

## Appendix 5b

### Lincolnshire Future Unitary Modelling of Adult's Social Care for South Kesteven, North Kesteven & South Holland

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## 2. Executive Summary

This Adult Social Care (ASC) report has been commissioned by South Kesteven District Council to inform future delivery models under Local Government Reorganisation (LGR). It provides a comprehensive analysis of the ASC landscape across Lincolnshire with a focus on what the ASC delivery model would be for the proposed future unitary comprising of South Kesteven, North Kesteven and South Holland.

The report draws on the Lincolnshire ASC Insights Report (which can be found in the appendices), this report integrates insights from deprivation indices, population data, ASC performance metrics, and workforce data. This document aims to support strategic planning by identifying service pressures, workforce challenges, and opportunities for transformation.

Key objectives include:

- Evaluating ASC performance and demand across the new proposed unitary.
- Assessing delivery model options.
- Mapping workforce structures and estimating future costs.
- Identifying priority areas for targeted commissioning and service redesign.
- Aligning ASC transformation with broader LGR milestones and governance reform.

Three delivery models were initially considered:

1. **Hub-and-Spoke** – centralised specialist hubs with satellite teams.
2. **Centralised Unitary** – fully unified delivery across the footprint.
3. **Integrated Locality** – multi-disciplinary teams aligned to local geographies.

Following comparative assessment using criteria such as integration, responsiveness, cost-efficiency, and alignment with LGR, the **Integrated Locality model** emerged as the preferred option. This model was then refined to explore how locality boundaries could be defined, whether by district, shared geography, or need, and how workforce and commissioning structures could be aligned to support it.

The result is a locality-based framework that:

- Enables place-based delivery tailored to geographic and demographic variation.
- Supports targeted resource deployment in high-need LSOAs.
- Aligns with strategic commissioning and pooled budgets.
- Facilitates integration with NHS, VCSE, and other partners.
- Provides a scalable governance model for future unitary operations.

This report sets out the evidence base, modelling rationale, and implementation considerations to support the adoption of the Integrated Locality model for ASC delivery in the new unitary.

## 2.1. Key Insights from Lincolnshire

- **Deprivation Hotspots:** South Holland and South Kesteven contain LSOAs in the lowest IMD deciles, particularly in their most rural areas. These correlate with poorer ASC outcomes and higher service demand.
- **Ageing Population:** All four districts show significant projected growth in the 65+ and 85+ cohorts. South Kesteven and North Kesteven are experiencing rapid ageing due to housing development being occupied by older adults relocating for retirement or downsizing and in-migration from urban centres.
- **Service Performance (ASCOF):** Lincolnshire performs slightly above the national average overall, but South Holland shows lower satisfaction and quality of life scores. North Kesteven leads in reablement success.
- **Workforce Structure:** The ASC workforce is concentrated in practitioner roles (G7–G9), with limited specialist capacity. Recruitment and retention are challenging in rural areas, particularly South Holland.
- **Provider Landscape:** South Kesteven, North Kesteven and South Holland hosts 108 registered ASC providers, with most rated 'Good' by CQC. However, small providers in deprived areas face fragility risks.

## 2.2. Strategic Modelling Considerations

- **Priority Zones:** LSOAs with overlapping deprivation, ageing, and poor performance have been mapped for targeted commissioning and workforce deployment.
- **Delivery Model Fit:** The Integrated Locality model is best suited to the future unitary's geography, enabling multi-disciplinary teams to operate within defined localities while reporting into a central ASC directorate.
- **Workforce Planning:** Future modelling must account for rurality, travel time, and vacancy rates. Proxy mapping of workforce to locality is recommended using establishment data and service footprints.
- **Commissioning Strategy:** A hybrid approach is advised, strategic commissioning at the unitary level, tactical commissioning at locality level, with pooled budgets and shared market development.
- **Partnerships:** Integration with NHS, VCSE, and police is essential. Lessons from East Sussex's Integrated Community Teams and Financial Inclusion Programme offer valuable templates.

Although this report focuses on the southern unitary configuration, the principles and modelling approach are equally applicable to the central unitary. In particular, the central unitary will need to balance the coastal ribbon (e.g. East Lindsey, Boston) with the urban centre of Lincoln, requiring a flexible locality model that can accommodate both dispersed rural communities and concentrated urban demand.

### 3. Population and Demographic Analysis Summary

#### 3.1. Current Population Overview

The future unitary area comprises a combined population of approximately **260,000**, with notable variation across districts:

- **South Kesteven:** 145,000
  - **North Kesteven:** 120,000
  - **South Holland:** 95,000
- The proportion of residents aged **65+** ranges from **24% in South Kesteven** to **27% in South Holland**, exceeding national averages.
  - The **85+ cohort**, most likely to require intensive ASC support, is growing fastest in **South Kesteven**

The map below visualises the **percentage of residents aged 65+ by LSOA**, highlighting areas where older adults are expected to comprise **20% or more** of the local population. These high-density ageing zones are particularly concentrated in rural fringes and market towns, reinforcing the need for **localised planning, targeted commissioning, and workforce alignment**.

