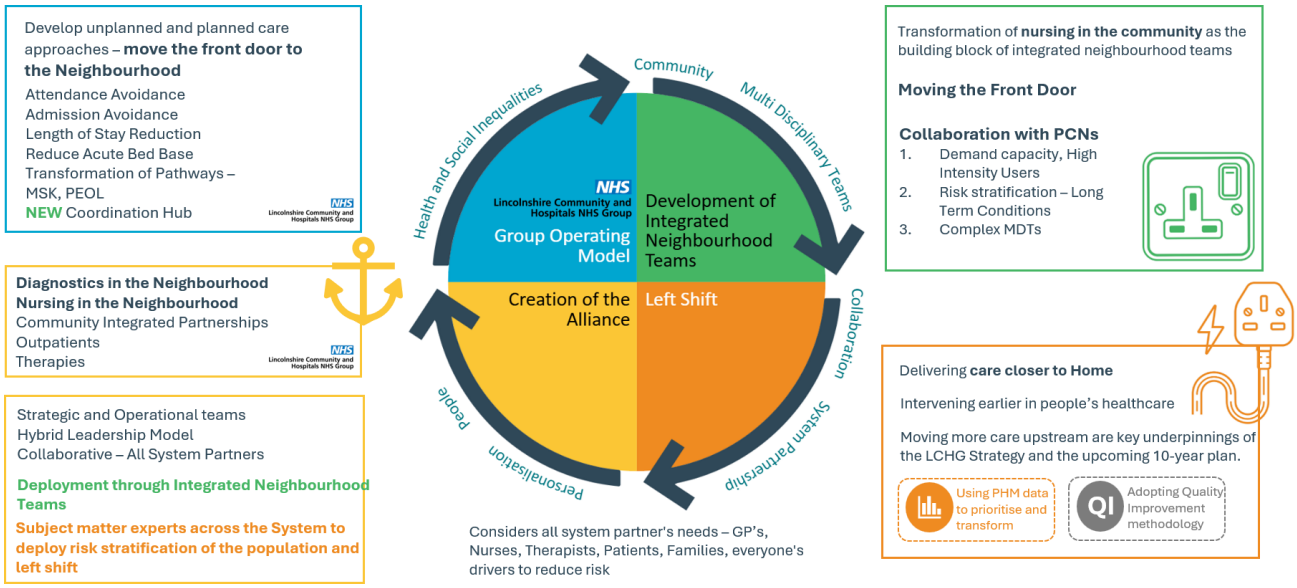

**Emergent Model for Organising Clinical Services Across Lincolnshire**

# 5. Delivery from Hospital to Neighbourhoods

The transition of services from acute to community-based care, is enabled through a **different operating model rather than additional services alone**. The **Alliance Care Group** plays a pivotal role as the bridge between acute and community provision. This is not simply a transfer of activity from hospital to community services. It requires redesign of pathways, workforce models, clinical decision-making and supporting infrastructure across both acute and community settings, ensuring that care is delivered differently rather than simply delivered elsewhere.

While the Alliance Care Group (previously Clinical Support Services) sits within the acute trust and holds activity contractually within the acute, its purpose is to **bring together services across acute and community settings into a single, integrated delivery model**. This includes both clinical support services and a wide range of community-based services, enabling care to be designed and delivered across organisational boundaries. Early examples of this model are already evident across **therapies, diagnostics, urgent community response and outpatient services**, demonstrating a shift toward more integrated and coordinated delivery.

The diagram below sets out how we are delivering a **whole-system shift from hospital-based care to neighbourhood-based, integrated care**, enabled through a new operating model centred on the Alliance Care Group.




**Continuous Improvement and System Learning**
The model is underpinned by:

- **Quality Improvement methodologies**
- Continuous use of **data and analytics** to drive transformation
- A system-wide focus on **length of stay reduction, admission avoidance and attendance avoidance.**

Delivery of this model relies on a **whole-system approach**, underpinned by strong partnerships across primary care, local authorities, voluntary organisations and wider stakeholders.

## Left Shift Transformation Ambition: What We Are Delivering

Left shift is a term used to describe expanding and improving care in local communities so that patients and service users can be better cared for at home, minimising the amount of time patients spend in hospital and, where possible, avoiding hospital admission or attendance in the first place.

