NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board
Annual Report and Accounts

1st July
2022
to
31st March
2023

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STATEMENT BY THE ICB CHAIR AND CHIEF EXECUTIVE

Introduction

We welcome you to the first Annual Report for NHS Lincolnshire Integrated Care Board which covers the period between 1st July 2022 to 31st March 2023. This Annual Report has been prepared in accordance with the National Health Service Act 2006 Directions by NHS England, in respect of Integrated Care Board's Annual Reports.

Overview

NHS Lincolnshire Integrated Care Board (ICB) was established on the 1st July 2022 under the Health and Care Act 2022 and is one of 42 ICBs in the country that replaced Clinical Commissioning Groups (CCGs). ICBs are described as taking the lead in:

- Setting system level strategy and plans, including the joint 5 year forward and capital plans.
- Working with partners to ensure effective arrangements are in place and across the system to deliver performance, transformation and outcomes.
- Commissioning and managing contracts, delegation and partnership agreements with providers and primary care.
- First line oversight of health providers across the Integrated Care System (ICS) - co-ordinating any support for providers and providing assurance input to regulator assessments.

Our ICB is a key part of the wider Integrated Care Partnership (ICP), which is a partnership of all organisations that deal with improving care, health and wellbeing for the people of Lincolnshire. Whilst we are a new organisation, the Lincolnshire system has been effectively operating as an ICS for a significant period of time before this.

We now want to build on this further by taking the opportunity to become one of the best health and care systems for the people we serve. We are resolute in our determination to achieve this by building on the foundations and strong relationships we have already established with our key partners and stakeholders.

Working with our partners

In our first nine months as an ICB we have worked extremely hard and in conjunction with our system partners to improve collaboration both within the NHS and across the health and care sector, to establish a culture and the right behaviours and values which enable us to work effectively together. At the same time we have been working really hard across the health and care system on delivery at the front line in terms of recovery from the COVID-19 pandemic. We have made excellent progress, particularly in areas such as mental health, learning disabilities, autism, children and young people, improving waiting times access for non-urgent appointments, improving staff satisfaction, as well as finding solutions to improve cancer screening. We have also made good progress in reduction of 78 week waits. All of this has been achieved despite the industrial action by both nursing and junior doctor staff, although we acknowledge the longer term impact and consequences of on-going strikes may not come to fruition for some months. We will continue to work really hard as a system to minimise the impact on both planned and routine care for the people we serve.

Integrated Care Partnership Strategy

As set out in the Health and Care Act 2022 the Lincolnshire Integrated Care Partnership (ICP) is required to develop an Integrated Care Strategy setting out how assessed needs can be met by partners across the Integrated Care System including the Integrated Care Board (ICB), local authorities, community and voluntary sector, and NHS England.

In February 2023, the interim Lincolnshire ICP Strategy was published. This was created as a partnership between the ICB and Lincolnshire County Council, and outlines 'how' the health and care system will focus integration efforts on key enablers to support delivery of the Health and Wellbeing Strategy and its priorities. The systems overarching ambition and aims, with the Health and Wellbeing Board's Strategy, outline 'what' the priority areas in the health and care system will focus on in light of the Joint Strategic Needs Assessment (JSNA).

To help guide us in our work we have developed a shared ambition as below.

For the people of Lincolnshire to have the best possible start in life, and be supported to live, age and die well

We are now all aligned in terms of our agreed aims of reducing health inequalities, improving the quality of access and outcome for our population, providing value for money, and together improving the social and economic power of health and care to the population we serve.

Underpinning this ambition, four key aims have been defined. These are set out in the ICP Strategy document and whilst they are aligned to those defined nationally for ICS's, they are specific to Lincolnshire, as they were identified through the engagement process led by the Lincolnshire Health and Wellbeing Board to develop its Joint Health and Wellbeing Strategy.

These aims are:

- Focus on prevention and early intervention.
- Tackle inequalities and equity of service provision to meet population needs.
- Deliver transformational change in order to improve health and wellbeing.
- Take collective action on health and wellbeing across a range of organisations.

In addition, the Integrated Care Partnership Strategy identifies the five priority enablers the Lincolnshire health and care system and its partners will focus their integration efforts on to deliver these aims and overarching ambition.

These priority enablers are:

1. Population health and prevention
2. Workforce and skills
3. Personalisation
4. Community engagement and involvement
5. Data and information systems

The Lincolnshire ICP Strategy can be viewed here: Better Lives Lincolnshire - ICP strategy January 2023

Joint Forward Plan

Following on from the ICP Strategy on the previous page, the Health and Social Care Act 2022 requires the ICB and its partner Trusts to prepare a first Joint Forward Plan (JFP) before the start of the financial year. The aim is to have the JFP published by the 1st April each year but as this is an interim year the requirement is to publish and share the final plan with NHS England, Integrated Care Partnerships (ICPs) and Health and Wellbeing Boards (HWBs) by the 30th June 2023.

NHSE has developed and published guidance to support the ICB and partner Trusts in this exercise, which was published the same day as the Operational Planning Guidance (23rd December 2022).

Working in conjunction with our wider group of Lincolnshire partners in the ICP, the planned approach is to produce an ambitious but achievable five-year NHS plan that describes the vision for the NHS in Lincolnshire and how that will be delivered. This plan will sit alongside and complement the ICP Strategy.

There are three constituencies that need to be central to the design and development of the Lincolnshire NHS Strategy. Firstly the clinicians across the system (oversight through the Clinical and Care Directorate), secondly the ICB partner organisations and finally people and communities. This all about co-production and the intention is to go through an open process with the people and communities of Lincolnshire, NHS partners, and wider system partners, to identify how NHS services will meet the population's physical and mental health needs over the next five years. Further information on the engagement work being undertaken is detailed under the section on Engaging People and Communities in this report.

The Lincolnshire NHS Strategy has been finalised and was published by the required deadline of 30th June 2023.

Winter pressures

Winter always sees great pressure on the health system and the winter of 2022/23 has been one of the most pressured the NHS has ever seen. In Lincolnshire we have been able to manage the pressures within hospitals and in primary care reasonably well through a number of initiatives, such as the establishment of virtual wards and improvements to hospital discharge processes, launch of the 'Breaking the Cycle' scheme by (ULHT) to tackle issues of long waits for beds in A&E, bed blocking by fit patients and lengthy ambulance waiting times and the active beds recovery initiative. Our System Control Centre (SCC) manages demand and capacity and ensures adequate oversight of operational pressures at all times, ensuring rapid decisions are made to respond to any emerging challenges.

Bed occupancy in hospital remained high during winter along with delays in transfers from ambulance to hospital departments. In short, there are more people needing to get into hospital facing delays due to the time it takes to get people out of hospital. A rise in flu cases over winter also placed extra pressure on services, with growing hospital admissions, along with the unanticipated increase in the number of cases of children with invasive group strep A.

However, staff continue to respond superbly. ICB staff have consistently gone the 'extra mile', have adapted rapidly to changing circumstances and demands and have served Lincolnshire exceptionally well. In meeting these challenges ICB staff have worked closely with all of our partners across Lincolnshire and have together made great progress in system and partnership working, in improving care for patients, in how health inequalities are tackled, and in improving health outcomes. Their hard work, commitment and dedication is hugely important and valued and we would like to express our genuine thanks and appreciation.

The ICB participated in the national staff survey in 2022 with the outcome published in March 2023. We are very proud to say that the ICB staff survey results were very positive and ranked us third in the country. Further information is set out under the Staff Report on page 99.

We would also like to say a big thank you to our partners who the ICB has worked with very closely across the health and care system in Lincolnshire, be that our GPs, our NHS Trust colleagues, those in local government, social care and the third sector. There has been a huge team effort in terms of getting us out the other side.

Provider Collaboratives

The 2022 Health and Care Act included a new 'duty to collaborate' for NHS providers. Each NHS provider is required to be a member of at least one provider collaborative. The Lincolnshire Health and Care Collaborative (LHCC) was established and is an innovative partnership which aims to improve the health and wellbeing of everyone in in the county.

In late 2022, the ICB working with NHS provider colleagues in the county, and in close liaison with NHSE Midlands Region, agreed to commission an external and impartial review of the NHS provider landscape in the county. The current phase of this piece of work came to a conclusion in March 2023. The next phase will be to consider the outcome of that review and how that will be taken forward.

Hewitt Review

In November 2022, the Rt Hon Patricia Hewitt was commissioned to lead an independent review into how the oversight and governance of ICSs can best enable them to succeed. The report was published on the 4th April 2023, and the government is now considering the recommendations made by the review.

Forward Look

Looking forward to 2023/24, a real focus for the ICB and the ICS, besides continuing to deliver better services to people, will be on solving our challenges. We are working hard as a system to get into financial balance within two years, we will want to fully bring in all our partners - the voluntary sector, the care sector, the Local Authority and the NHS, together with patients, to build a new model of care in the community for many of our patients. To enable us to do this we will need to focus on three priority areas:

Firstly, a co-produced plan to build a self-sustaining workforce pipeline for staff, so that we are not held to ransom by exorbitant fees from agencies and bank organisations. Together we will build a solution around what time staff can offer so that they are more in control of their employment.

Secondly, we will continue to explore the power of digitalised solutions to help us transform the way we provide services.

Thirdly, those organisations and colleagues who provide care to patients will begin to do so in a different way. Our mantra will be to devolve patient services to the lowest possible level - the neighbourhood - where it makes sense to do so; we will want to keep people safely in their own homes suitably supported by all of our system staff if we can.

On a final note, we would like to express our thanks to those ICB Board Members who will not be going forward with us into 2023/24, namely Mr Pete Moore, Non-Executive Director and Dr Dave Baker, Partner Member – Primary Medical Services. Mr Moore unfortunately was unable to join the ICB following his appointment for personal reasons and resigned in January 2023. Dr Baker has supported the ICB Board since its inception as the Interim Primary Care Partner Member. This was only on an interim basis until the 31st March 2023. Dr Kevin Thomas has been appointed as the new Primary Care Partner Member and we look forward to working with him going forward.

We hope that you find this Annual Report of interest. If you have any comments or questions you would like to raise, please do not hesitate to contact us either via email or telephone as per the details specified on the back of this report.

Sir Andrew Cash
Interim ICB Chair

Mr John Turner
Chief Executive
(Accountable Officer)

PERFORMANCE REPORT

Overview

The purpose of the overview is to give a brief summary of the ICB, its purpose and activities, demographic profile, how we work in the health system, and with whom we have contracts. It also summarises our performance against key targets, risks to achieving our strategic objectives and what our main challenges have been this year. We have provided more detail on all these areas later in the report.

Who we are

ICBs were created on 1st July 2022 following amendment of the National Health Service Act 2006 and the passage of the Health and Care Act 2022. ICBs replaced Clinical Commissioning Groups but continued to provide the same services. ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan health and care services to meet the needs of their population.

They exist to achieve four aims:

- Improve outcomes in population in health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development

Lincolnshire is the fourth largest county in England covering an area of 5,921 square kilometres with a resident population of 768,400 (Census 2021) with a 49% male and 51% female breakdown. It is rural, with no motorways, little dual carriageway and 80 kilometres of coastline. Residents are dispersed across Lincoln city, market towns, rural and coastal areas.

A map of the geographical area covered by NHS Lincolnshire Integrated Care System is detailed opposite.

The geographical area covered by the ICB is served by seven District and Borough Councils. The upper tier Local Authority is Lincolnshire County Council.

The following partner organisations are part of the Lincolnshire ICS:

- East Midlands Ambulance Service NHS Trust (EMAS)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire County Council (LCC)

The Lincolnshire ICS is named
Better Lives Lincolnshire

Each ICS is comprised of an Integrated Care Board (ICB), NHS providers, local authorities and other local partners in a given geographical area. An Integrated Care Board has the function of arranging for the provision of services for the purpose of the health service in accordance with the NHS Act 2006 and the Health and Care Act 2022.

The Integrated Care Board and each responsible local authority whose area coincides with or falls wholly or partly within the Board's area must establish a joint committee known as an Integrated Care Partnership. Further information on the Integrated Care Partnership is set out on page 14.

Lincolnshire COUNTY COUNCIL *Working for a better future*

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

Lincolnshire District Councils

- **City of Lincoln**
- **Boston Borough**
- **East Lindsey**
- **West Lindsey**
- **North Kesteven**
- **South Kesteven**
- **South Holland**

NHS Lincolnshire Integrated Care Board

Single NHS ICB planning, commissioning and developing healthcare services for the population of Lincolnshire.