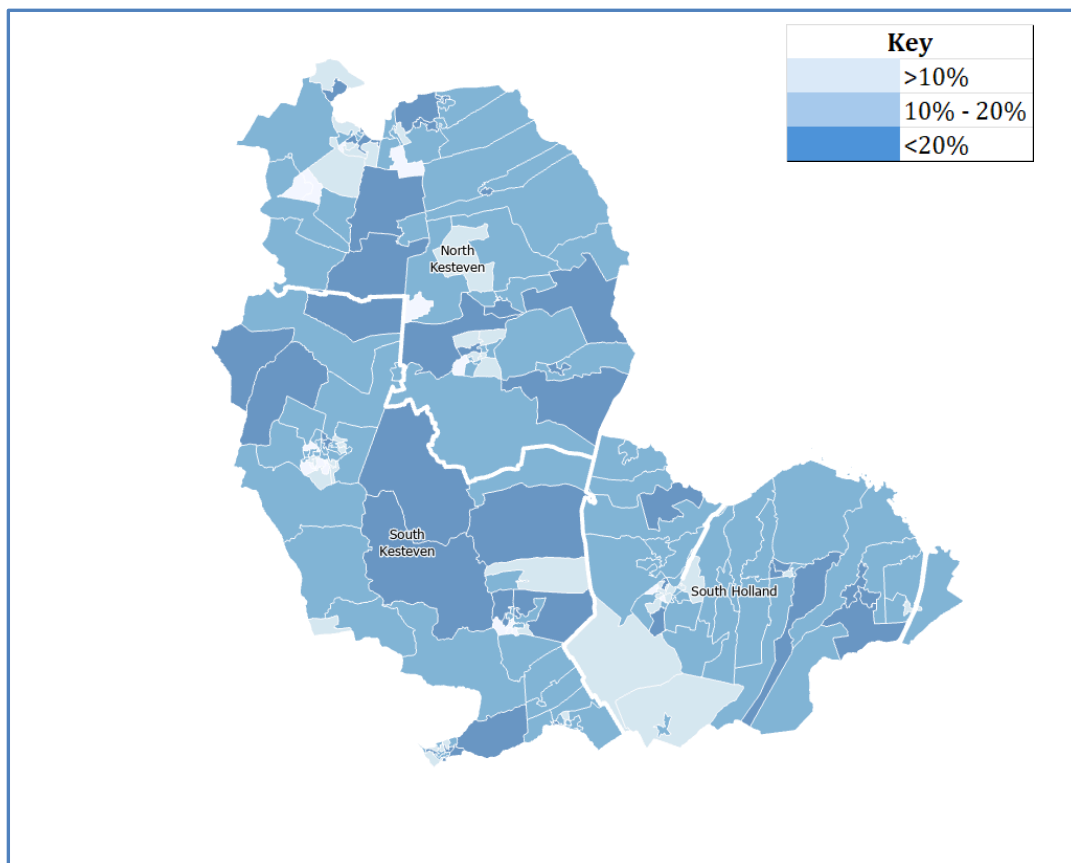


Figure 1 Percentage of Population Aged 65+ by LSOA

### 3.2. Population Projections

By **2040**, the population aged **65 and over** across the future unitary area (South Kesteven, North Kesteven, and South Holland) is projected to increase by **35–45%**, with the most significant growth expected in **South Kesteven** and **North Kesteven**. The **85+ population**, which typically requires the most intensive forms of Adult Social Care (ASC), is expected to **double** over the same period.

This demographic shift will place substantial pressure on ASC services, particularly in areas already experiencing workforce shortages or limited provider coverage. The projected growth will drive increased demand for:

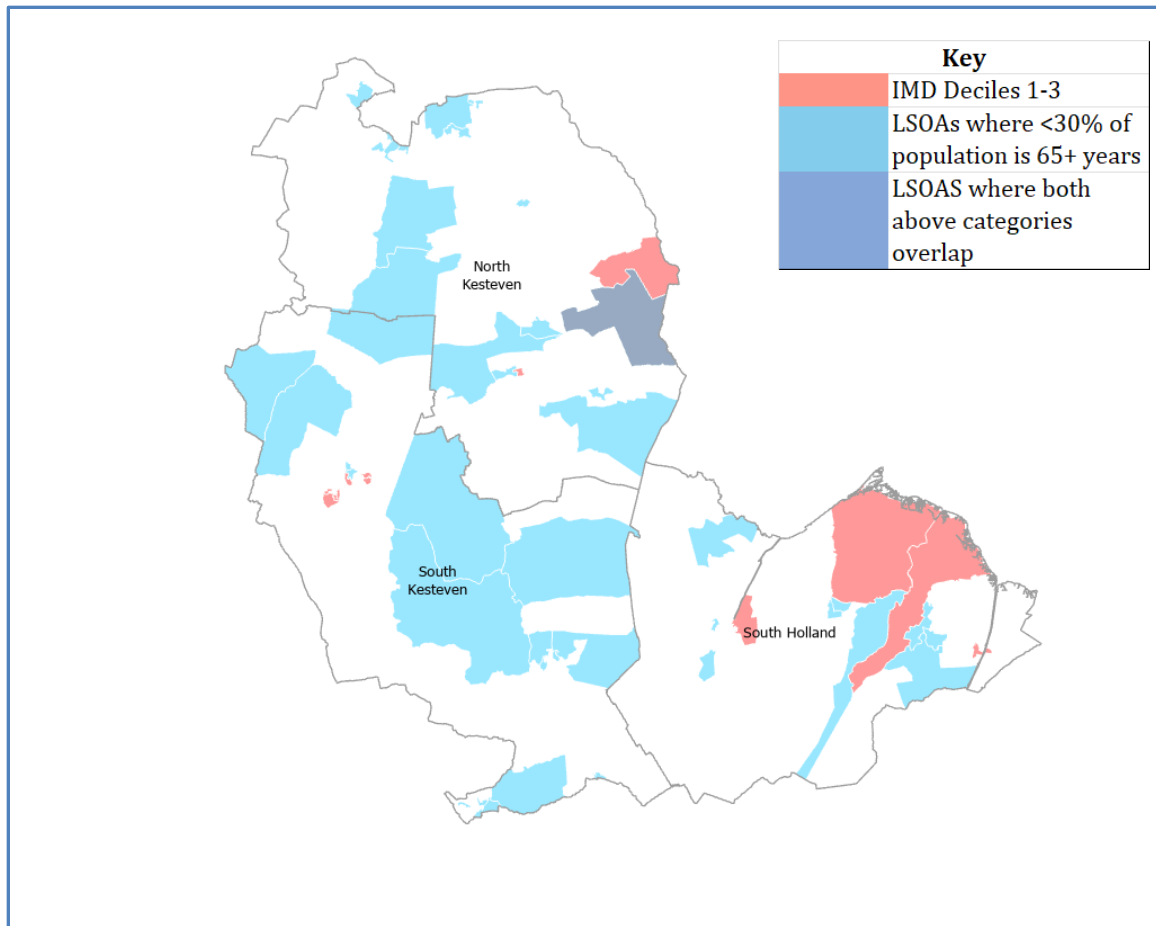
- **Reablement services** to support recovery and independence after hospital discharge.
- **Residential and nursing care**, especially for those with complex needs.
- **Carer support and community-based provision**, including day services, respite, and preventative interventions.