The LCHG left shift programme delivers a **structural rebalancing of care across the system**, moving routine, diagnostic, rehabilitative and long-term condition management into community settings. At its core, this means:

- **Relocating high-volume outpatient and long-term condition care** into community settings
- **Expanding community diagnostics, monitoring and treatment pathways**
- **Delivering interventions using AI and digital tech in more accessible locations**, including homes, community hospitals, primary care and neighbourhood hubs

This transformation spans the full breadth of clinical services, reflecting a deliberate and large-scale change in how care is organised and delivered.

Across **long-term conditions**, care is shifting into neighbourhood models, including the management of **diabetes, cardiovascular disease (including heart failure), respiratory conditions, frailty, Parkinson's and dementia**. These pathways are being redesigned to support proactive, ongoing management within primary and community care, reducing reliance on routine outpatient activity and acute consultant-led delivery, and enabling earlier intervention.

**Location Shift** – moving a current service from where it is currently delivered to a new location. This could be taking a consultant led clinic and moving it from the hospital site to community hospital or GP practice. Patients will still see the same consultant, but in a different venue. This may enable patients to see health care professionals closer to home.

**Delivery Shift** – this type of shift is about changing how the service is delivered. For example, with the introduction of new and innovative roles such as Nurse Consultants or Advanced Clinical Practitioners (ACPs) a clinic that was once delivered by a consultant could now be delivered by an alternative healthcare professional. By utilising the skills of our workforce differently, we would hope to see patients quicker and provide more continuity of care meaning a patient would be more likely to see the same person each appointment.

**Model Shift** – the biggest transformation, a model shift combines both location and delivery changes so that care can be provided in more innovative ways in order to reduce waiting times whilst retaining or even improving the quality of care provided.

A wide range of **outpatient specialties** are also moving into community settings. Services such as **dermatology, rheumatology, neurology and ophthalmology** are being redesigned to be delivered through community clinics, shared care models and primary care pathways, while **haematology monitoring** (including conditions such as CLL and MGUS) is transitioning into primary care. These changes reflect a shift away from hospital-based outpatient models toward **distributed, locally delivered care**.

Within **surgical pathways**, activity is being reconfigured to enable more delivery outside acute hospitals. This includes **pre-operative assessment, screening,**

**fracture clinics, minor procedures, orthotic services and day-case surgery**, supported by Community Diagnostic Centres and neighbourhood hubs. Post-operative follow-up and monitoring are also increasingly delivered locally, improving access and reducing unnecessary hospital visits.

In family health services, there is a significant redesign through community and neighbourhood-based provision, including community paediatrics, children's community nursing and therapy provision, maternity and neonatal pathways, gynaecology, gynae-oncology and women's health services. This includes the development of neighbourhood-based hubs and more integrated pathways across primary, community and specialist services, including services such as breast and menopause clinics. The aim is to ensure that children, young people, families and women are supported through more coordinated models of care, with specialist input available where required and care delivered closer to home where clinically appropriate.

Clinical support services are also shifting, with increased delivery of **chemotherapy (where clinically appropriate), OPAT, endoscopy and outpatient diagnostics** in community settings. This is supported by the expansion of **Community Diagnostic Centres**, enabling patients to access investigations closer to home and reducing demand on acute sites.

Within community planned care, left shift is driving:

- Development of **integrated neighbourhood models** including District Nursing and Community Hospitals Transformation
- Expansion and utilisation of **Community Diagnostic Centres**
- Strengthening of **palliative and end-of-life care pathways**
- Deployment of **transitional care beds** to support step-down care and reduce hospital length of stay
- **Virtual wards** are being developed to support both step-up and step-down care, and work is ongoing to strengthen performance measures and system alignment.

Across community unplanned care, we are focussing on **preventing admission and managing demand in the community**, including:

- Expansion of **Urgent Community Response (UCR) and home visiting services** (Phases 1 and 2 complete)
- Integration of **IV therapy into community models**, including exploration of hub-and-spoke delivery
- Alignment of **virtual ward pathways** to support admission avoidance and earlier discharge
- Enhanced coordination with **ambulance services (EMAS)**, including tracking patients post-urgent care contact

In parallel, elements of **unplanned care** are shifting into the community, supported by:

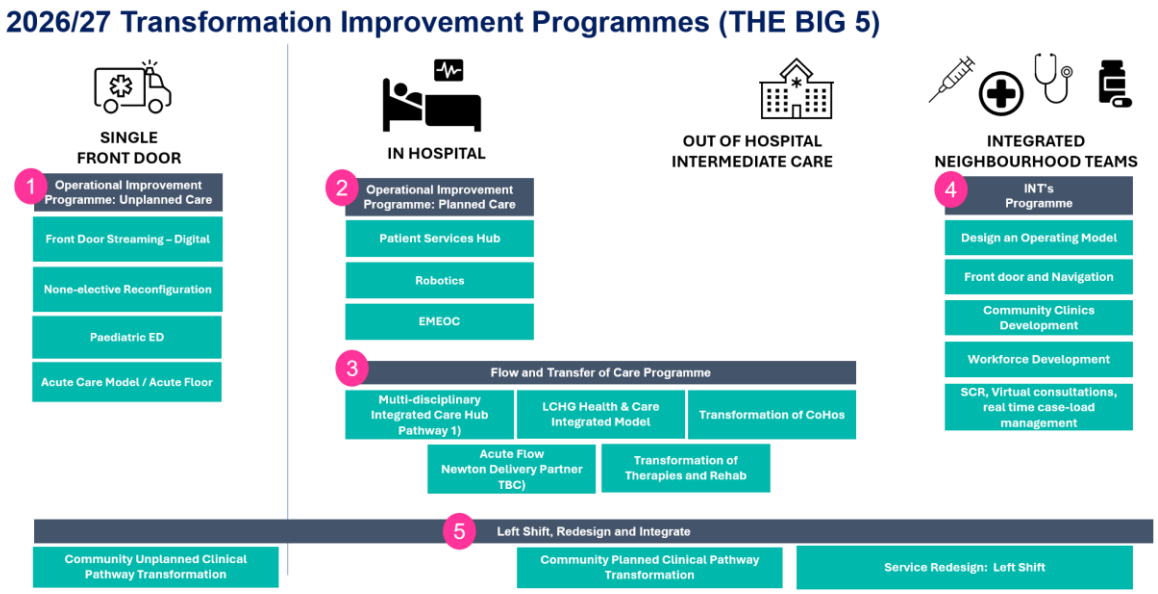
- **Community stroke and orthopaedic beds**
- Expanded access to **diagnostics and imaging outside hospital settings**
- Strengthened **pharmacy and home-based care models**

# 6. Delivery and Enablers

The delivery of this strategy is underpinned by a set of **core enablers** that ensure transformation and improvement is coordinated, scalable and sustainable across the system:

- **System Partnership and Integration**
  Delivery is guided by the **LCHG Partnership Plan** and the **Lincolnshire Strategic Neighbourhood Health and Care Plan**, which provide the framework for aligned, integrated and equitable care across organisations. This collective approach supports progression toward an **Integrated Health Organisation (IHO)** model, with greater alignment of services, resources and accountability.

- **Muti year LCHG Productivity, Improvement and Transformation Programmes**
  The transformation and improvement portfolio is structured **around five core programmes** that together deliver a **coherent, clinically led and system-wide approach** to improving access, flow, quality and long-term sustainability. Rather than a set of disconnected initiatives, **the Big 5** represent a **whole-pathway transformation**, addressing immediate operational pressures while enabling a fundamental shift towards more integrated, community-based care.




### 1. Operational Improvement: Unplanned Care

This programme focuses on **stabilising and improving urgent and emergency care performance**, addressing longstanding challenges in demand, patient flow and emergency department crowding. Key initiatives such as **digital front door streaming, non-elective reconfiguration, paediatric ED redesign and acute floor model** are transforming how patients enter and move through emergency care services.

Collectively, this programme is:

- Ensuring patients are **seen in the right place, first time**
- Reducing waiting times and overcrowding in ED
- Improving flow through better streaming and use of alternatives to admission

This is the foundation for delivering safer, more responsive urgent care.

**2. Operational Improvement: Planned Care**

The planned care programme addresses **waiting lists, access to services and outpatient efficiency**, ensuring elective care is delivered in a timely and sustainable way. Through initiatives such as the **Patient Services Hub, robotics, and East Midlands Elective Orthopaedic Centre (EMEOC)**, the programme is modernising how planned care is organised and delivered. Planned care transformation is not solely about reducing waiting lists. It is also about redesigning pathways so that care is delivered in the most appropriate way, reducing unnecessary outpatient activity, increasing use of digital follow-up, supporting patient-initiated follow-up where appropriate, enabling self-management and removing low-value steps from pathways. This will help ensure that elective recovery is delivered in a way that is clinically sustainable, productive and better for patients.