Voluntary Engagement Team

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

Lincolnshire Care Association

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

Lincolnshire Primary Care Network Alliance

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

NHS Lincolnshire Community Health Services NHS Trust

NHS Lincolnshire Partnership NHS Foundation Trust

NHS United Lincolnshire Hospitals NHS Trust

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

The NHS Lincolnshire Integrated Care Board was established as a statutory body on the 1st July 2022 under the Health and Care Act 2022 and by 'The Integrated Care Boards (Establishment) Order 2022'

The following members must sit on an ICB: A Chair and Chief Executive. a Director of Finance, Medical Director and Director of Nursing. at least two Non-Executive Members. at least three 'partner' members to bring 'knowledge and a perspective from their sectors', nominated by NHS Trusts, Primary Medical Services and local authorities in each ICB area, and an individual with expertise and knowledge of mental illness.

The diagram below demonstrates the breakdown of the NHS Lincolnshire Board by role. Details of the names of the Board Members can be found under the Corporate Governance section of this report.

LINCOLNSHIRE ICB BOARD

Non-Executive Members	Executives	Partner Members	Other Members
1 Chair	1 Chief Executive Officer	1 Local Authority	1 Executive Board Mental Health Member
5 Non-Executive Members	1 Director of Finance	1 Provider of Primary Medical Services	
	1 Director of Nursing	1 NHS Trust	
	1 Medical Director		

For the period 1st July 2022 to 31st March 2023, the ICB Interim Chair was Sir Andrew Cash. The ICB Chief Executive (Accountable Officer) is Mr John Turner, who has overall responsibility for managing the work of the ICB.

The ICB has regular participants at its Board meetings as set out below:

- Chair of the Health and Wellbeing Board
- Public Health Representative
- Director of Strategic Planning, Integration and Partnerships
- Director for System Delivery
- Director for Primary Care and Community and Social Value
- Director for Health Inequalities and Regional Collaboration
- Healthwatch Representative
- Voluntary and Care Sector Representative

The ICB is required to hold its formal meetings in public. However, these are not public meetings in the normal sense, but they are meetings held in public. The main difference is that the public are entitled to come along and listen to the Board discussion, but they are not able to take part or ask questions during the formal meeting.

Further details on the Board meetings are contained in the ICB Constitution and on the ICB website: www.lincolnshire.icb.nhs.uk

Integrated Care Partnerships (ICPs)

Each ICS is required to have a Partnership at system level established by the NHS and local government as equal partners. The ICP is a Joint Committee of the ICB with the local authority, rather than a statutory body.

Lincolnshire only has one upper tier local authority - Lincolnshire County Council, and as such only has one ICP - the Lincolnshire Integrated Care Partnership.

The ICP operates as a forum to bring partners – local government, NHS and others together across the ICS area to align purpose and ambitions with plans to integrate care, and improve health and wellbeing outcomes for their population.

The ICP has specific responsibility to develop an 'integrated care strategy' for its whole population (covering all ages) using the best available evidence and data, covering health and social care (both children's and adult's social care), and addressing health inequalities and the wider determinants which drive these inequalities.

The strategy must set out how the needs assessed in the Joint Strategic Needs Assessment(s) for the ICB area are to be met by the exercise of NHS and local authority functions. This will be complemented by the Joint Health and Wellbeing Strategy prepared by each Health and Wellbeing Board in the geographical area of the ICS.

Further details on the Lincolnshire Integrated Care Strategy are contained later in this report. The Lincolnshire Integrated Care Strategy is also available here: https://www.lincolnshire.gov.uk/downloads/file/7598/lincolnshire-integrated-care-strategy

The Lincolnshire Integrated Care Partnership is composed of the following members:

- Executive Councillor for NHS Liaison, Community Engagement, Registration and Coroners (Chair)
- ExecutiveCouncillor for Children's Services, Community Safety and Procurement
- Executive Councillor for Adult Care and Public Health
- Five further County Councillors
- Director of Public Health
- Executive Director of Children's Services
- Executive Director of Adult Care and Community Wellbeing
- ICB Chair
- ICB Chief Executive
- Chair Primary Care Network Alliance
- Three Chairs of Lincolnshire NHS Trusts
- Three Chief Executives of Lincolnshire NHS Trusts
- One designate District Council representative
- Police and Crime Commissioner for Lincolnshire
- Designated representative of Healthwatch Lincolnshire

Associate Members

- Designated representative from NHSE
- Chief Constable / representative Lincolnshire Police
- Designated representative for the Voluntary and Community Sector

The following roles attend both the Integrated Care Board and the Integrated Care Partnership meetings:

- ICB Chair
- ICB Chief Executive
- Local Authority Partner
- NHS Trust Partner
- Chair of the Health and Wellbeing Board
- Public Health Representative

Provider Collaboratives

As of 1st July 2022, all Trusts providing acute and/or mental health services were expected to be part of one or more provider collaboratives. For Lincolnshire this includes the following organisations:

- Lincolnshire Community Health Services NHS Trust (LCHS)
- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)

Place-based Partnerships

There is no area within the Lincolnshire geographical area described as a 'Place' as per the terminology set out in NHS England and Improvement national guidance. As a consequence, there will be no 'Place' plans in Lincolnshire.

Integrated health and care at a local level in the county will be primarily based on the Primary Care Network (PCN) geographical footprints.

PURPOSE AND ACTIVITIES OF THE ICB

The ICB budget for 1st July 2022 to 31st March 2023 was £1.3m and the organisation employs almost 400 staff.

The ICB is responsible for commissioning, or buying, the majority of healthcare services for the population of Lincolnshire. Those services include planned care, cancer care, emergency care, mental health, learning disability and Autism, maternity services, and community and GP services for our 813,240 registered patients across 82 GP practices. We commission services from a wide range of providers in and outside of Lincolnshire.

Our vision and priorities shape who we are, how we work and help us to make the right decisions of behalf of people in Lincolnshire.

Our goal is to ensure that everyone living in Lincolnshire has the best possible health and wellbeing they can. To achieve this, we work alongside our health and care partners to provide people with access to quality healthcare and reduce the health inequalities that exist today.

The ICB uses its resources and powers to achieve demonstrable progress on the four key aims of an ICS, collaborating to tackle complex challenges, including:

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long-term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible.

We involve local patients, carers, the public and organisations, such as Healthwatch Lincolnshire, to help us better understand local need and commission high-quality care that is safe, effective and focused on the patient experience – as set out in the NHS Constitution and the ICB Constitution.

ICBs are accountable to the Secretary of State for Health, although NHS England, has responsibility for the other third of the NHS healthcare spend (for example, dental services and some specialised hospital services). Read more about the NHS structure here: https://www.england.nhs.uk/

NHS England currently commissions the majority of dental, pharmaceutical, optometry and some vaccination services.

General Practice (GP) services are commissioned by the ICB under delegated agreement from NHS England.

From 1st April 2023, all ICBs will assume delegated responsibility for primary care services, including Pharmacy, Optometry and Dentistry, and ICBs will will also enter into joint working arrangements with NHS England to jointly commission some specialised services. It is intended that NHS England will delegate further direct commissioning functions to ICBs from April 2024.

OUR MAIN PARTNERS AND PROVIDERS

Members

We commission services from a number of local organisations, including:

- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- Northern Lincolnshire and Gooles Hospitals NHS Foundation Trust (NLAG)
- North West Anglia NHS Foundation Trust (NWAFT)
- East Midlands Ambulance Service NHS Trust (EMAS)
- All GP practices in Lincolnshire

NHS 111 - the local provider of NHS 111 is Derbyshire Health United.

Non-Emergency Transport Services are provided by Thames Ambulance Services Limited (TASL).

We work closely with local councils to ensure that health and social care services are as effective as possible. The council also employs public health specialists who promote healthy lifestyles and prevent ill health.

Further information on Lincolnshire County Council and Public Health Lincolnshire can be found here:

Homepage – Lincolnshire County Council

Other key partners include:

Public Health

We have continued our close working with Public Health colleagues based within Lincolnshire County Council on a number of areas, including the development of the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and social prescribing, which are referred to later in the report.

The Consultant in Public Health (or an appropriate deputy) regularly attends ICB Board meetings as identified on page 14.

Healthwatch Lincolnshire

Healthwatch Lincolnshire is the independent consumer champion for health and social care in Lincolnshire, putting patients at the heart of health and social care services. Their role is to give local people a voice to influence and challenge how health and social care services are provided locally. Healthwatch provides the ICB with regular feedback from patients on their experiences of accessing NHS services, and assists the ICB to carry out surveys and consultations when we are making key decisions about the services we commission.

Representatives from Healthwatch regularly attend and participate in Board, Primary Care Commissioning Committee and Quality and Patient Experience Committee meetings.

Find out more about Healthwatch Lincolnshire here: www.healthwatchlincolnshire.co.uk

Health and Wellbeing Board

The ICB also works closely with the Health and Wellbeing Board, which is a forum that brings together key leaders from the NHS, Public Health, and care systems to work together to improve the health and wellbeing of the people of Lincolnshire and reduce health inequalities.

Board members collaborate to understand communities' needs, agree priorities and encourage commissioners to work in a more joined up way, and the Board has a duty to encourage integrated working for the purpose of advancing the health and wellbeing of the people of Lincolnshire.

The Chair of the Health and Wellbeing Board regularly attends and participates in the ICB Board meetings and the ICB Chief Executive is the Vice Chair of the Health and Wellbeing Board.

Further details can be found here: www.lincolnshire.gov.uk/health-wellbeing/health-wellbeing-board

Voluntary Sector Services

The voluntary sector supports volunteers, voluntary and community organisations across Lincolnshire, and will often provide assistance to the ICB to ensure the voluntary/third sector are informed about local health services and involved in any key decisions about we make the services we commission.

The Deputy Chair of the Lincolnshire Voluntary Engagement Team regularly attends and participates in the ICB Board meetings as identified on page 13.

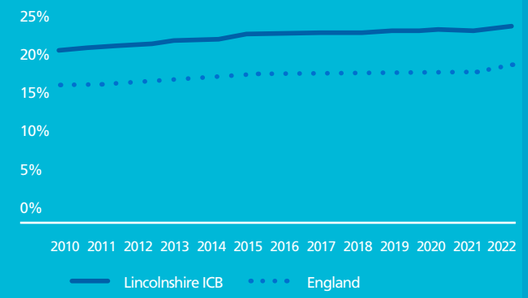
SOCIAL, COMMUNITY AND HUMAN RIGHTS ISSUES

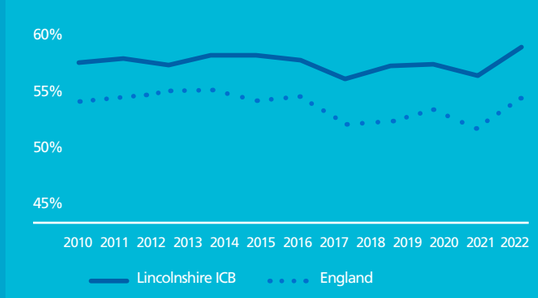
The ICB places a high priority on ensuring that it discharges it obligations as a good corporate citizen and takes into consideration its responsibilities towards serving and meeting the needs of local people, including safeguarding their human rights.

We ensure equality and diversity run through our work as described in detail in our section on equality and diversity on pages 63 and 64.

KEY ISSUES AND RISKS

The population represented by Lincolnshire ICB has a higher level of complex health issues such as diabetes, coronary heart disease, and Chronic Obstructive Pulmonary Disease (COPD) than the national average. Similarly the percentage of our population over the age of 65 and the index of deprivation continue to be above the average in England. The COVID-19 pandemic has starkly exposed these existing inequalities and, whilst they are key to our planning, they also continue to place pressure on the majority of our services.





GOING CONCERN

The ICB has adopted a 'Going Concern' approach in the preparation of its annual financial statements, despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014 as made by the ICB's External Auditors. This follows the interpretation in the Government Accounting Manual of Going Concern in the public sector.

In summary this interpretation provides that where a body can show anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that function in published documents (such as financial allocation plans), there is sufficient evidence of Going Concern. The only exception to this approach would be for public sector organisations which are classed as trading bodies. ICBs being funded by direct allocation through NHSE England are not trading bodies.

PERFORMANCE SUMMARY
– CHIEF EXECUTIVE

2022/23 remained an incredibly challenging year for the NHS nationally as it focused on the recovery of services following the COVID-19 pandemic, and this has been echoed within Lincolnshire. Much of this has impacted on performance throughout 2022/23, as the NHS remains under significant pressure - we continue to see extra demands on health services, whether from disrupted routine operations, higher mental health needs and increased demand for emergency care. In particular, staff have faced one of their busiest winters ever with record numbers of A&E attendances and the most urgent ambulance call outs, all alongside another wave of COVID-19. Thanks to the professionalism and commitment of those staff, the ICB continued to provide care to over 40,000 urgent and emergency care patients each week.