### 3.3. LSOA-Level Insights

Detailed LSOA mapping of each of the constituent areas of the future unitary shows clusters of older adults in:

- **Stamford and Bourne (South Kesteven)**
- **Spalding and Holbeach (South Holland)**

These areas also show **limited provider coverage** and **higher travel times**, indicating potential service pressure zones. LSOAs with high older adult density often overlap with **lower IMD deciles**, compounding vulnerability.



**Figure 2 Areas of Ageing Population Overlaid with Areas of Deprivation**

The map above overlays LSOAs where 30% or more of the projected population are 65+ years old with LSOAs that are in IMD deciles 1-3, highlighting priority zones where ageing and deprivation intersect. These areas, particularly in Spalding, Holbeach, and rural South Kesteven, are likely to experience compounded demand for ASC services.

### 3.4. Migration and Settlement Patterns

The future unitary is experiencing **inward migration of older adults**, particularly into **South Kesteven**, driven by retirement relocation and new housing developments targeting downsizers.

This trend is increasing demand in areas not traditionally resourced for high ASC need.

### 3.5. Dependency Ratios and Carer Availability

The **dependency ratio** (non-working age vs working age) is rising, especially in **South Holland**. Informal carer availability is constrained by:

- Outmigration of younger adults
- Rural isolation
- Limited VCSE infrastructure in some LSOAs