Its focus is to:
- **Reduce waiting times** and improve patient experience
- Increase productivity through **standardisation and technology**
- Support more efficient use of clinical and operational capacity

This programme underpins recovery and long-term resilience in elective services.

**3. Flow and Transfer of Care**

This programme tackles one of the most critical system challenges: **delays in patient flow and transfers of care across hospital and community settings**. It brings together multiple transformation strands including:
- Integrated care hubs
- Health and care models across LCHG
- Transformation of community hospitals (CoHos)
- Therapies and rehabilitation redesign
- Acute flow improvement (e.g. Newton partnership work)

The programme is designed to:
- Improve **timely discharge and reduce length of stay**
- Strengthen **integration between acute, community and social care**
- Ensure patients **move seamlessly through the system**

By focusing on flow as a whole pathway, this programme unlocks capacity and improves patient outcomes.

**4. Integrated Neighbourhood Teams (INTs) Programme**

The INT programme represents a **fundamental shift towards place-based, integrated care**, bringing services together around the needs of local populations.

It includes:

- Developing a **clear operating model for neighbourhood working**
- Strengthening **front door navigation and coordination**
- Expanding **community clinics**
- Investing in **workforce development and digital tools** (e.g. shared care records, virtual consultations)

This programme is key to:

- Delivering **care closer to home**
- Improving coordination across services
- Enabling proactive, population-based care

It lays the foundation for long-term transformation beyond hospital-based models.

**5. Left Shift Programme**

This cross-cutting programme brings together the overarching ambition to **shift care out of hospital settings and redesign pathways around patient need** (described in section 4). This programme is the unifying thread across the portfolio, ensuring all transformation aligns to a common direction of travel.

The above programmes are managed through Productivity, Improvement and Transformation Oversight forum (PITOF) - our internal LCHG programme that oversees the delivery of our core transformational and improvement schemes.

Together, these programmes provide the mechanism through which the benefits of this strategy will be realised. Each programme will need to maintain a clear focus on measurable outcomes, including improvements in access, flow, quality, productivity, experience and reduction in unwarranted variation. Benefits realisation will therefore be tracked systematically, so that the impact of transformation can be demonstrated and used to inform future prioritisation and investment.

Each improvement and transformation programme will therefore be expected to demonstrate impact through a quality lens, not only through activity or productivity measures. This includes evidence of improved safety, patient experience, clinical outcomes, equity, reduced variation and better continuity of care.

Over the next 12 to 24 months, delivery will focus on a small number of priority areas that create the foundations for the 2030 model. These include strengthening urgent and emergency care front door models, progressing acute floor and flow transformation, expanding community and neighbourhood-based pathways, accelerating outpatient redesign, improving use of digital tools and shared information, and developing the workforce models required to support more integrated care. This near-term focus will ensure that the strategy is translated into visible delivery while maintaining alignment with the longer-term clinical model.

**Delivering Change at Scale**

Successful delivery of this strategy will require more than structural, pathway or organisational redesign. Experience from previous transformation programmes has shown that sustainable change depends on visible leadership, sustained engagement,

clear communication, trust between teams and the active involvement of staff, patients and partners in shaping how change is delivered.

Transformation at this scale takes time. It requires organisations, services and professional groups to work differently, often across long-standing boundaries. Delivery will therefore place equal emphasis on culture, behaviours and relationships alongside programme management, governance and operational delivery.

The ambition is not simply to implement new models of care, but to create the conditions in which continuous improvement, innovation, integration and learning become the normal way of working across the Group and wider system. This means learning from implementation, adapting where required, supporting teams through change and building confidence through visible progress and early benefits.

- **Workforce and Culture**

  A flexible, skilled and increasingly integrated workforce will be central to delivery of this strategy. As care shifts from hospital to neighbourhoods, the workforce will need to operate differently, with a greater emphasis on multidisciplinary working, care coordination, prevention and delivery across organisational boundaries.

  This will require continued expansion of advanced and non-medical roles, alongside stronger integration across primary care, community services, urgent care and specialist pathways. Workforce design will increasingly need to reflect population need and pathway delivery, rather than traditional organisational or service silos.