As we continue to manage living with COVID-19, we are also beginning to be able to see significant strides in our recovery plan as a result of protecting elective capacity in secure areas; for example, the NHS was able to reach its key ambition of eliminating the number of patients who had been waiting more than 104 weeks. However, we also recognise that we still have a big recovery challenge ahead to get waiting lists down to pre-pandemic levels.

Indicator	Standard	2022/23 latest period
A&E Waiting Time	<4 Hours	Not Achieved
Ambulance Catergory One	90% <15 Mins (life threatening)	Not Achieved
Ambulance Category Two	90% <40 Mins (emergency calls)	Not Achieved
Ambulance Category Three	90% <2 hours (urgent calls)	Not Achieved
Ambulance Category Four	90% <3 hours (less urgent calls)	Not Achieved
Referral To Treatment	< 18 Weeks	Not Achieved
Diagnostic Test Waiting Time	< 6 Weeks	Not Achieved
Cancer - All Suspected Cancers	< 2 Weeks	Not Achieved
Cancer - Asymptomatic Breast Cancer	< 2 Weeks	Not Achieved
Cancer - First Treatment from Decision	< 31 Days	Not Achieved
Cancer - Subsequent Surgery	< 31 Days	Not Achieved
Cancer - Subsequent Chemotherapy	< 31 Days	Achieved
Cancer - Subsequent Radiotherapy	< 31 Days	Achieved
Cancer - To First Definitive Treatment	< 62 Days	Not Achieved
Cancer - First Treatment From Screening Service Referral	<62 Days	Not Achieved
Cancer - First Treatment from Consultant Upgrade	< 62 Days	Not Achieved

PERFORMANCE ANALYSIS –
NHS CONSTITUTIONAL TARGETS

The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

The ICB seeks compliance with the constitution in conjunction with our healthcare providers by setting plans to deliver and requiring providers to provide remedial action plans where standards are not delivered. As many services were stopped, paused or operated at much reduced capacity in 2020 due to the pandemic, delivering the standards set as part of the NHS constitution remains challenging both nationally and in Lincolnshire, and we are working hard to mitigate the impact on our patients. Working in partnership with our main hospital provider is a key element of this.

The assessment of performance for each target is based on the following:

- Achieved - Performance at or above the standard
- Underachieved - Performance between the standard and the lower threshold (determined nationally)
- Not achieved - Performance below the lower threshold

How We Report Performance

A publicly available ICB Integrated Performance Report is tabled at the ICB Board and Board Committees - such as System Quality and Patient Experience and Service Delivery and Performance which provides comprehensive up-to-date detail of performance against all the ICB constitutional standards and targets across urgent care, cancer, planned care, mental health, primary care and a chapter on further key quality measures e.g. mortality rates, hospital infections and learning disability health checks. The report sets out causes for areas of underperformance along with key actions being taken to improve performance.

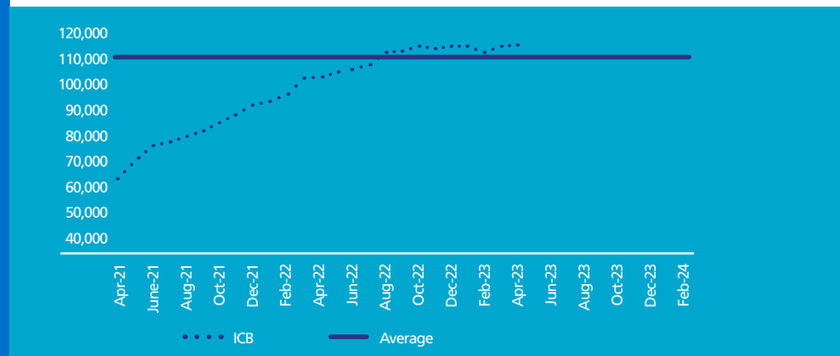
This monthly report is available to the public on the ICB website.

Planned Care

Lincolnshire ICB works with a wide range of providers to increase capacity and improve the time patients wait for treatments. The COVID-19 pandemic caused unprecedented disruption to routine services, with record numbers of patients waiting for appointments as well as those who have waited over a year for treatment nationally. This picture has been reflected in Lincolnshire, which has followed the national trend. Across 2022/23 the focus has been on eliminating the number of patients having to wait 104 weeks (two years) unless complex and reducing the number of patients waiting over 78 weeks (18 months).

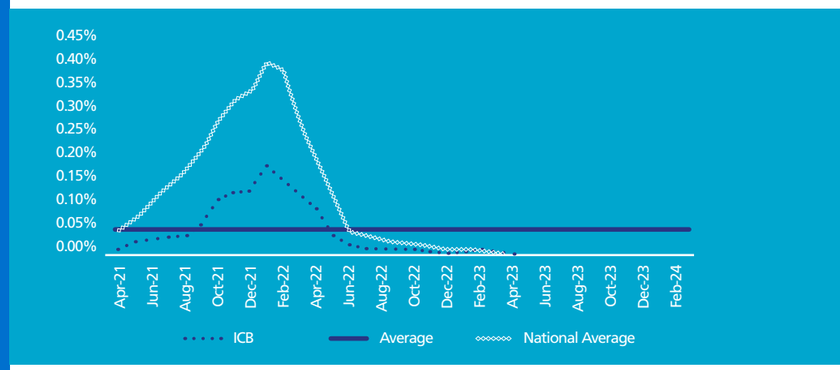
As expected, the total waiting list size for Lincolnshire patients at all hospitals has continued to increase and the reported figure for March 2023 was 114,151. However, there are signs that this is beginning to stabilise as visible in the run chart below.

Total Waiting List



We have continued to strengthen our oversight of patients waiting over 104 weeks with our main acute providers, and as a result of this work the percentage of our waiting list has remained under the national average (0.01% compared to 0.02%) and the number of patients waiting over 104 weeks has reduced from a peak of 172 to nine in March 2023.

Percentage of patients waiting over 104 weeks



The ICB Elective Activity Coordination Hub (EACH) has continued to work in partnership with our main provider on a process of validation which includes calling patients to reassure them that they are on the waiting list, determine if they still require an appointment, offer them the most appropriate appointment for their needs and to transfer clinically suitable patients to alternative providers where waiting times are shorter if appropriate. Over 15,000 patients have been contacted by the EACH in 2022/23 and it has significantly contributed to the reduction of patients waiting over 78 weeks.

Emphasis continues to be placed on increasing Advice and Guidance (A&G) to GPs to help reduce patient referrals where appropriate, providing more virtual appointments and offering more Patient Initiated Follow Ups (PIFU) to prevent unnecessary patient journeys and utilise clinical time more efficiently. As a system we are overachieving above plan for A&G with every months utilisation being above 30% against a 16% target, and have sustained a consistent position of above 28% for virtual consultations against a 25% target. Work is ongoing to engage with clinical teams to increase the PIFU position and expand this option to other providers. The system continues to be engaged in the Midlands Elective Delivery Programme both sharing and learning from best practice for certain clinical specialties to ensure we are maximising opportunities to deliver best clinical outcomes and experience for patients

The new Community Optometrist Triage Assessment and Treatment Service started on the 1st April 2023 with four providers operating with 27 optometrists across 25 locations with a delivered increase in provision and greater geographical coverage of the county, to improve patient access and experience. The service incorporates the Low Vision Service

(with three providers), further work is planned to increase the number of providers for the Low Vision Service. The service triages approximately 7,000 referrals per year and diverts 55% - 60% of referrals away from the hospital eye service, it assesses and treats nearly 4,000 patients, the main condition being suspected glaucoma which is assessed and monitored by the service and only referred to the hospital eye service when clinically appropriate.

The ICB has also been working with the Midlands Eyecare Transformation Network (METN) to procure an Electronic Eyecare Referral Service (EeRS) The procurement was completed in January and the ICB is working with the METN and preferred provider to implement EeRS in 2023/24.

Plans to expand the services currently being provided at the Grantham Community Diagnostic Centre (CDC) have now been approved by NHS England and, in addition to the existing plain film, NOUS, ECHO, AAA and diabetic eye screening, which started to deliver activity last year, the Grantham CDC will also start to deliver some MRI, CT, Spirometry, Fractional Exhaled Nitric Oxide (FeNo), ECG and blood test activity before the end of 2023. To date the CDC programme in Lincolnshire has successfully delivered an additional 47,318 diagnostic tests (as of 5th March 2023), and now operates services at Grantham seven days per week.

Since the start of the Lincolnshire CDC programme in 2021, the NHS Lincolnshire System have been successful in attracting an additional £4.6m in capital and £9.4m revenue investment into the county, with further investment expected for the development of a new CDC facility in the Skegness and coastal area in the next 12 months. This will provide some much needed, additional diagnostic capacity in an area of the county which experiences some significant challenges, including access to health services, high levels of deprivation and notable health inequalities.

Overall, during 2022, the number of quarterly diagnostic tests being carried out has increased by approximately 6% from the first three months (January to February 2022) compared to last three months (October to December 2022). This has, however, also been coupled with an increase in the overall size of waiting lists with an increase of just over 10% across the comparable period, with more patients requiring tests across several modality areas.

Following the issues experienced because of the fire at Lincoln County Hospital, and the damage which was caused to some of the imaging equipment, waiting lists for DEXA (bone density scan) experienced some significant rises. The DEXA machine was successfully repaired in November and waiting lists are now seeing a sustained reduction. This, together with the development of more capacity in CDC facilities, is now supporting the goal to reduce the number of patients on diagnostic waiting lists and to ensure that, by the end of March 2024, at least 85% of patients referred for diagnostics are receiving their test within six weeks of referral.

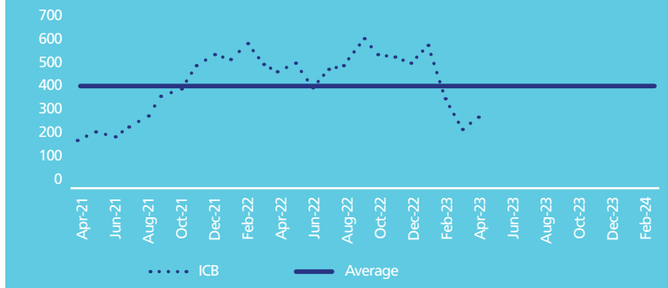
The system secured funding from NHS digital to obtain dermatoscopic equipment for Lincolnshire GP practices in 2022/23 to improve dermatology outcomes for patients. This helps with diagnosing patients sooner and reduces necessity for hospital appointments. 88% of GP practices have requested the equipment and training sessions on how to use the new scopes are being delivered. ULHT have since seen A&G requests increase from 50 requests per month to an average of 310 requests per month over the past six months. The service has provided a consistent average response rate of 97% within 48hrs since implementation of the enhanced A&G service, which is an increase on the previous average of 72%. Dermatology A&G requests now equate to over 25% of routine dermatology referrals

Whilst Lincolnshire ICB and the wider system continues to work well together to improve services and reduce waiting times, there are some considerable risks to maintaining this position and being able to meet the future national performance ambitions. Industrial action and urgent care demands have an impact on available clinical capacity, with appointments and procedures occasionally having to be rescheduled. This is always done as a last resort and processes are in place to clinically prioritise and ring-fenc planned care capacity wherever possible. Wider workforce challenges are well documented within Lincolnshire, as well as nationally. As we look to continue with the CDC expansion, workforce availability is the highest national risk and could constrain ambitions if services aren't able to be staffed. Diagnostic networks, academies and systems are all working together at regional and national levels to implement plans to support the increase of trained clinicians into the NHS.

Cancer

There are nine cancer standards monitored looking at time to be seen, diagnosis and treatment; details of the performance against each of these standards are shown in the constitutional standards at the beginning of the performance analysis on page 18. Nationally the focus remains on reducing the backlog of patients waiting 62 and 104 days for treatment and the 28 day Faster Diagnosis Standard. In March 2023, 243 patients were waiting more than 62 days for diagnosis and/or treatment, a reduction from the peak of 620 in September.

Patients waiting more than 62 days for treatment



Improvement work in the last two quarters of the year has significantly picked up within the cancer pathways, with a heavy focus on the colorectal cancer pathway, at the end of last year the number of colorectal patients waiting over 62 days accounted for 62% of the overall backlog, the colorectal backlog position has seen great improvement since December 2022 and now accounts for 45% of the overall backlog, which has also significantly reduced. An intense recovery programme has been in place to recover the colorectal backlog working in collaboration across the Lincolnshire system, locally, regionally and nationally. This work has led to the development of a new Rapid Access Colorectal Cancer Pathway, ensuring the right patients are seen at the right time by the right person. There has also been an improvement in the 28 day Faster Diagnosis Standard, which will help ensure patients are diagnosed or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer.