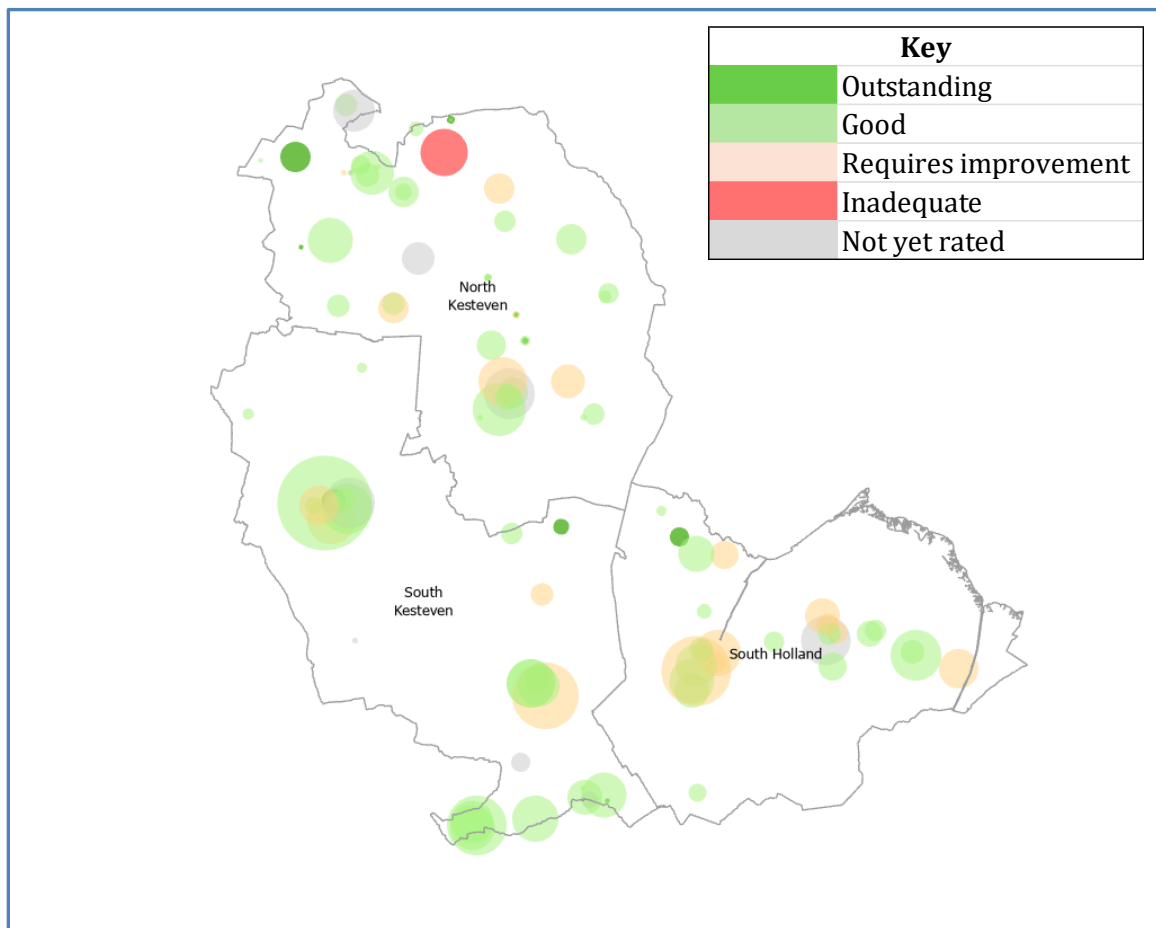


### 3.6. Asset Provision and Infrastructure

Across the future unitary footprint, there are **operational ASC assets** distributed as follows:

- **South Kesteven:** Strong provision of **day care and residential services**
- **South Holland:** Fewer assets, with gaps in **community-based provision**
- **North Kesteven:** Moderate provision, but with rural access challenges

The map below visualises Care Quality Commission (CQC) ratings for registered ASC providers across the three districts. Each provider is represented by a circle, with the size indicating maximum service capacity.



**Figure 3 CQC Ratings and Capacity of ASC Providers**

This visual illustrates the uneven distribution and quality of ASC assets across the future unitary, highlighting the importance of locality-based planning and targeted investment in areas where service capacity or quality may need to be strengthened.

### 3.7. Service Pressure Zones

The map below shows LSOAs where 30% or more of the population are 65+ years old, overlaid with provider capacity. Green clusters show the approximate locations of providers, with nearby providers combined into the same cluster. The size of the circles is linked to the 'maximum service capacity' of a cluster, which is the value shown in the circle. Notably, several high-density areas coincide with limited provider coverage, suggesting potential service pressure zones in the coming decade.