  Over time, the workforce will also need to become more digitally ready, with staff increasingly supported by shared records, digital tools, remote monitoring and new technologies that improve coordination, productivity and patient experience. This will require not only technical capability, but confidence in using digital systems as a routine part of care delivery.

  Job planning and workforce planning will increasingly need to support delivery across pathways and settings, rather than within isolated services. This includes enabling consultants, advanced practitioners, nurses, therapists and other professionals to work more flexibly across acute, community and neighbourhood-based models of care, ensuring that workforce deployment aligns with the future clinical model described in this strategy.

  This transformation will be delivered in alignment with the Group's wider workforce planning, ensuring that workforce capability, role development, leadership and culture are shaped around the needs of the future model. "Grow your own" approaches, workforce development and leadership support will all be important to building a sustainable pipeline of staff able to work in new and more integrated ways.

  This is reinforced by a culture of collaboration, shared ownership and continuous improvement. Delivering the future model will depend not only on new roles and

skills, but also on a workforce culture that supports partnership working, flexibility, learning and innovation across the Group and wider system. In this way, workforce transformation becomes a core enabler of the clinical strategy, translating the Group's ambition into day-to-day models of care that can be delivered at scale.

Delivery of the future clinical model will also require strong partnerships with education providers. The Group will work with universities, colleges, the Lincolnshire Talent Academy and wider training partners to develop future workforce supply, support new professional roles, expand advanced and non-medical practice, and create education pathways aligned to integrated, digitally enabled and neighbourhood-based models of care. This will help ensure that workforce development reflects the future skills, roles and ways of working required to deliver this strategy.

By 2030, care will increasingly be delivered through multidisciplinary neighbourhood teams, with consultants, nurses, allied health professionals, advanced practitioners and support staff working across pathways and organisational boundaries, enabled by digital tools, new professional roles and stronger partnerships with education providers.

- **Digital Enablement**

  Digital capability underpins the entire clinical model, supporting how residents access services, how clinicians coordinate care, how risk is identified, and how productivity and quality are improved across the system.

  Digital infrastructure will be fully embedded across the operating model, enabling seamless, coordinated care delivery across organisational and pathway boundaries. This will include continued implementation of Electronic Patient Records, Electronic Document Management Systems and a shared care record approach, improving the availability, quality and flow of patient information across services. Over time, this will support real-time clinical decision-making, more effective care coordination and a reduction in duplication and administrative burden.

  Digital tools will also increasingly support remote monitoring, virtual care, self-management and improved patient access. AI-enabled technologies and automation will be deployed where they improve quality, safety, productivity or experience, supporting better triage, pathway management and service planning. Together, these developments will help ensure that digital access becomes a routine and reliable part of how care is delivered, rather than an additional layer around traditional models.

  By 2030, digital capability will support every stage of the patient pathway. Residents will increasingly interact with services through digital channels, supported by self-management tools, remote monitoring and virtual care models. Clinicians will work within integrated, data-enabled pathways that provide a real-time view of patient need, support decision-making and improve coordination between teams. This will help turn reactive services into proactive services, enabling earlier intervention and more personalised care.

Digital access will need to be inclusive and supported by alternative routes, ensuring that residents are not disadvantaged by digital exclusion, low confidence or additional communication needs.

Delivery of this ambition will depend on the wider Digital Strategy and associated programmes, including Electronic Patient Records, shared care records, digital front door developments, data and analytics capabilities, automation, AI-enabled tools and digital access for residents and staff.

More fundamentally, digital is not viewed as a standalone enabler, but as a fundamental component of the future clinical model. Digital capability will increasingly underpin the way residents access services, clinicians work across organisational boundaries, and care is coordinated across pathways, helping to turn reactive models of care into proactive and personalised approaches.

- **Estates and Infrastructure**
  Estate development ensures that physical infrastructure supports the development **of acute floor**, **community-based and ambulatory models of care**, aligning facilities with future service delivery and supporting best use of system-wide estate.