Cancer two week wait (2WW) referrals have increased by 6.5% compared to the previous year. We continue to work with ULHT to develop alternative pathways with the aim of reducing the number of patients who access specialist care on a 2ww pathway. Last year we implemented the Mastalgia pathway as a pilot for patients presenting with breast pain alone, this pathway is reducing demand on the 2ww breast cancer pathway by 15% and is now being implemented on a permanent basis. Alternative pathways including urgent pathways are under development currently, with the intention of ensuring patients are able to access the right level of care that they need whilst reducing anxiety and stress.

The non-specific symptoms pathway is now fully embedded in Lincolnshire. The overall aim of this pathway will be to support earlier and faster cancer diagnosis where a patient's symptoms do not fit into a relevant clinical speciality. 100% of Lincolnshire GPs have access to this pathway with 64.6% of GP practices having used it to date. Since the inception of the pathway 15 patients have been diagnosed with cancer.

The second phase of the NHS Galleri trial is about to commence here in Lincolnshire. The trial is intended to demonstrate if a new blood test works in diagnosing cancers at an early stage before symptoms appear. The trial has recruited over 4,000 participants here in Lincolnshire. Phase Three will be rolled out in 2024 with the outcome of the trial to be shared in due course.

This year we have delivered a full day of training for 100 primary care colleagues, updating them on current best practice, informing them of available cancer care pathways and services In Lincolnshire. This training was well received, and another full day of training is planned for 2023.

The Living with Cancer Programme is in its delivery phase. By the end of June 2022, we implemented Personalised Follow Up Pathways in breast, prostate, endometrial and colorectal pathways including remote monitoring. We continue to deliver the four Personalised Care elements in cancer – Holistic Needs Assessments (HNA) and Personalised Care and Support planning, end of treatment summaries, cancer care reviews in primary care, and health and wellbeing interventions. Currently 71% of all cancer patients are offered an HNA, this has risen from 53% in May 2019.

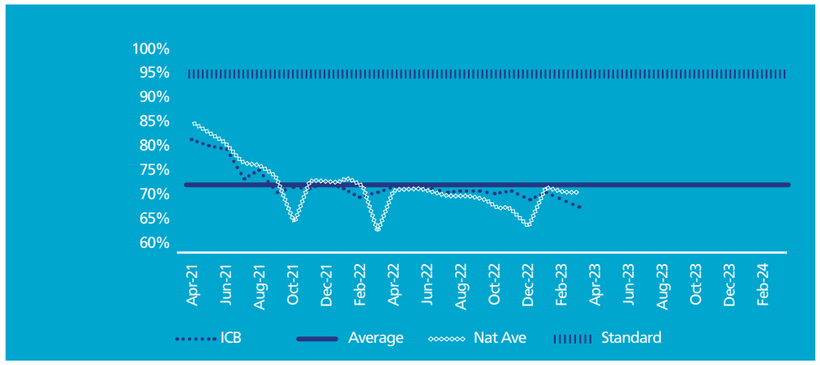
We have offered a menu of support to all GP practices in the county to improve the quality of cancer care reviews and already 30% of GP practices have taken up this offer.

Macmillan Community Cancer Care Co-ordinators are integrated into all Neighbourhood Working Teams and are supporting practitioners from acute and community services to identify and meet the holistic needs of individual patients. In health and wellbeing, we have focused on psychological and emotional support and physical activity. People Living with Cancer (LWC) now have access to psychosocial support services at all levels, and we have started Fighting Fit courses in Lincoln, Mablethorpe and Gainsborough, and 5K Your Way in Lincoln and Boston. We have mapped over 1400 community assets and shared this with the Connect2Support website. We have helped new support groups to start for secondary breast cancer and kidney cancer.

The Lincolnshire Cancer Support website went live on 23rd June 2022, and the Lincolnshire Cancer Summit 2022 took place on 8th June at the University of Lincoln Medical School.

Patient involvement remains at the heart of the programme, and we now have two Cancer Co-Production Groups, and the Cancer Expert Reference Group was established in May 2022, in partnership with ULHT. In November 2002, the team was asked to host a workshop for colleagues from around the UK at the Macmillan Professionals' Conference and the programme's impact was recognised when the team won a Macmillan Excellence Award in the Integration category.

A&E admission, transfer, discharge within four hours



The Lincolnshire system has continued to experience significant pressure within urgent care throughout 2022/23, including managing multiple periods of industrial action. The pressure on services spans the entire UEC pathways and this year has been felt within all partner organisations. This has presented the system with a greater challenge than we have seen in previous years.

Attendances have remained high but, as shown in the run chart above, the challenges we are experiencing are shared nationally; many areas continue to see rising attendances and an impact on their performance levels as well. For the constitutional 4-hour A&E target, Lincolnshire performance has consistently remained close and at times above the national performance; the latest reported percentage of patients being seen within 4 hours was 70% compared to 71.5% nationally. The number of patients waiting over 12 hours in department has again reduced but remains very high. This measure is quite volatile month on month. The time to first assessment within 60 mins measure remains above the regional and national average.

The UEC programme focus continues to be on discharge and flow, attendance and admission avoidance, and management of the risk within the pathways due to the level of pressure. Integrated Discharge Hubs have been established on the two main acute sites, bringing together the partners involved in supported discharge to ensure timely discharge for pathways 1, 2 and 3. The acute improvement work within ULHT is focusing on the simple/pathway of zero discharges.

Ambulance mean response times are now below our average performance. Ambulance handover delays have improved at Pilgrim Hospital and remained stable at Lincoln.

Challenges remain around overall demand (time profile and acuity), system wide workforce, capacity for supported discharge and flow through all bedded services. Occupancy rates have remained high both in acute and community. This has continued to impact on the level of performance against national indicators and on the ability to release crews who have attended acute sites.

The Mental Health Urgent Assessment Centre is fully operational providing an alternative to emergency departments (ED) for those patients requiring mental health support without a physical health need. This service is well utilised by police and ambulance staff and has a good working relationship with the emergency department.

The system has continued delivery of the winter capacity and demand schemes and the discharge schemes funded through the various allocations from national pots. The review and prioritisation of these schemes has been completed and they are currently being modelled for the planning submission.

Looking forward, a system wide strategy workshop was held on 7th March to support identification of quick wins and fixes for urgent care, and also to support development of the programme for 2023/24.

Urgent Care

The core standard for Urgent and Emergency Care (UEC) is that all patients should be seen and discharged from A&E within four hours. However, there continues to be challenges with the delivery of urgent care targets, and in particular the delivery of the current four-hour accident and emergency (A&E) target as a consequence of the response.

The Two Hour Urgent Community Response service is now fully established and in conjunction with wider out of hospital services, such as the evolving Virtual Ward model of care, is supporting the Lincolnshire population to be cared for at home wherever safe and appropriate to do so. This helps to reduce the risk to patients around hospital acquired infections and deconditioning that are a consequence of hospital admissions for the frail population.

Mental Health

Improving Access To Psychological Therapies (now called NHS Talking Therapies for anxiety and depression)

The NHS Talking Therapies programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. It developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS and is widely recognised as the most ambitious programme of talking therapies in the world. In recent years in Lincolnshire more than 1.2 million people accessed services for help to overcome their depression and anxiety, and better manage their mental health.

The service is appropriately prioritising recovery rates and waiting times over increasing the number of people being seen.

Access to the service has increased to 2.1% of patients entering the service

(people that enter treatment against the level of need in the general population).

The NHS Talking Therapies Recovery Rate has dipped and remains just under the 50% target at 49.6% in March.

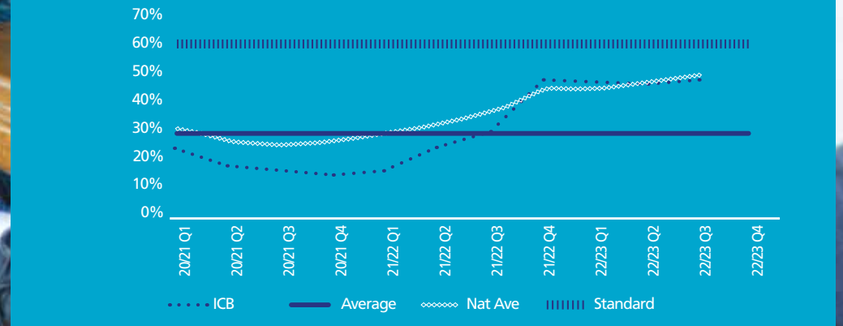
It is still seen as a consequence of increased levels of referrals to the service post COVID-19.

There have been increased demand and challenges faced to keep up and deliver to target. The service continues to work with commissioners and NHSE colleagues to understand the gap between current workforce and the increased access target – its focus will be on seeing as many people as can be scheduled, ensuring waiting times are kept as short as possible and quality is good, rather than outreaching to achieve access and people waiting much longer with reduced outcomes.

The online system is now embedded and supporting self-referral via the service website. Recruitment of staff continues to increase to manage the overall increase in referrals. Staff members are settling into roles. Access has increased. As new team members begin to work up to capacity, performance is expected to increase over the next few months. This is part of the overall recovery phase for the service.

Physical Health Checks for people with Severe Mental Illness (SMI)

Lincolnshire ICB is committed to leading work to reduce the premature mortality among people living with severe mental illness (SMI). People with severe mental illnesses are at higher risk of poor physical health. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder.



As set out in the NHS Long Term Plan, by 2023/24, the NHS will increase the number of people receiving physical health checks to an additional 110,000 people per year, bringing the total to 390,000 checks delivered each year. For Lincolnshire, this means that access to physical care interventions should cover over 4,000 of the population with SMI on the GP register by March 2023. There has been consistent improvement in this area in Lincolnshire. In recent years more than 10.9% in March 2021 to 58.1% by the end of March 2023.

A multi-agency SMI Health Checks Steering Group is in place, co-ordinating and overseeing actions to achieve targets for this work. Performance data and updates at a practice level are made available through locality clinical Committees. Guidance on coding SMI health checks was presented to Committees and shared with practices during December and ongoing support is provided.

We have a digital solution to ensure we capture all EMIS practice data from the end of March which has not been included to date. An incentive scheme to support GP practice delivery in Quarter 4 was also agreed – practices received additional funding based on year-end delivery against QOF and will continue to work closely with Primary care to increase effectiveness and delivery of health checks. We also have support from our Mental Health Trust provider to target some of the harder to reach individuals.

A dedicated post to develop and deliver a community outreach model to support SMI Health Check delivery commenced in post on 3rd April so this will improve performance by developing a robust model in 2023/24. We are looking to ensure a whole system approach and are committed to delivery against target in 2023/24.

Community Mental Health Transformation

Lincolnshire was one of twelve national Early Implementer Sites chosen to deliver Community Mental Health Transformation. As an early implementer site an ambitious plan was mobilised to ensure that the development and transformation of both new and existing community services was designed, developed and delivered in an integrated manner.

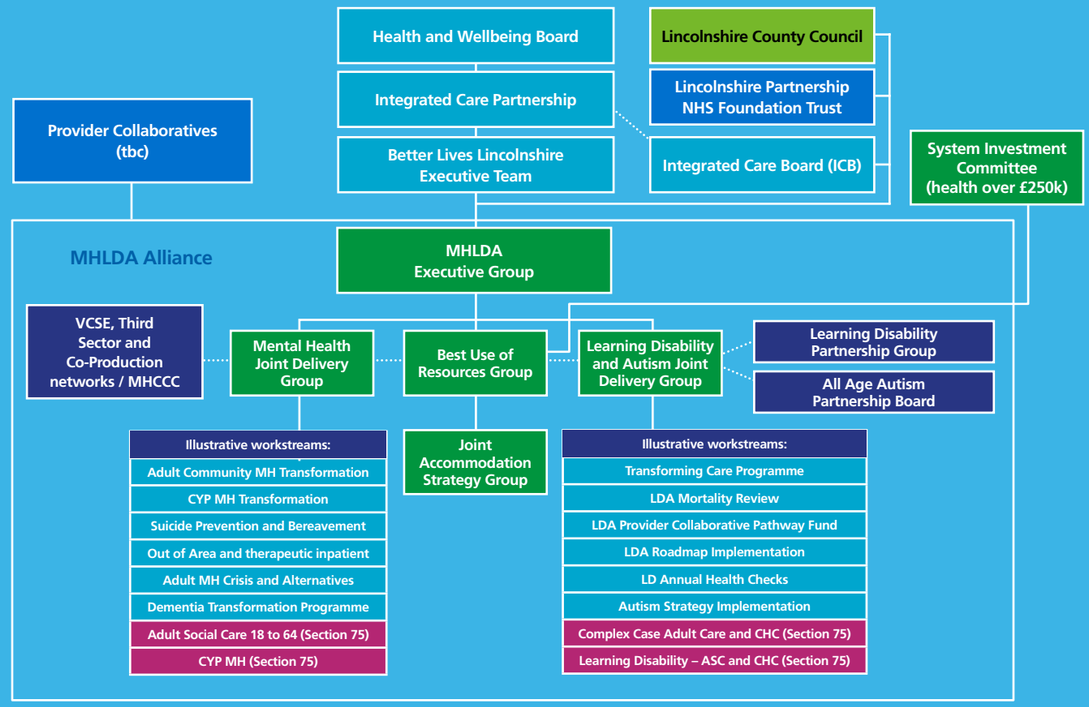
At the heart of this programme has always been people with lived experience; ensuring that services are led by people and not just about people. Experts by experience are embedded across every facet of the programme and, as such Lincolnshire is recognised by NHSE as an exemplar site for the work that it has done to realise and embed this new way of working.