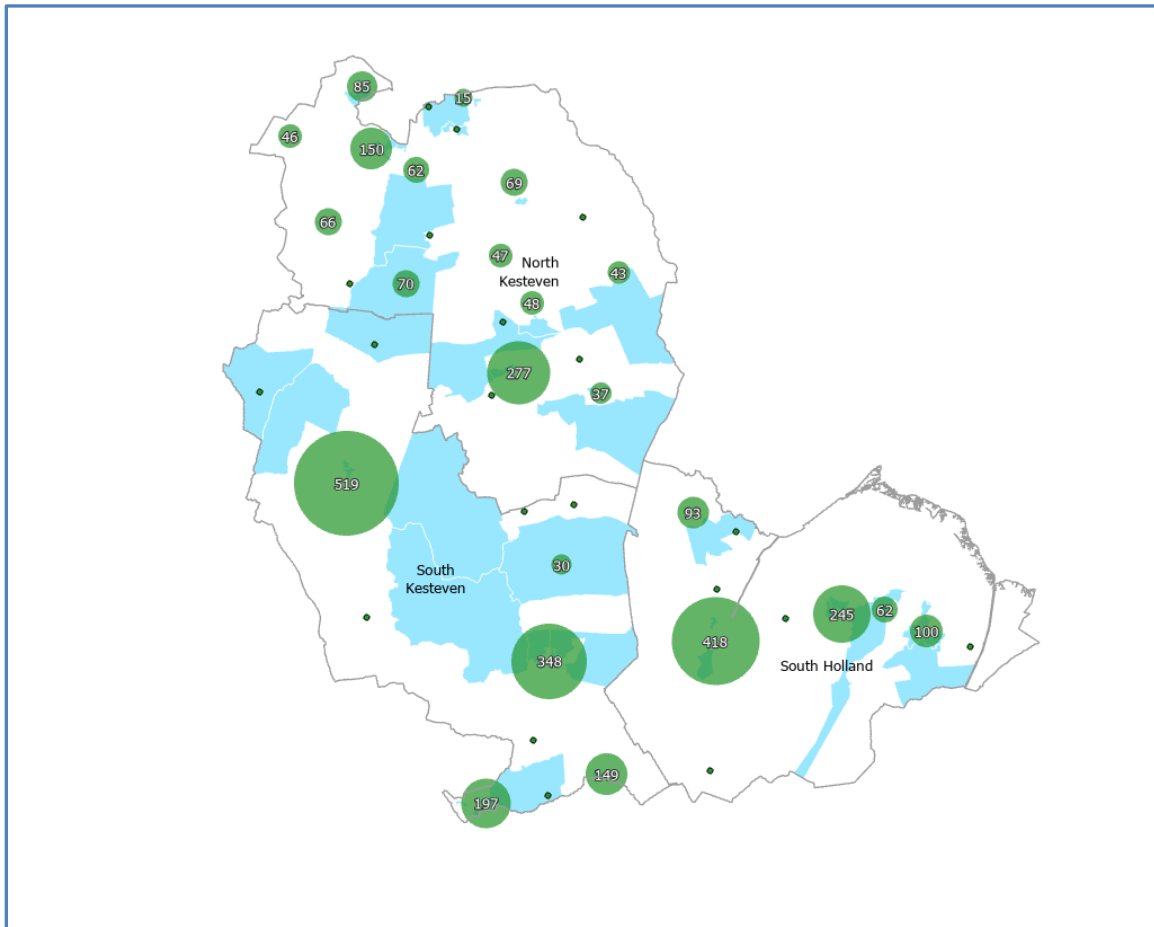


Figure 4 Areas of Ageing Population Overlaid with Provider Capacity

## 4. Assessment of Delivery Models

This section explores three strategic models for structuring ASC delivery under the future unitary. Each model is assessed for its suitability in the context of LGR, rurality, workforce constraints, and the need for responsive, equitable services.

Model	Description	Strengths	Challenges
<b>Integrated Locality</b>	Services delivered through defined localities with integrated teams and budgets	<ul style="list-style-type: none"> <li>• High responsiveness to local need</li> <li>• Strong community integration</li> <li>• Aligns with LGR</li> </ul>	<ul style="list-style-type: none"> <li>• Requires robust locality governance</li> <li>• Risk of duplication without coordination</li> </ul>
<b>Hub-and-Spoke</b>	Central hubs deliver specialist services, supported by satellite local teams	<ul style="list-style-type: none"> <li>• Economies of scale</li> <li>• Easier central workforce management</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced local responsiveness</li> <li>• Travel/access issues in rural areas</li> </ul>
<b>Centralised</b>	Services managed and delivered from a single central structure	<ul style="list-style-type: none"> <li>• Simplified governance</li> <li>• Easier to standardise systems</li> </ul>	<ul style="list-style-type: none"> <li>• Poor fit for rural areas</li> <li>• Limited tailoring to local needs</li> </ul>

While both the Integrated Locality and Hub-and-Spoke models involve a central structure, the key distinction lies in how services are organised and delivered:

- The Hub-and-Spoke model centralises specialist functions in a hub, with satellite teams delivering generalist services. It is more hierarchical and suited to economies of scale but may reduce responsiveness in rural areas.
- The Integrated Locality model embeds multi-disciplinary teams within defined geographies, with each locality having autonomy over delivery, commissioning, and performance. These teams report into a central directorate but retain operational flexibility. This model allows for local ownership, tailored service delivery, and stronger community integration, while still enabling central coordination of strategic functions such as commissioning, safeguarding, and performance oversight.

#### 4.1. Comparative Scoring Matrix of Delivery Models

To support strategic decision-making around ASC delivery under Local Government Reorganisation, a comparative scoring matrix has been developed to evaluate the three potential delivery models: Integrated Locality, Hub-and-Spoke, and Centralised. Each model is assessed against key criteria including responsiveness to need, cost efficiency, rural suitability, and alignment with LGR principles. The scoring provides a structured basis for selecting the most appropriate model for the future unitary, balancing strategic ambition with operational feasibility.

Criteria	Integrated Locality	Hub-and-Spoke	Centralised
<b>Responsiveness to Need</b> - ability to tailor services to local population characteristics and emerging demand	3	2	1
<b>Cost Efficiency</b> - potential to deliver services within budget constraints while maintaining quality	2	3	3
<b>Workforce Alignment</b> - fit with current and projected workforce availability, recruitment, and retention	3	2	2
<b>Rural Suitability</b> - effectiveness in serving dispersed and isolated communities with access challenges	3	2	1
<b>VCSE Integration</b> - ability to work in partnership with voluntary, community, and social enterprise organisations	3	2	1
<b>LGR Compatibility</b> - alignment with the principles and governance structures emerging from Local Government Reorganisation	3	2	1
<b>Total</b>	<b>17</b>	<b>13</b>	<b>9</b>

Based on strategic fit, responsiveness to need, and alignment with Local Government Reorganisation principles, the **Integrated Locality Model** is recommended as the preferred approach for ASC delivery in the future unitary.

This model offers the most balanced and future-proof structure, particularly in the context of a geographically dispersed and demographically ageing population. It enables:

- **Local Accountability** - each locality can take ownership of service delivery, performance, and community engagement. This supports transparent governance and allows for tailored responses to local challenges.
- **Service Equity** - by aligning resources with need at the locality level, the model helps reduce inequalities in access and outcomes. It enables targeted investment in high-demand or high-deprivation areas, ensuring no community is left behind.
- **Workforce Sustainability** - locality-based teams can be built around existing workforce strengths, reducing travel burdens and improving retention. It also allows for more flexible staffing models that reflect rurality, vacancy rates, and training capacity.
- **Community Integration** - the model supports deeper collaboration with VCSE organisations, informal carers, and community assets. This strengthens preventative approaches and builds resilience, particularly in areas with limited formal provision.

In contrast, the hub-and-spoke and centralised models score lower on responsiveness, rural suitability, and community integration. While they offer efficiencies, they risk undermining the place-based ethos required for effective ASC transformation under LGR.

## 5. Locality Modelling Options

This section explores how ASC services could be geographically structured within the future unitary, building on the preferred Integrated Locality Model. It evaluates three locality structuring approaches, each designed to balance need, geography, and operational feasibility.