  This will be delivered in explicit alignment with the Group Estates Strategy, ensuring that estate decisions are driven by the future clinical model described in this strategy. This includes supporting the development of acute floor models, elective and local cold sites, community and neighbourhood hubs, Community Diagnostic Centres and local hospital infrastructure, so that the estate enables, rather than constrains, the shift in how and where care is delivered.
  Many of the changes described in this strategy are dependent on corresponding changes to the estate. The development of neighbourhood hubs, Community Diagnostic Centres, local hospital provision, elective facilities and acute floor models are all examples of how the Estates Strategy and Clinical Services Strategy must be delivered in parallel. Neither can be fully realised in isolation from the other.

- **Quality, Safety, Governance and Continuous Improvement**
  Quality, safety and continuous improvement will be core to how the Clinical Services Strategy is delivered. Transformation will be assessed not only by whether activity, access and productivity improve, but by whether pathways become safer, more reliable, more equitable and more effective for patients, residents and staff.

  The key quality tests for delivery will include:
  - safer and more reliable pathways
  - reduced unwarranted variation
  - improved patient and resident experience
  - better clinical outcomes
  - earlier intervention and reduced avoidable deterioration
  - improved equity of access and outcomes

  Transformation is supported by:
  - Robust governance through partnership structures and committees

- Use of **quality improvement methodologies through the embedding of our QI enabling plan**
- Continuous use of data and analytics to monitor outcomes, manage risk and drive improvement

This will be supported by continued cultural development across the Group, including implementation of the Patient Safety Incident Response Framework (PSIRF). A stronger learning culture, supported by transparent review, continuous improvement and shared ownership of quality and safety, will be essential to delivering the future model described in this strategy.

An increased focus will also be placed on reducing unwarranted variation in pathways, practice and outcomes across the Group. This will include greater use of GIRFT recommendations, mortality review, benchmarking and clinical outcome analysis to identify where variation exists and to support more consistent, evidence-based care. The intention is not only to improve standardisation and productivity, but to translate quality improvement into measurable improvements in safety, outcomes and equity for the population of Lincolnshire.

This will ensure that transformation is not judged only through access and flow, but through measurable improvements in safety, quality, experience and clinical outcomes.

Delivery of this strategy will also need to be reflected through the Group's assurance arrangements, including Committee and Board oversight and, where appropriate, the Board Assurance Framework. This will support clearer articulation of strategic risks, dependencies and mitigations, enabling the Board to monitor progress, assure delivery and respond where transformation is not proceeding at the pace or scale required.

- **Research, Innovation and Education**

  Research, Innovation and Education will be increasingly fundamental to the future clinical model of LCHG. The Group will strengthen its role as a clinically led learning organisation, embedding research, service evaluation and innovation within routine care delivery. Working in partnership with academic institutions, including the University of Lincoln, LCHG will support the:

  - development of evidence-based care models
  - adoption of digital, AI-enabled and genomic technologies where these improve prevention, diagnosis, treatment and personalised care
  - workforce development and clinical leadership
  - more access to clinical trials that improve population outcomes
  -

Advances in genomics and personalised medicine will create new opportunities to identify risk earlier, tailor treatments more effectively and improve outcomes for the Lincolnshire population.

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Taken together, these developments will strengthen the Group's ambition to secure University Trust status, recognising that education, research, innovation and workforce development must be embedded across the whole Group, spanning acute, community and neighbourhood-based services.

# 7. Successes So Far

Early progress across Lincolnshire demonstrates that the model described in this strategy is already beginning to take shape in practice. Developments across urgent care, flow, neighbourhood delivery, diagnostics and pathway redesign are providing proof of concept for more integrated and coordinated models of care, and create a strong foundation for wider system transformation.

### Integrated Same Day Access (SDA): Improving System Flow and Access

**The problem**
Patients were navigating **fragmented access routes across primary care, CAS and urgent care**, leading to duplication, delays, and unnecessary escalation to urgent treatment centres and ED.

**What changed**
A single, coordinated SDA pathway aligned triage and access across services with shared ownership of demand.

**Impact**
- **56% managed within CAS** without onward referral
- Only **14% escalated to UTC/ED**
- Demand shifted into **core hours**, improving alignment with services
- Reduced reliance on high-cost urgent care

**Why it matters**
Integration at the front door improves patient access and experience while reducing avoidable hospital demand

### Digital First: Reducing DNAs and Improving Elective Recovery

**The problem**
High levels of **Did Not Attend (DNA) appointments** were reducing available capacity, increasing waiting times, and limiting the ability to deliver timely elective care.