The model developed is committed to the delivery of right care, at the right time and in the right place. This has meant that the model of delivery spans the continuum of care, encompassing secondary, primary and voluntary, community and social enterprise provision and ensuring that services are accessible for people within their own local communities.

The programme delivers a vast array of initiatives and projects as well as the implementation of new workforce roles such as community connectors, Psychological Intervention Facilitators and Mental Health and Wellbeing practitioners. All these workstreams are set against the NHS Long Term Plan deliverables and the NHSE Community Mental Health Transformation Roadmap, and more recently is now working towards embedding the NHS Confederation No Wrong Door; A Vision for Mental Health, Learning Disabilities and Autism in 2032. To support this delivery a robust governance structure has iterated over time; influenced strongly by the partnership working developed within this programme of work, and the programme now reports into the new Mental Health Joint Delivery Group that is held to account by the MHLDA Executive Group.

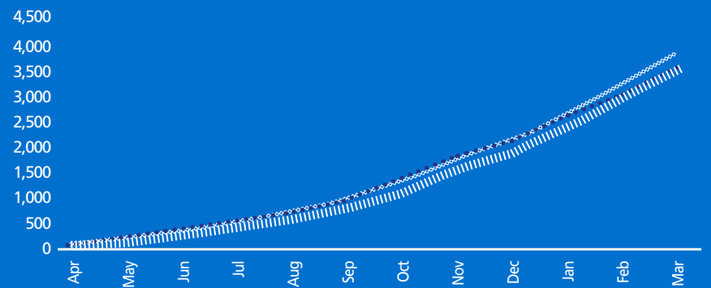
The diagram on the opposite page, details the relationships in place and highlights the mental health Co-Production Network that the programme has put in place to ensure that experts by experience and the VCSE sector are working together to support each other as they work within specifically identified programmes.

Mental Health, Learning Disability, and Autism (MHLDA) Alliance Governance Arrangements



Learning Disability Annual Health Checks

Annual Health Checks support people with a Learning Disability stay well by helping to find health problems earlier and giving time to agree on the right care. The ICB has worked closely with primary care and system partners to refocus efforts on improving access to Annual Health Checks for people with a Learning Disability since 2020/21. A dedicated ICB team was tasked with supporting improved performance by linking with system stakeholders and GP practices, providing direct support to practices and developing real time performance monitoring. As a result, an additional 1,185 annual health checks were delivered in 2022/23 when compared to 2019/20, and the ICB achieved 82% against the national target of 80% of people registered with their practice as having a Learning Disability receiving a Health Check.



KEY ACHIEVEMENTS

Musculoskeletal (MSK) Programme

Working together, clinicians are re-designing the elective hip and knee joint replacement care pathway to support a single MSK service working as a multi-disciplinary team across primary care, community, acute and social care. The programme has embedded co-production, involvement, and patient experience throughout each stage, consistently gathering feedback and reporting it into the working groups and decision- making steering group. This has been supported by the ICB engagement team working alongside our local Healthwatch team and Every-One, a Lincolnshire based charity that aims to work inclusively with people to ensure that carers and people that are cared for are at the centre of their own wellbeing. The MSK programme was shortlisted for the Patient Involvement & Experience Award during the LCHS Celebrating Success 2022 Staff and Volunteer Awards.

From the start of the programme, engagement was undertaken with current patients to understand their experiences of the MSK service as well as surveying service users and the public to gather their views on the proposed new care pathways. Staff across the service were also provided with opportunities to share what they felt worked well in the service and how it could be developed and improved further.

Healthwatch Lincolnshire undertook some concentrated engagement to understand the experiences of patients using the new care pathway at several early adopter sites, reporting results into the programme. Every-One led on the establishment of a co-production group of MSK service users to ensure that all those involved, including people with lived-experience, carers and staff feel they have had the opportunity to contribute to the work of the programme. This will include development of action plans from the patient experience feedback and help to shape the involvement plans going forward.

Community Diagnostic Centres

Working in partnership, partnership, the ICB and ULHT have developed a programme to establish Community Diagnostic Centres (CDCs) in Lincolnshire. From the programme's inception, we have embedded a robust approach of patient, public and stakeholder involvement, ensuring their views have shaped the principles and future options for the development of CDCs at the earliest stage.

An initial survey to the public gathered views to help us develop principles and criteria on which our future CDCs would be based. This feedback was woven into the programme and considered by system clinical leads, partners and the CDC working group and CDC board; discussed at two stakeholder engagement events; presented at a stakeholder away day and options appraisal event, ensuring that the patient voice fully informed the service developments.

From this, options for future CDC locations were proposed and further extensive engagement was undertaken with patients and the public to evaluate each of the options and identify potential impacts of each. Working closely with over 100 stakeholder and partner organisations, their views fed into this service development.

Our previous engagement identified the need to understand the views and experiences of our communities on the east coast who are a key population group with health inequalities and reduced access to services. This targeted engagement at a local community venue, church and foodbank included conversations with a range of people such as those with a disability, carers, people from disadvantaged backgrounds who were attending the centre for a free hot meal, as well as a cancer support group and members of a wellbeing group. We also spoke to people attending the centre for their COVID-19 vaccination.

A co-production group was also established to provide opportunities for patients with lived experience to play a vital role in shaping the project by sharing their experiences of diagnostic services, working alongside the programme team and clinicians in the options appraisal and evaluating each stage of the patient journey through the pathways and identifying opportunities for improvements.

They have also supported the development of action plans from the ongoing collection and analysis of patient experience feedback being undertaken to constantly monitor and inform service delivery at existing and new CDC locations.

Summer 2022 Community Roadshows

The LICB engagement team undertook a seven-week roadshow over the summer to promote opportunities for members of the public to get involved with local NHS services and engagements as well as listening to experiences and views of the communities and reporting this back into the ICB. Working in partnership with provider trusts, local authorities and translation services, the team attended numerous local community events to access those who potentially wouldn't get involved with us in other ways and focussed on areas with high levels of deprivation and health inequalities.

The roadshows raised awareness of and provided information on current projects within the NHS where members of public can 'have their say'; continued to strengthen relationships with communities and stakeholders across Lincolnshire, adding a further 3,000 contacts onto our stakeholder database; increase subscribers to our fortnightly ICB Engagement Bulletin; increase the membership of the NHS Lincolnshire Citizens Panel; supported patients by signposting them to and providing information on other services, such as vaccinations, GP registrations and mental health; escalated patient issues, where appropriate, to the Quality Team for resolution; and enabled system working across the NHS and local authority organisations.

Urinary Tract Infections

In September 2021 a new pharmacy-led UTI test and treat service was launched in conjunction with Healthy.io and Lincolnshire Co-op pharmacies, the aim of which was to deliver a pharmacy-led test and treat service for uncomplicated urinary tract infections (UTIs).

Since launching in September 2021, the new pharmacy-led UTI test and treat service has enabled over 1,400 women in Lincolnshire to be tested and treated for painful urinary tract infections (UTIs) in the same day without having to book an appointment with their practice. This has helped release an estimated 210 hours of general practice time and support appropriate prescribing of antibiotics.

Under the test and treat service, women can visit one of 38 Lincolnshire Co-op pharmacies across the county which offer the service, where a pharmacist will ask some basic questions about eligibility and symptoms. Those who are eligible will be asked to download a free 'Dip UTI' app onto their phone and take away a Dip UTI urine dip-stick testing kit.

In the comfort of their own home, the user dips a testing strip into a mid-stream urine sample, places it on a colour board and scans it with their smartphone camera. The whole test takes three minutes. The scan is downloaded onto the app and analysed to provide an indication of how likely a UTI is present. The user can then return to the pharmacy for interpretation by a pharmacist and the best course of treatment, based on the result and symptoms.

Lincolnshire ICB is proud to reveal that its work with Healthy.io and Lincolnshire Co-op pharmacies, was shortlisted for the 'Primary and Community Care Innovation of the Year' at the 2022 Health Service Journal (HSJ) Awards. Representatives from the team attended the awards event and were delighted to win the award – which represents an absolutely fantastic achievement for the team.

"In collaborating with Lincolnshire Co-op Pharmacies and Healthy.io we have been able to introduce this innovative, accessible, digital testing solution for women experiencing symptoms of UTI. Utilising the latest technology and a smartphone app women are able to complete a UTI test, access a quick clinical consultation with a pharmacist and get appropriate treatment faster than before. We have seen some fantastic results, and this is testament to the great partnership working."

Duty to promote innovation

In line with in section 14Z39 of the NHS Act 2006 as amended by The Health and Care Act 2022, the ICB has discharged its duty to promote innovation through various workstreams including establishing close links with the East Midlands Academic Health Science Network (AHSN). We are exploring a support package from the AHSN to the ICS Clinical Directorate. This would enable sharing best practice from national and regional teams, to evaluate at a local clinical level and into front line practice. We have used this in Lincolnshire. For example, we have used the AHSN to improve our detection rates for atrial fibrillation.

Duty to obtain appropriate advice:

As outlined in section 14Z38 of the NHS Act 2006 as amended by The Health and Care Act 2022, the ICB has discharged its duty to obtain appropriate advice through the establishment of the Care and Clinical Professional Directorate. This includes senior clinicians and care sector leaders from medicine, nursing allied health professionals adult and children's care services supported by a management team. Senior colleagues form the ICB are also part of the core membership. We invite other clinicians' dependant on the pathway redesign topic who are not part of the core membership but have the relevant expertise. The outputs are shared widely, including through the Primary Care Advisory Group, which includes all of primary care not just general practice.

We are developing our links with the University of Lincoln and the Academic Health Sciences Network to formulate the process of evidence synthesis. This will be a fundamental part of service redesign, starting with gathering current clinical evidence, best practice and inviting leading clinical experts to inform pathways.

As an example, we have recently completed the redesign of the colorectal pathway. We had an uptake of FIT (faecal immunochemical test) testing below 30% for new Two Week Wait referrals for suspected colorectal cancers. With the methodology described, and with the help of the chair of the British Gastroenterology Society, we have redesigned that pathway. The result has seen an increase in the adoption of FIT testing to well above 80% and often nearing 100%.

The process outlined has been used in practice, and we now want to expand that to other areas of clinical practice.

The Director of Public Health is a core member of the Clinical Directorate and is the key link to the JSNA, as well as the conduit of the clinical voice in the JHWS.

Through that mechanism, we installed WHZAN (teleheatlh) technology into our care homes that enable much greater support to care home staff for remote monitoring. This improves the standard of care we can offer to care home residents.

Medicines Optimisation Team

The NHS Lincolnshire ICB Medicines Optimisation (MO) Team, like most teams within the NHS, has experienced a challenging and constantly changing health landscape over the last few years.

Not only have the team shown true resilience but have expanded with the recruitment of several clinical staff, including a Chief Pharmacist, who will provide the direction and leadership the team needs to succeed.

In the last 12 months, the team has focused on the development and implementation of the Work Plan Prioritisation Tool, which has enabled the team to score areas of work and create a 2023/24 work plan. The work plan will be supported by the new Data Sharing Agreements between ICB and practices allowing the team remote access to a clinical system to support efficiency savings.

To enable the delivery of the work plan the team has been networking with our system and primary care colleagues, through the release of the MO monthly newsletter and the re-instating of the Primary Care Prescribing Forums. These are valuable engagement tools to highlight areas of unwarranted variation and promote training that the team can provide on safe and clinically effective prescribing. Cross-organisational working has also been a big achievement in the last 12 months, evidenced in the updating of the Shared Care Agreements and the collaborative approach in Clinical Reference Groups for the System Delivery Program which has seen guidance adopted across all systems in Lincolnshire.

Lincolnshire ICB's Living with Cancer team win prestigious award at the 2022 Macmillan Conference

The Lincolnshire ICB's Living with Cancer team won a prestigious award at the 2022 Macmillan Conference.