### 5.1. Option A: Place-Based Localities (Aligned to Districts)

**Structure:** Four localities matching the existing district boundaries of the future unitary: South Kesteven, North Kesteven, South Holland.

**Strategic Fit:**

- Aligns with current political and operational boundaries.
- Supports continuity and ease of transition during LGR.

**Operational Implications:**

- Existing teams and commissioning arrangements can be adapted with minimal disruption.
- Risk of maintaining legacy inequities if boundaries do not reflect demand hotspots.

**Advantages:**

- Familiar governance and identity
- Easier transition from current structures
- Clear accountability and existing leadership structures

**Limitations:**

- May not reflect demand hotspots or deprivation clusters

- Risk of uneven resource allocation and service pressure in high-need LSOAs

## 5.2. Option B: Clustered Localities (Shared Geography/Demographics)

**Structure:** Group LSOAs with similar characteristics (e.g. rural isolation, high older adult density)

### **Strategic Fit:**

- Enables targeted responses to shared challenges (e.g. transport, workforce, isolation)
- Supports thematic commissioning and shared service models

### **Operational Implications:**

- Requires new governance arrangements and cross-district collaboration
- May improve efficiency in rural service delivery and workforce deployment

### **Advantages:**

- Responsive to shared challenges
- Enables targeted commissioning and resource pooling
- Supports innovation in rural service models

### **Limitations:**

- Less alignment with existing boundaries
- May require bespoke governance and data-sharing agreements

## 5.3. Option C: Need-Based Localities (Deprivation and Demand)

**Structure:** Localities defined by IMD deciles and ASC demand

**Example:** Spalding and Grantham as high-need zones

### **Strategic Fit:**

- Strong alignment with equity and outcome-based commissioning
- Prioritises investment in areas with greatest need

### **Operational Implications:**

- Requires robust data infrastructure and dynamic resource allocation
- May challenge traditional governance and community identity

### **Advantages:**

- Prioritises equity and outcomes
- Supports targeted investment and performance improvement
- Aligns with national ASC reform priorities

### **Limitations:**

- Complex to operationalise and communicate
- May lack community cohesion and identity
- Governance and leadership structures may be harder to define

#### 5.4. Comparison Table: Locality Structuring Options

This table presents a comparative assessment of three locality structuring options: Place-Based, Clustered, and Need-Based; using criteria that reflect both strategic and operational considerations. These include governance and fit, community identity, equity, and responsiveness to local need. The scoring framework enables a transparent evaluation of each option's strengths and limitations, supporting the recommendation of a preferred locality configuration for ASC delivery within the future unitary.

Criteria	Place-Based	Clustered	Need-Based
<b>Strategic Alignment</b> - fit with LGR goals and existing governance structures	3	2	3
<b>Operational Simplicity</b> - ease of implementation and transition	3	2	1
<b>Responsiveness to Need</b> - ability to reflect local demand, demographics, and service pressure	2	3	3
<b>Equity &amp; Outcomes</b> - potential to reduce inequalities and improve ASC outcomes	2	2	3
<b>Governance Fit</b> - clarity and feasibility of leadership and accountability arrangements	3	2	1
<b>Community Identity</b> - alignment with local identity and cohesion	3	2	1
<b>Total Score</b>	<b>16</b>	<b>13</b>	<b>12</b>

Following this comparative assessment of locality structuring options, **Option A: Place-Based Localities is recommended as the preferred model for the future unitary.**

This approach offers the strongest alignment with existing governance structures, enabling a smoother transition during LGR. It builds on familiar district boundaries, which supports

continuity, stakeholder engagement, and operational clarity. While it may not fully reflect demand hotspots or deprivation clusters, these limitations can be mitigated through targeted commissioning and performance monitoring within each locality.

This model provides a stable foundation for integrated locality working, while allowing flexibility to evolve service models and resource allocation as data maturity and digital infrastructure improve.

While Option A, is recommended for initial implementation due to its alignment with existing governance and ease of transition, it is anticipated that the unitary will evolve operationally. Over time, there may be a shift toward Option B (Clustered) or Option C (Need-Based) models, particularly as data maturity improves and commissioning becomes more targeted. This phased approach supports both continuity and innovation.

This model is recommended as the basis for detailed design, with scope to incorporate elements of clustering or need-based targeting within each locality as part of commissioning and delivery planning.

## 6. Workforce Modelling

This section outlines indicative workforce structures and associated costs for Adult Social Care (ASC) across the proposed future unitary area comprising South Kesteven, North Kesteven and South Holland. The aim is to provide a baseline understanding of workforce requirements and financial implications to inform future service design and integration planning as part of LGR.

### 6.1. Data Constraints and Assumptions

A key constraint in this phase is the **absence of geo-coded workforce data**. Without granular information on where staff are currently deployed or where future demand will be concentrated, it is not possible to model locality-based workforce deployment with precision. As a result, the following assumptions have been made:

- **Vacancy rates** and **rurality factors** have been applied to base FTEs to estimate adjusted workforce needs.
- **Standardised pay bands** have been used across localities for consistency.
- The modelling is limited to **Level 3 workforce design** — i.e., indicative structures by role and locality. **Detailed design** (Level 4 and beyond) will require geo-based data and service mapping in the next phase.