**What changed**
A predictive digital tool was developed to **identify and risk-stratify patients most likely to DNA**, enabling targeted contact and intervention to improve attendance and optimise use of capacity.

**Impact**
DNAs reduced from **12.8% to 4.9%** in the target cohort
**Attendance increased by 8.9%**
**Cancellations improved by 2.1%**, allowing better reallocation of slots
No additional cost to deliver improvement
Approach recognised with **HSJ Digital Award 2025 shortlist**

**Why it matters**
Using digital tools to proactively manage demand improves utilisation of capacity, reduces wasted appointments, and supports **faster elective recovery and improved patient access**.

## Co-located Clinical Triage in Ambulance Control: Right Care First Time

**The problem**
Ambulance services faced high volumes of lower-acuity 999 calls, often resulting in unnecessary dispatches and hospital conveyances, with long waits for category 3–4 patients.

**What changed**
Community clinicians were embedded in the control room to triage and redirect patients to appropriate community services.

**Impact**
400+ fewer ambulance dispatches
Reduced conveyances and ED pressure
Faster response for lower-acuity patients
Improved system-wide demand management

**Why it matters**
Early clinical decision-making ensures patients get the right care first time while protecting ambulance and ED capacity

## Non-Elective Flow Reconfiguration: Improving ED Performance

**The problem**
Emergency departments faced **poor flow, long waits, and overcrowding**, driven by inefficient streaming and limited use of alternatives to admission.

**What changed**
Non-elective pathways were reconfigured with improved streaming, CDU expansion, and better specialty flow processes.

**Impact**
**4-hour performance improved to 85.3%**
Significant reduction in **12-hour waits**
Increased streaming to UTC and SDEC

**Why it matters**
System redesign of front-door pathways delivers rapid improvement in performance and patient experience

## Women's Health Pathway Redesign: Shifting Care Left

**The problem**
Women were **routinely referred into urgent hospital pathways unnecessarily**, causing anxiety, travel burden and pressure on outpatient services.

**What changed**
A redesigned pathway enabled care in community settings, supported by GP education and nurse-led clinics.

**Impact**
Care delivered **closer to home**
**~40% reduction in urgent referrals** expected
Improved patient experience
Reduced pressure on outpatient clinics

**Why it matters**
Left-shifting care improves access and experience while ensuring acute services focus on those most in need

## Digital First Transformation: Enabling Data-Driven Service Redesign

**The problem**
Service planning was not consistently aligned to **where patients live**, resulting in unnecessary travel, variation in access, and missed opportunities to design care closer to home.

**What changed**
A predictive optimisation tool was developed to map demand by location and identify the **most appropriate sites for care delivery**, supporting pathway redesign and left-shift planning across services such as Diabetes and Endocrinology.

**Impact**
Significant reduction in patient travel distance
Diabetic Medicine: **195K → 96K miles (↓ 98K)**
Endocrinology: **69K → 35K miles (↓ 34K)**
Improved alignment of services to population need

**Why it matters**
Using digital and data-driven insights enables smarter service design, reducing inequalities in access and supporting delivery of care **closer to home, more efficiently and sustainably**.

# 8. Conclusion

This Clinical Services Strategy sets a clear direction for transforming care across Lincolnshire, moving from fragmented and reactive services to a **joined-up, proactive and population-focused model**.

By 2030, care across Lincolnshire will be delivered through a **joined-up, proactive and population-focused system**, replacing the fragmented and reactive models of the past. Pathways are designed and delivered across organisational boundaries, with **neighbourhood-based services as the default setting for care**, supported by digitally enabled, multidisciplinary teams. As a result, care is **closer to home, seamlessly coordinated and responsive to individual and population need**.

This model will lead to **improved outcomes and experience for patients and communities**, alongside a sustained reduction in health inequalities. The system will operate more effectively and efficiently, with resources aligned to need and greater emphasis on prevention, early intervention and continuity of care. Overall, Lincolnshire will be a **more resilient, sustainable and equitable health and care system**.

The Lincolnshire Community and Hospitals NHS Group will work as part of a **fully integrated partnership**, with the LCHG Partnership Plan and the Lincolnshire Strategic Neighbourhood Health and Care Plan collectively embedded in how services are organised and delivered. Organisations function as **one system with shared objectives, accountability and outcomes**, ensuring that care is consistently high-quality and centred on the needs of the population.