The team scooped the top accolade in the 'Integration Excellence' category, for ground-breaking work across the Lincolnshire health and care system focussed on improving the lives of people living with or beyond cancer.

Macmillan Living with Cancer Programme Manager, Kathie McPeake, said **"The award was a wonderful recognition of how health and care professionals across the county had worked tirelessly as one to innovate and cross boundaries. Those living with cancer or beyond are at the very heart of everything we have done and continue to do," she said. "This award is for everyone who continues to contribute so passionately to that mission. We are absolutely delighted with the award!"**

National Accolade for the ICB Cancer Team

In 2022, on behalf of Lincolnshire ICB, Louise Jeans, Programme Lead Cancer and Debbie Hocknell, ICB Finance Team Lead entered the HMFA (Healthcare Financial Management Association) Awards 2022 and won the 'Governance' award, for implementing a proactive programme which put in place arrangements to ensure funds are directed quickly to the most challenged areas across the whole health and care system in Lincolnshire.

The judges agreed unanimously that the work undertaken to liberate cancer funds in a well governed way enabled earlier treatment for many patients. They also stated that if applied nationally, the improvement could "hugely benefit citizens".

Louise said they were delighted to receive the accolade.

"We developed an integrated decision-making process, agreed by the Director of Finance, called 'Cancer Prioritisation Process'. The new system resulted in monies being allocated to the most challenged cancer areas, with a fair and equitable approach to bids being submitted and rated in line with a clear process and timeframe.

To win an award and hear such positive feedback from the judges is wonderful."

Suicide Bereavement Support Service

In November 2022 the ICB announced the launch of a new Suicide Bereavement Support service in Lincolnshire. Amparo, a unique Suicide Postvention service, is part of Listening Ear; a registered charity and growing social enterprise offering support and counselling services (accredited by the British Association for Counselling & Psychotherapy), with its headquarters in Merseyside.

The new Amparo service,funded by the ICB, provides free support to individuals and families across Lincolnshire, as well as for professionals supporting the bereaved.

The Amparo footprint covers a population of over 13 million people, or approximately 23% of the population of England, making it the largest provider of support after suicide in the country. Within these areas, there are significant demographic differences, in particular their population make up and the diversity of their communities. Amparo has been successful in both urban and rural areas, providing a service that is individualised for each beneficiary.

The service is free, and the support offer includes:

- Contact within 24 hours of a referral
- One to one support from a named Amparo Liaison Worker
- Information, practical and emotional support
- Practical support liaising with Police and other agencies
- Support at Inquest
- Help with any media enquiries
- Help overcoming any feelings of isolation
- Referrals and signposting to other services as required
- Adult Counselling
- Counselling for children and young people
- Critical Incident Debriefing
- Zoom awareness sessions for professionals – https://amparo.org.uk/free-briefing-session/

Lincolnshire Young Voices wins national award for its dedication to supporting children and young people with SEND

Lincolnshire Young Voices (LYV) has collected the top prize for Co-production at nasen's sixth annual Awards. LYV was put in the spotlight at a glittery ceremony at The Grand Hotel in Birmingham for its remarkable work in helping their pupils with special educational needs and/or disabilities (SEND) and learning differences thrive and achieve.

The Awards are hosted by nasen – the National Association for Special Educational Needs and Disabilities – and supported by sponsors Scanning Pens, who is also the awards headline sponsor, Axcis Education, and official awards media partner, Schools Week. nasen is the leading membership charity that supports children and young people with SEND to reach their full potential, whilst being a champion, friend and protector of the SEND workforce.

Scooping nasen's Award for Co-Production with Children and Young People and their Families, LYV was recognised for its creation of an accessible and impactful film, The Rough Guide – A Guide to Not Putting Your Foot In It, for any practitioner or professional nervous about understanding how best to communicate with, and support, a child or young person with additional needs.

The young people working with LYV have lived experience, and their ideas and thinking have led The Rough Guide to become a first-rate practical resource. In addition to creating this film, which is now being rolled out across Lincolnshire, the Midlands region and beyond, the group has led the way in enabling others to understand how to support young people with additional needs to live the lives they want to live.

LYV joins 17 other award winners, judged by a panel of leading professionals with a wealth of experience in education and SEND – as well as individuals with lived experience.

Emma Cross, Co-Chair of Lincolnshire Young Voices said:

"It's wonderful for the hard work of our committee members to be recognised in this way, and I would like to thank them for all the enthusiasm and dedication they have shown in making this training a reality.

"We knew GPs and other professionals wanted more training on working with those with SEND. And we knew we were the perfect people to help because we have lived experience of disabilities and additional needs and a passion to inspire change for people in our position and those around them.

"We've created a resource which is honest, yet light-hearted, and the overriding message is one that not only professionals can learn from: We all get it wrong or 'put our foot in it' sometimes, but keep trying, keep communicating.

"We're confident this approach will lead to better outcomes for people who have SEND."

"We received an amazing number of nominations for the awards this year and it has been a great honour to recognise and reward the people who are making a real difference for SEND. We very much hope the inclusive work of our winners, who go above and beyond every day to help children and young people thrive, will inspire more great work in the sector going forward, and help strengthen our community's sense of unity, collaboration and possibilities."

Lincolnshire Maternity and Neonatal Services

The Lincolnshire Maternity and Neonatal programme team is collaborating with partners to enhance equity and equality in maternity and neonatal care. We aim to provide safe, personalised, compassionate, professional, and family-friendly services.

The team is dedicated to ensuring women have the necessary information to make informed decisions and providing support tailored to their needs.
In the past year, over 6,000 babies were born in Lincolnshire. What happens in pregnancy and early childhood impacts on physical and emotional health all the way through to adulthood. This highlights the importance of ensuring a system approach to improving the chances of healthy pregnancy.

To engage with NHS Maternity and Neonatal staff we run several Equity and Equality events.

We have run over ten events since they commenced in August and met with over 70 members of staff.

This has provided further insight into the needs of our maternity and neonatal population, the intelligence from which will help shape our equity and equality strategy.

To improve services, it is imperative we listen to service users and co-produce initiatives with women and families. To engage with families, we are holding roadshows around the county and asking the question – 'What matters to you?' The roadshows provide an opportunity for families to meet with health care and financial services, who can provide them with support and for the services to receive feedback.

We have held two events so far, in Skegness and Boston, and met over 100 hundred families. We have three more planned for 2023.

Launch of the Lincolnshire Military Maternity Voices

The Lincolnshire Military Maternity Services team, which comprises of a Military Care Navigator and Military Maternity Voice Partnership Lead (LMMVP), assist military families living on or around the military bases in the county. These family have unique issues such as sudden changes in family life due to deployment and postings, making it difficult for military families to access quality and consistent healthcare. The Military Care Navigator works one to one with families and has engaged with 40 families helping mothers/dads and mothers to be navigate the health and care system and:

- provide personalised treatment plans to support individuals
- meet with individuals regularly to discuss progress
- provide behavioural support
- provide free stop smoking aid, including Nicotine Replacement Therapy (NRT) such as nicotine gum, patches, lozenges, and inhalators.

The services also support NHS smoke-free policies.

All pregnant women have access to services for the treatment of tobacco dependency as part of their routine care.

This includes:

- carbon monoxide reading at every contact
- smoking status recorded
- ongoing support and advice throughout your pregnancy.

All acute hospital inpatients, mental health inpatients and high-risk outpatients who are identified as smokers are offered:

- carbon monoxide reading at every contact
- smoking status recorded
- onward referral for support from One You Lincolnshire upon discharge from NHS services.

Website link: "https://lincolnshire.icb.nhs.uk/" Lincolnshire ICB - Supporting healthcare for the population of Lincolnshire.

New app to help people WaitLess for urgent and emergency care services in Lincolnshire

In March 2023, the NHS across Lincolnshire introduced a smartphone app, which is designed to help people choose the least pressured urgent and emergency care services and to understand waiting times better.

The WaitLess app combines current waiting time, queue numbers and travel-time at urgent care facilities in the county. This displayed information helps people make an informed decision about where to seek the fastest treatment for minor illness and injuries. Along with this, the app displays all available pharmacies in the area as an alternative treatment option.

The times shown on the app combine travel, waiting and treatment time, to give patients the most accurate picture of how long they may spend at each location, allowing them to decide on the most appropriate setting to attend. The app also displays a full list of services available at each site, as well as parking and opening-time information.

Emergency Planning, Resilience and Response (EPRR)

In June 2023, the ICB acquired Category One responder status under the Civil Contingencies Act (2004), requiring compliance against a full set of civil duties.

The annual EPRR self-assessment against a set of core standards provides an assurance that NHS organisations are working to meet their EPRR statutory duties and obligations. The ICB declared noncompliance against the core standards which is a reduction from substantial compliance in 2021/2022.

The ICB has recruited specialised EPRR resource and completed work in 22/23 that will restore compliance for 23/24. Additional plans have been implemented including the Incident Response Plan and Adverse Weather Plan.

Lessons learned have been identified within both incident response and exercising. The ICB's response to the Lincoln Hospital Fire in March 2023 identified a need to strengthen its on-call capability, therefore the number of trained commanders increased. The ICB remains engaged with Local Health Resilience Partnership to share lessons learned and best practice.

76% of strategic and 86% of tactical commanders have received Principles in Health Command Training, with additional courses also being provided with other agencies to promote interoperability.

To further demonstrate system and partnership working, the communication team have been co-chairing the Lincolnshire Resilience Forum's (LRF) Warn and Inform group for the past twelve months. During this time not only have they been representing the ICB but also the wider health system and partner organisations, at both a strategic and tactical level.

The LRF, in conjunction with the communications lead, has developed an introduction to the County Emergency Centre and Warn and Inform training package. Other areas of support across the wider system include the flu and vaccination booster campaign, Flood-Ex (a multi-agency national exercise to test plans for major flooding), the extreme heat we experienced over the summer of last year, together with Operation London Bridge. There has also been involvement in the development and delivery of a promotional campaign for the LRF, which it is intended will be rolled out nationally. The team has also been involved in supporting the wider system during periods of Industrial Action.

PRIMARY CARE, COMMUNITIES AND SOCIAL VALUE

Access to Primary Care and Restoration

The ICB has continued to work with GP practices and Primary Care Networks (PCNs) to enable people to access primary care services and to get the support they need from across the health and care system.

3,596,421

Total GP Appointments
Year to Date (YTD) 2022/23

52.6%

Patients seen on Same Day or Next Day
| YTD 2022/23

12.9%

(410,849)

Change in Total Appointments
| between YTD 2019/20 and YTD 2022/23

45.9%

Patients seen on Same Day
| YTD 2022/23

69.0%

Patients seen within 7 Days
| YTD 2022/23

81.6%

Patients seen within 14 Days
| YTD 2022/23

The most recent data at time of writing shows that Lincolnshire GP practices provided 3.6 million appointments over 2022. Comparing the current year to the same period in 2019/20 an extra 410,840 appointments were provided, an indication of the significant increase in level of service being provided by GP practices. Of the GP practice appointments provided so far in 2022/23, 53% were seen within one day and 82% within two weeks. Considering the high demand for appointments including those of a routine nature, these waiting times highlight how hard local primary care services have been working in order to provide care for our local population, which is so important and valued. There has also been a significant increase in the rate of GP appointments provided as face-to-face consultations – 63% in December 2022 compared to 51% in January 2022.

The ICB wishes to express its sincere thanks to the entire primary care system for all that has been done and continues to be done to provide excellent care for our local population.

Offering assessment for patients accessing their GP practice in person, by telephone or online continues to be important in terms of optimising patient experience and outcomes, and to this end work is ongoing to improve and broaden primary care digital and telephone capacity and capability. Assessment by a healthcare professional over the telephone or online, has enabled many patients to choose from a wider range of options to get the advice and care they need without necessarily having a face-to-face appointment.

The ICB has provided dedicated support to GP practices to support the development and management of digital and telephony systems, including support to develop GP practice websites including improved formatting and making information easier to access, providing the tools to enable PCNs and practices to monitor and review performance against key quality measures, and for professionals across local of health and care services to improve care by being able to share and view patient information securely through the Lincolnshire Care Portal.

The responsibility for providing primary care Enhanced Access into the evening and at weekends moved to PCNs in October 2023. These services are provided by GP practices working together to enable access for local people in line with their needs. The proportion of time available through Enhanced Access in Lincolnshire is significantly above the national target at the time of writing (70 minutes for 1,000 adjusted population compared to the national ambition of 60 minutes per 1,000 adjusted population). Uptake of these appointments is currently around 76%, the ICB will continue to work with PCNs to promote and maximise the use of these appointments.