### 6.2. Approach and Methodology

The modelling approach involved the following steps:



1. **Baseline FTEs** were sourced from existing service data provided by Lincolnshire County Council.
2. **Vacancy rates** were applied to reflect current recruitment challenges.
3. A **rurality factor** was introduced to adjust for service delivery complexity in dispersed geographies.
4. **Adjusted FTEs** were calculated to reflect realistic workforce needs.
5. **Role-based costings** were applied using standard pay bands.
6. A **central senior management structure** was modelled separately to reflect strategic leadership and commissioning functions.

### 6.3. Adjusted FTE Estimates

The vacancy rates in the workforce modelling below were applied using the following formula:

$$\text{Adjusted FTE} = \text{Base FTE} \times (1 + \text{Vacancy Rate}) \times \text{Rurality}$$

This means each locality's base staffing level was first increased to account for vacancies, and then further adjusted to reflect rurality-related service delivery complexity.

Locality	Base FTE	Vacancy Rate	Rurality Factor	Adjusted FTE
<b>South Kesteven</b>	120	12%	1.05	141
<b>North Kesteven</b>	100	10%	1.10	121
<b>South Holland</b>	90	15%	1.15	119

These figures provide a locality-level estimate of workforce requirements, adjusted for recruitment and delivery context.

### 6.4. Workforce Cost Estimates

#### 6.4.1. Local Delivery Roles

Locality	Role	Estimated FTE	Standardised Salary (£)	Estimated Cost (£)
<b>South Kesteven</b>	Care Worker	113	22,000	2,486,000
	Senior Care Worker	14	26,000	364,000

<b>North Kesteven</b>	Team Leader	10	32,000	320,000
	Manager	4	45,000	180,000
	Care Worker	97	22,000	2,134,000
	Senior Care Worker	12	26,000	312,000
<b>South Holland</b>	Team Leader	8	32,000	256,000
	Manager	4	45,000	180,000
	Care Worker	95	22,000	2,090,000
	Senior Care Worker	12	26,000	312,000
	Team Leader	8	32,000	256,000
	Manager	4	45,000	180,000

#### 6.4.2. Total Estimated Local Delivery Costs

Locality	Total Estimated Cost (£)
<b>South Kesteven</b>	3,350,000
<b>North Kesteven</b>	2,882,000
<b>South Holland</b>	2,838,000
<b>Total Local Delivery Costs</b>	<b>9,070,000</b>

#### 6.4.3. Central Senior Management Structure

The below structure reflects the strategic leadership required to oversee integrated ASC delivery across the future unitary.

Role	FTE	Pay Band (£)	Total Cost (£)
<b>Director of Adult Services</b>	1	95,000	95,000
<b>Assistant Director</b>	2	80,000	160,000
<b>Strategic Commissioning Lead</b>	2	70,000	140,000

## 7. Operational Considerations

### 7.1. Purpose

This section outlines operational considerations for the future unitary ASC workforce, building on the Level 3 workforce modelling. It aims to identify key factors that will influence service delivery, workforce deployment, and management efficiency across the localities.

### 7.2. Scope and Constraints

Operational modelling is constrained by the absence of geo-coded workforce deployment data, which limits the ability to assess travel time, caseload distribution, and supervision structures at a granular level. Assumptions have therefore been made based on indicative FTEs and standard delivery models.

### 7.3. Key Themes

#### 7.3.1. Locality vs Centralisation

- The future unitary must balance **local responsiveness** with **economies of scale**.
- Locality-based teams may be preferable for reablement, safeguarding, and community support.
- Centralised functions (e.g. commissioning, brokerage) can drive consistency and efficiency.

#### 7.3.2. Supervision Ratios

Indicative modelling assumes:

- 1 Manager per 25–30 staff
- 1 Team Leader per 10–12 staff

These ratios will need to be validated against service complexity and geography.

#### 7.3.3. Shift Patterns and Coverage

Care delivery requires 7-day coverage, with peak demand in mornings and evenings.

Modelling assumes standard full-time equivalents, but future design must incorporate:

- Part-time and flexible contracts
- Night and weekend shifts
- On-call arrangements

#### **7.3.4. Digital Enablement**

A digital maturity review has not been completed as part of the scope of this report however mobile working, scheduling tools, and digital case management will be critical for future delivery. Investment in digital infrastructure will be a key opportunity to reduce travel time and improve productivity.

#### **7.3.5. Travel Time and Rurality**

Rurality factors have been applied to FTE estimates, but actual travel time modelling is needed. South Holland may require additional staffing or flexible deployment models.

### **7.4. Implications**

- Workforce deployment must be tailored to geography, demand, and service type.
- Management structures must support supervision, escalation, and quality assurance.
- Operational resilience will depend on flexible staffing, digital tools, and locality intelligence.

### **7.5. Recommendations**

- Undertake geo-coded workforce mapping in the next phase to provide greater granular modelling.
- Model caseloads and travel time using GIS and service data.
- Engage operational leads to co-design shift patterns, team structures, and deployment models.
- Pilot digital enablement tools to assess impact on productivity and service quality.

## **8. Strategic Considerations**

This section outlines the strategic enablers and partnerships required to support a sustainable and integrated ASC system across the future unitary authority. It focuses on commissioning, partnerships, and digital infrastructure which are all critical to shaping future delivery models and aligning with wider system reform.