Funding for additional Enhanced Access capacity, mainly additional GP sessions, to support increased demand in the winter period was provided to PCNs over December and January 2023. Additional Enhanced Access was provided across ten of the county's Primary Care Networks providing an additional 466 sessions as a mix of GP, Advanced Nurse Practitioner, Paramedic and Clinical Pharmacist appointments.

Additional funding to support medical care for people placed in short term residential and nursing beds, and to reduce the impact on GP practices was provided through winter pressures funding, ongoing funding to support patients discharged from hospital into these intermediate and active recovery beds into 2023/24 is under review. Initial information indicates the complexity of health needs for people being discharged from hospital into short-term residential beds and further analysis will support a better understanding of the needs of this group and how primary care services can best support them.

PCNs also used winter pressures funding to develop innovative approaches to providing care to the people with most need. Examples include K2 Grantham and Rural and K2 Sleaford PCNs using PCN workforce funding and winter funds to pilot a paramedic model providing additional clinical capacity, and the Deepings Practice using winter pressures funding to provide additional appointments for vulnerable older patients and children.

People and workforce

Data from January 2023 shows that GP practice clinical and non-clinical workforce capacity in Lincolnshire compares favourably to the national picture.

As at January 2023	Full Time Equivalent posts per 100,000 patients				
	Regular GP (excluding Locums)	TOTAL Nurses	TOTAL Direct Patient Care	TOTAL CLINICAL STAFF	TOTAL Admin
Lincolnshire ICB	56.3	40.2	53.9	150.3	143.3
National	55.6	26.3	25.3	107.1	117.8

Further work to recruit and retain primary care staff is underway. The Primary Care People Group (PCPG) has been established to bring together key stakeholders from across the county to agree a Primary Care People Plan which delivers on the priorities as developed within the national and system NHS People Plan: Growing our people, Valuing our people, Developing our people and Retaining our people.

To support primary care workforce developed a clinically led, countywide Primary Care Education and Networking programme has been rolled out – initial attendance has been very good with clinicians from across the primary care workforce and positive feedback on the sessions offered from those attending. It provides a unique multi-disciplinary training opportunity for primary care and has covered topics such as cardiology training on ECG interpretation, hip and knee pathways, basic life support training, workforce health and wellbeing sessions.

Making best use of the available PCN Additional Role Reimbursement Scheme (ARRS) funding to maximise primary care workforce capacity has been a priority for the ICB and the Primary Care Network Alliance in 2022/23. The projected ARRS spend for the year for Lincolnshire is around £12 million – this is an improvement in the proportion of funding used compared to 2021/22. Recruitment to some ARRS posts has proved challenging for a number of PCNs and there is further work to do in 2023/24 to ensure all available funding is claimed. This will be supported by work across the system including the Lincolnshire Training Hub's apprenticeship scheme for the new GP Assistant role and work with Lincolnshire Partnership Foundation Trust on expanding and integrating community mental health practitioners within PCNs.

Estates

The ICB has been working as part of the national programme to review current primary care premises and model the future estates requirement based on clinical strategy and PCN development plans, this review has been clinically-led with PCN Clinical Directors and key stakeholders.

The programme is supportive of and responsive to wider stakeholder strategies, responding to and feeding into the ICS's system level strategies and addressing the needs of the PCN's local population. The requirements of the local neighbourhood teams have also been incorporated in this programme. The scope of the project is to produce PCN Clinical Principles and a PCN Estate Strategy for each of the 14 Lincolnshire PCNs. This work should be completed in the early part of 2023/24.

As well as developing primary care estates strategy the ICB has continued to work with practices to support improved patient access and experience, the refurbishment of Abbey Medical Practice premises in Lincoln is one example.

Abbey Medical Practice in Lincoln celebrates its redevelopment and extension

Situated on Monks Road in Lincoln, Abbey Medical Practice looks after 8,100 patients, most of whom live in the local area, and benefited from £1.2 million of NHS Estates and Technology Transformation Funding, as well as support from local partners, allowing it to redevelop the practice site, including a large extension, and provide much needed additional clinical space, helping to generate a vastly improved environment for patients and clinicians alike. The grand re-opening of the practice took place on 12th January 2023.

Communities and Primary Care Networks

A priority area of work is transforming care and improving outcomes for people who are frail, living with long-term conditions or at the end of their life. This is being delivered through Primary Care Networks and system partners. Work is ongoing to support Primary Care Networks develop and put in place the structures they need to address health inequalities for the patient populations through integrated neighbourhood approaches.

Boston, First Coastal and South Lincoln Healthcare PCNs have implemented local Strategic Partnership Boards in 2022/23 to develop relationships across local health and care partners and to identify opportunities to work together and to agree local priorities to be addressed. This approach will be developed with the aim of rolling this out to all PCNs and neighbourhoods.

PCNs have continued to deliver and develop the Enhanced Health in Care Homes (EHCH) service to support all people living in residential and nursing care across Lincolnshire. Over the last year there have been further developments in care homes and PCNs using the WHZAN telehealth system to support integrated and pro-active patient care alongside the introduction of additional support to improve outcomes for patient's whose health is deteriorating through earlier identification of issues.

Integrated models of care and creating capacity

Virtual clinics are now live and operating for MSK hip and knee pathway and Integrated Cardiology which includes the consultant, primary care clinician and patient. This enables shared decision making, informed choice and avoids unnecessary hospital activity. A cardiology virtual ward is now live with 30 beds, delivering intensive supportive care enabling people to stay at home for longer and leave hospital early than otherwise expected. These new care arrangements are underpinned by our vision and principles to deliver our ambition of admission by exception, care closer to home and better integrated working creating capacity.

Co-ordinating Care

A Palliative Single Point of Access (pSPA) is now live 24/7 for access to urgent care. The pSPA introduced a single number for access by patients, carers and families. This initiative was shortlisted in 22/23 for a national award. The impact has been improved care co-ordination and admission avoidance.

EPaCCS (Electronic Palliative Care Coordination Systems) records from the clinical system, for those recognised as palliative and end of life, can now be accessed via the Lincolnshire Care Portal. This information is therefore shared with the health and care providers and improves coordination of care for that individual.

Patient & Carer Experience (PaCE)

Initiatives drawing on Patient and Carer Experience have guided our service development in Palliative and End of Life Care and MSK. This has included: Surveys (PEOL Discharge (2022) Voices Post-Bereavement (2022), MSK (2022), engagement events and co-production groups facilitated by the ICB engagement team and our partners Healthwatch Lincolnshire and Every-One. This co-production work allows us to follow an experience based co-design approach in the development of our service redesign arrangements aimed at improving the quality of care in Lincolnshire, that will focus, above all else, on delivering what is important to the person, their family and their carers.

Primary Care Network Health Inequalities Directed Enhanced Services (PCN DES)

Tackling neighbourhood health inequalities - PCNs were asked to work from October 2021 to identify and engage a population experiencing health inequalities within their area, and to co-design an intervention to address the unmet needs of this population. Thirteen out of fourteen PCNs have provided a Direct Enhanced Service (DES) plan for delivery in 2023/24 based on the local inequalities data, population health management intelligence and feedback from the identified patient cohort. All 14 PCNs have identified Health Inequalities Lead.

Vaccination Programme

The COVID-19 vaccination programme continued in 2022/23 with two vaccination phases being delivered in that time alongside an ongoing evergreen offer for patients who had not yet come forward for their full course of vaccinations.

Based on Joint Committee on Vaccination and Immunisation (JCVI) guidance the Spring booster programme was launched in March 2022 with those aged 75+, residents in older adult care homes and individuals aged 12+ with a weakened immune system eligible for a vaccination. As with previous phases of the programme, the delivery model in Lincolnshire gave patients options of vaccination sites, including GP Practices, Community Pharmacies, Hospital hubs and the two Mass Vaccination sites. As has been the case with previous vaccination campaigns the uptake across Lincolnshire during spring was very good and compared favourably to the regional and national position.

The Autumn booster programme of 2022 went live in September after the JCVI recommended a further vaccination for those that had been eligible during the spring as well as extending the offer to those aged 50+, health and social care workers and anyone aged 5+ considered in a clinical at-risk group.

Outside of defined COVID-19 vaccination phases the Lincolnshire team's focus has been addressing the variance in uptake across the county. Our aim is to make it as easy as possible for every eligible individual who wants a vaccine to be able to access one. Summer 2022 saw the launch of our vaccination bus, working in partnership with Public Health colleagues we commissioned a mobile vaccination service that would allow us to take vaccines out to communities who may otherwise struggle accessing one of the Lincolnshire sites, as well as being able to attend community events to offer vaccinations as well as wider health promotion. A number of engagement events also took place over the summer months where members of the team from our two mass vaccination centres could speak to patients about any queries that they may have had about the vaccine.

As of 15th March 2023, over two million COVID vaccinations have been given in Lincolnshire since the inception of the vaccination programme. The continued success of the Lincolnshire programme has only been made possible by the strong partnership approach within the NHS and with colleagues in local government, the care sector, and the voluntary sector.

ENVIRONMENTAL MATTERS

With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play.

Two clear and feasible targets are outlined in the Delivering a 'Net Zero' National Health Service report:

The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040

The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

Laid out in the NHS Long Term Plan, these extended sustainability commitments range from reducing single-use plastics and water consumption, through to improving air quality.

On the 1st July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. This places duties on NHS England, and all all Trusts, Foundation Trusts, and ICBs to contribute towards statutory emissions and environmental targets. The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets. It also covers measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

Climate change and its effects on the environment, and the health and wellbeing of the population is now recognised on a global scale. Tackling climate change through reducing harmful carbon emissions will improve health and save lives.

- Air pollution is the single greatest environmental threat to human health in the UK, accounting for 1 in 20 deaths.
- The UK heatwaves of 2020 claimed more than 2,500 lives. Nine of the hottest years on record occurred out of the last ten.

Lincolnshire is not immune to the health harms and impacts of climate change. As a coastal county, some areas of our region are under serious threat of flooding from future rising sea levels, making this issue even closer to home. Responsibility for tackling climate change and reducing carbon emissions cannot be achieved by government or governing bodies alone; everyone needs to play their part and contribute, no matter how small the contribution. Across the NHS in Lincolnshire and with our County and District Council partners, we are steadfast in our resolve to really make a difference and achieve our collective net zero carbon targets and ambitions. We are working together and recognise the benefits and opportunities that a Greener NHS can have on health inequalities, improving social value and our roles as anchor partners.

We have adopted Lincolnshire County Council's three guiding principles:

- **Don't waste anything**
- **Consider wider opportunities**
- **Take responsibility and pride**

Trusts and ICBs are meeting this new duty through the delivery of their localised Green Plans, and the ICB Board in Lincolnshire has a board-level lead and a Green Plan Plan based on the strategies of our member organisations.
The link to our Plan is www.lincolnshire.icb.nhs.uk

Our ICB Green Plan supports our net zero ambition, it sets out their aims, objectives, and delivery plans for carbon reduction. The ICB 'net zero lead' is Mrs Sarah Connery, the Chief Executive of LPFT, who is responsible for overseeing its delivery.

For the ICB a key focus of work involves medicines and inhalers. Inhalers are a key treatment for respiratory conditions, with approximately 60 million dispensed in England every year. However, inhalers are not always used in an optimal way, which can lead to poor disease control and avoidable deaths. Inhaler emissions account for approximately 3% of the NHS carbon footprint. The propellant used in metered dose inhalers is responsible for most of these emissions. Alternative options with a significantly lower carbon footprint exist, such as dry powder inhalers. The UK has a higher metered dose inhalers prescribing rate compared with other European countries. These countries have demonstrated that safe and effective care can still be delivered using other inhaler devices.

Supporting patients over the age of 12 to consider using lower carbon inhalers, where clinically appropriate, creates an opportunity to improve patient outcomes while reducing harmful carbon emissions. The Medicines Optimisation Team are leading this work with our primary care colleagues, and we look forward to sharing progress with you in 2023.

We recognise that sustainability impacts on all that we do in terms of changes to services and capital projects. We have a system Lincolnshire NHS Green Board and there are regular reports into the ICB Board.

Key achievements to report:

- We have agreed to use a single Sustainability Impact Assessment across the Lincolnshire System
- ICB Staff can now lease Electric Vehicles and Ultra Low Electric Vehicles through the Lease Car Scheme
- The ICB has agreed to move out of Cross O'Cliff in Lincolnshire, which will reduce its the carbon-footprint
- The agile working policy supports the reduction in ICB travel mileage alongside the continued use of digital platforms for meetings where appropriate

Information on the ICB's use of energy and water is detailed below for the period 1 July 2022 to 31 March 2023.