### **8.1. Commissioning**

#### **8.1.1. Strategic vs Tactical Commissioning**

The future unitary presents an opportunity to shift from fragmented, tactical commissioning to a strategic commissioning model that aligns with population needs and long-term outcomes at a more localised level than the current provision, whilst supporting integrated pathways across health and care.

#### **8.1.2. Pooled Budgets**

To enable integrated commissioning, the future unitary should explore pooled budgets with NHS partners, particularly for discharge pathways, community health and reablement, and

mental health and learning disability services. This would support joint accountability and reduce duplication across systems.

### **8.1.3. Market Development**

The care market across Lincolnshire is fragmented and fragile, with rurality and workforce pressures impacting sustainability. Strategic commissioning must develop local provider capacity, especially in rural areas; support VCSE sector growth and innovation; use block contracts or alliance models where appropriate to stabilise provision.

## **8.2. Partnerships**

### **8.2.1. Police and Safeguarding**

Effective safeguarding requires strong operational and strategic links with Lincolnshire Police. The unitary should:

- Review and update multi-agency safeguarding hubs (MASH).
- Align thresholds and escalation protocols.
- Share data securely across agencies.

### **8.2.2. VCSE Sector Integration**

The VCSE sector plays a vital role in prevention, wellbeing, and community support. Strategic partnerships should:

- Formalise VCSE involvement in commissioning and delivery.
- Provide core funding and capacity-building support.
- Embed VCSE organisations in locality teams and discharge pathways.

### **8.2.3. NHS / ICB Alignment**

Alignment with the Lincolnshire Integrated Care Board is essential. Priorities include:

- Joint planning for community health services.
- Integrated discharge pathways and reablement.
- Shared workforce planning and digital infrastructure.

The unitary should co-develop place-based plans and participate in ICB governance structures to ensure ASC is embedded in system-wide transformation.

## **8.3. Housing Integration**

The formation of the future unitary authority presents a unique opportunity to align housing services and ASC within a single system framework. The merger of three Housing Revenue Accounts (HRAs) will consolidate housing stock, repairs, and tenancy management functions, creating the conditions for joined-up service delivery that supports independence, wellbeing, and prevention.

### 8.3.1. Strategic Opportunity

Housing is a key determinant of health and social care outcomes. Poor housing conditions, insecure tenancies, and delayed repairs can exacerbate physical and mental health issues, increase care needs, and hinder hospital discharge. Conversely, well-managed housing services can:

- Enable safe discharge from hospital into suitable accommodation.
- Support reablement and recovery through adaptations and responsive repairs.
- Reduce demand for residential care by enabling independent living.
- Improve carer sustainability through housing-based respite and support.

### 8.3.2. Locality-Based Integration

As ASC locality teams are established, there is a strategic opportunity to co-locate or align them with housing officers, repairs teams, and voids management functions. This could include:

- Joint case management for individuals with complex needs.
- Shared digital systems for tracking housing and care interventions.
- Coordinated responses to safeguarding, hoarding, or tenancy breakdown.
- Integrated planning for supported housing, extra care, and adaptations.

### 8.3.3. Operational Implications

- Locality alignment of housing and ASC teams will require joint workforce planning, shared training, and clear governance.
- Digital interoperability between housing and ASC systems will be essential to enable real-time coordination.
- Asset planning should consider the role of housing stock in delivering care (e.g. step-down beds, supported living units).

### 8.3.4. Next Phase Considerations

- Map housing assets and tenancy data against ASC demand hotspots.
- Pilot integrated housing–ASC locality teams in areas with high need.
- Explore joint commissioning of housing-related support services.
- Engage tenants and service users in co-designing holistic support pathways.

## 9. Conclusion

The analysis presented in this Discovery report reinforces the strategic case for a **locality-based model** of Adult Social Care delivery across the future unitary area of South Kesteven, North Kesteven and South Holland. This model is not only responsive to the distinct demographic, geographic, and socioeconomic profiles of each locality, but also aligns with national policy direction toward integrated, place-based care.

The locality model offers a compelling framework for:

- **Tailored service delivery** that reflects local needs, deprivation levels, and population projections.
- **Operational resilience**, particularly in rural and hard-to-reach areas, through adjusted workforce deployment and flexible staffing.
- **Partnership integration**, enabling closer alignment with NHS, VCSE, and safeguarding partners at the place level.
- **Strategic commissioning**, with the potential to move beyond fragmented, tactical approaches toward pooled budgets, market shaping, and outcome-based contracts.
- **Digital transformation**, through interoperable systems, mobile working, and performance dashboards that support real-time decision-making and accountability.

The workforce modelling undertaken in this phase provides a robust Level 3 foundation, estimating adjusted FTEs and costs across localities and roles. It highlights the scale and complexity of ASC delivery in a unitary context, and the need for strategic investment in workforce planning, digital infrastructure, and commissioning capability.

However, the absence of geo-coded workforce and service deployment data remains a critical constraint. Without this, it is not possible to fully model travel time, caseload distribution, or locality-based supervision structures. Addressing this gap will be essential in the next phase of design.

The strategic considerations explored — from commissioning reform and partnership alignment to digital enablement — underscore the importance of a whole-system approach. The future unitary must not only consolidate structures, but also reimagine how care is planned, delivered, and experienced across communities.

This report sets the stage for a transformation programme that is ambitious, evidence-led, and grounded in the realities of local delivery. It provides a clear rationale for change and a practical framework for moving from discovery to design and implementation.