	Bridge House	COC
	£	£
Utilities - Gas	N/A	14,369
Utilities - Electricity	4,153	23,742
Water	1,125	2,121
Total Spend	5,278	40,232

IMPROVEMENTS IN QUALITY

Quality Governance

The Integrated Care Board has a duty outlined in section 14Z34 of the NHS Act 2006 as amended by The Health and Care Act 2022 to improve the quality of services and to ensure patient safety and positive patient experience. In view of this the Integrated Care Board has established the Quality and Patient Experience Committee (QPEC) as a sub-committee to maintain oversight of the quality functions and responsibilities of the ICB. The Committee meets bi-monthly, is chaired by the ICB Non- Executive with responsibility for Quality and is attended by the ICB Medical Director and the ICB Director of Nursing ; the three Trusts respective Non-Executive Directors who lead on Quality plus their counter-part Executive Quality Leads; also with leads from Public Health and Healthwatch.

The Integrated Care System Quality Group (SQG) establishes the areas of concern pertaining to Quality and the actions being taken to address identified concerns with subsequent escalation to the ICB QPEC for awareness and to provide assurance on the mitigating actions. The main purpose of the SQG is to ensure quality concern escalation and to ensure quality improvement support is given from relevant system partners as needed and also for assurance to all the organisation Quality Leads represented, that required improvement actions are being addressed effectively either by individual organisations or collaboratively where necessary.

In support of QPEC and SQG the ICB has established Quality oversight groups for all providers, with linked Quality Team staff members who support the Quality functions of the ICB and are aligned with all providers across primary and secondary care. These officers also attend provider local quality committees or meet regularly with their allocated providers, so they are aware of and able to support with any areas of quality concern.

The work of the ICB Quality Team members is aided by intelligence gathered about quality from wide ranging and established processes, for example via incident and serious incident reporting from providers; through quality dashboards; through complaints received; through information provided by Healthwatch and other patient voice avenues; from regulators and health and care education, and through many other sources.

Some of our providers are under an enhanced level of surveillance and support from the ICB and other partners because of previous regulator and/or ICB performance and quality concerns. For these providers the ICB Quality Leads attend dedicated Quality Review Meetings with the provider at a frequency indicated by the level of concern. They also undertake, where relevant, quality visits to seek assurance on actions or any other quality/ safety concerns. Direct support is given to the organisation where required to facilitate quality improvement.

Of particular positive note in 2022/23 is ULHT's progress with Care Quality Commission (CQC) required improvement actions, removal of all CQC Section 31 conditions and exit from the CQC Special Measures regime.

Quality Priorities

The System Quality Group has identified several areas which have required ongoing focus for quality improvement in 2022/2023:

- Right place, right care, right time for care within Urgent and Emergency Care (UEC) with a need to maintain focus on patient access to services, care closer to home, reducing unnecessary hospital attendance and admission and long lengths of stay in hospital post-admission.
- Reducing care treatment delays within both unplanned and planned care pathways, necessitating robust harm review processes for patients waiting a long time for treatment.
- Palliative and end of life care (PEOL) with continued work to improve advanced care planning plus Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) discussions and documentation.
- Health Protection – with a continued focus on infection prevention and control in light of COVID-19 and an increased prevalence of other infections/ viruses.
- Ongoing work to reduce the incidence of pressure ulcers, which will be an area of further focused work in 2023/2024, with a system improvement group established to collectively progress this work.
- Workforce challenges across many services, requiring a constant focus on staff health and wellbeing, plus recruitment and retention initiatives.

Lots of this improvement work has taken place through respective system programme boards and within and across our providers, supported by provider and ICB quality team members, and will be further highlighted in the relevant sections of this report for example UEC, Cancer, Elective, POEL, and the work of the People Board.

Specific areas which come under the direct responsibility of the ICB Nursing and Quality Team are covered in more detail below:

Children and Young People (CYP)

Lincolnshire Integrated Care Board has made "Improving the health of children and young people" one of its key priorities. Working in partnership with children and young people and families is an essential element of our work and we do this in conjunction with health providers, children's services, education and the voluntary sector.

There was already good partnership working in place which has only strengthened since becoming an ICS. There is good engagement from all partners at our Children and Young People Integrated Transformation Board, where we determine the system priorities for system priorities.

Health Inequalities are a key driver for determining where our priorities should be and the Core 20 Plus 5 Programme has identified key areas as being asthma, epilepsy, diabetes, oral health and mental health and there are transformation workstreams being undertaken in all areas to improve the support we give to young people and their families.

Our emotional wellbeing services have a positive impact on reducing referral rates to Children's and Adolescent Mental Health Services (CAMHS) locally, although in line with the national picture there have been sustained higher referral rates across all service following the pandemic. Increased demand has meant waiting times from assessment to first treatment remain a concern, particularly for more specialist interventions within specialist CAMHS and eating disorder services and this is subject to a comprehensive CYP Mental Health Review and Transformation Programme. There has been Increased investment in early, low/moderate intervention and more preventive and community support for CYP. There is continued roll-out of Mental Health Service Teams (MHSTs) in Lincolnshire as part of national programme with schools/colleges.

Prevention is a key part of ensuring that our children stay healthy and fulfil their potential and key work programmes continue within areas such as obesity and dental health, and in ensuring those with long-term conditions, such as asthma, epilepsy and diabetes, are well controlled so that children can access education and access normal childhood activities.

The ICB has also raised the profile of children across other programmes of work, such as mental health, learning disability and autism (MHLDA); primary care; and palliative and end of life care and as new services are being developed, and existing services transformed, the needs of children and young people are being considered, especially at the point of transition from childhood into adult where young people can be at their most vulnerable. There is now more of an emphasis on the development of all age pathways to ensure transition becomes seamless.

Special Educational Needs and Disability (SEND)

The Designated Clinical Officer (DCO) for Children and Young People (CYP) with Special Educational Needs and Disability has continued to deliver on all statutory functions.

Throughout 2022/23 the DCO team have submitted/or been interviewed around a series of six self-assessment tools for the ICB's transition from CCG with particular focus on governance and infrastructure around Special Educational Needs and Disability.

This is designed to provide oversight to:

- Ensure local systems are sighted on children & young people with Special Educational Needs and Disabilities (SEND), and their impending statutory duties.
- Enable Health leaders to develop leadership, governance and infrastructure arrangements, that are informed by and ensure compliance with the existing SEND code of Practice and the statutory requirements of the Children and Families Act 2014.
- Enable an assessment of the ICS's maturity in relation to children and young people with SEND.
- The self-assessment tool is informed by NHS England and NHS Improvement ICS Design Framework (2021) and NHS Oversight Framework tab (2021/22) utilising the methodology of Key Lines of Enquiry (KLOE). The themes or KLOEs are leadership, governance, joint inspections, data intelligence, performance data, quality improvement partnerships, widening participation.

As an ICB we rated the Lincolnshire system as Green and is the only system in the East of England, East and West Midlands to do so – this is supported by NHSE who provided extremely positive feedback as below

'It's absolutely brilliant to see the breadth of evidence showing how SEND is well and truly on the ICS/ICB agenda and how you intend to progress this further. I believe your SEND Health Committee and partnership with Lincolnshire Young Voices and Lincolnshire Parent Carer forum is a real strength for Lincolnshire. I have to say what has been provided is one of the best examples, it's amazing and I'm certain other systems could learn a lot from you. This work is really down to your continued dedication and commitment in supporting the SEND agenda and I wanted to thank you'.

Deborah Ward, Children & Young People Learning Disability & Autism and SEND Senior Manager, Learning Disabilities and Autism Programme, NHS England.

ICB Nursing & Quality Team

Health Protection

Infection Prevention and Control (IPC) with safe environments of care for patients and staff continued as a vital focus in 22/23 due to the continued prevalence of COVID-19, increased rates of seasonal influenza following the lockdowns and social restrictions of the previous two winters and an unusual increase in group A Streptococcus infections. The ICB assisted with this through the work of our Health Protection Team.

The ICB Health Protection Team works on behalf of the ICB to ensure good health protection systems and processes are in place for NHS commissioned providers, member GP practices and to support the wider public health of the population. The work of this team covers three work streams: Infection Prevention and Control (IPC); Communicable Disease Control; and Vaccinations and Immunisation, and therefore during this year the work of this team has continued to be of paramount importance.

In Quarter One 2022/23 the Health Protection Team, which itself was now fully established after a period of vacancies and expansion of the team, was able to re-establish further assurance reporting and support visit processes with our providers, which had been suspended necessarily during the height of the COVID-19 pandemic. Each Trust receives at least a quarterly visit from the team and for all other providers, the aim is to visit most practices annually. The outcomes of visits were positive with overall good compliance to IPC standards. Where issues were identified the team have worked with the relevant provider to advise and support mitigating actions. Formal thanks were expressed at the ULHT IPC Group in February 2023 for the support received with IPC from the ICB Health Protection Team.

The team have supported the system to keep local guidance on living with respiratory illness up to date and relevant. Following the emergence of Mpox (moneypox) which spread amongst susceptible groups of the population in spring and summer 2022, the team have, with input from system partners, developed local guidance for the management of suspected and confirmed cases of Mpox.

The ICB Health Protection team attend regular briefings and webinars to ensure that the Lincolnshire processes are clear and in line with national and regional guidance.

The Lincolnshire pathways were highlighted by NHSE as being a good example and shared with the region. The team coordinates the Lincolnshire Primary Care IPC Link Practitioner network and hold quarterly update and teaching sessions via video call. Attendance has been increasing throughout the year.

The team have attended several conferences and other training events relevant to health protection to ensure that the staff are qualified and competent to provide up to date advice and guidance to system partners. The team also attended the Lincolnshire Show with LCC Health Protection colleagues, using this as an additional way to provide proactive health protection advice to the attending public.

The team continue to support the Influenza and vaccination campaigns e.g. IPC training updates have been delivered to the teams at the mass vaccination sites and IPC support was given with the refurbishment of a new mass vaccination site in Lincoln.

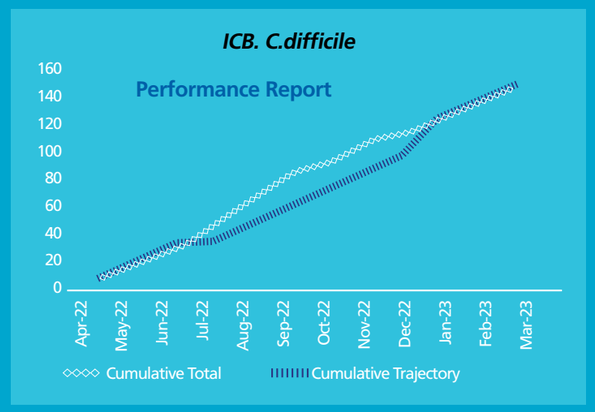
The team has increased resource to manage both the expected demand and the unexpected remit of the Health Protection function i.e. communicable disease outbreaks. There was a significant avian influenza outbreak in Lincolnshire, spanning several months from December 2021 until the late summer of 2022, affecting a number of farms. The ICB Health Protection Team continued to support the response to this in Quarter One and Quarter Two. In May 2022 the team coordinated the follow up to a case of Hepatitis A in a school, and hepatitis A vaccine was offered to all of the contacts identified. In November 2022 the team co-ordinated the system response following the arrival in the county of a group of asylum seekers who had been present in an immigration arrival centre during an outbreak of diphtheria. A rapid response was required, and, in conjunction with system partners, the affected individuals were offered antibiotic prophylaxis and diphtheria vaccination at an event held within the required timescale. In addition, two scabies outbreaks were identified amongst the affected groups, and appropriate follow-up arranged. During December 2022 the team supported the LCC Health Protection Team with the response to a number of outbreaks of influenza in care homes. A rapid response team was set up to provide support with issuing antiviral prophylaxis. In March 2023 the team co-ordinated a TB screening event for a hard-to-reach population. In addition to the TB screening, a wide range of system partners participated in the event to provide health promotion advice and signposting to local services.

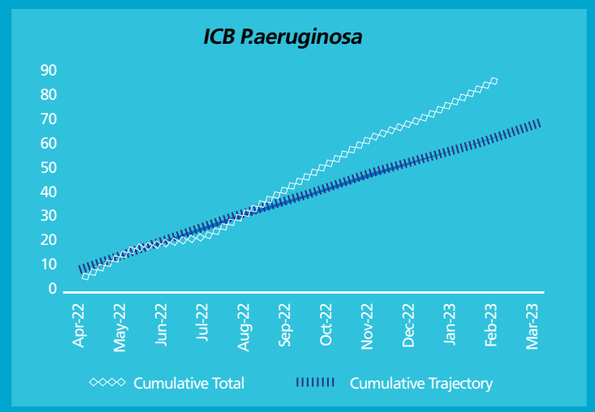
ICB Healthcare Associated Infections

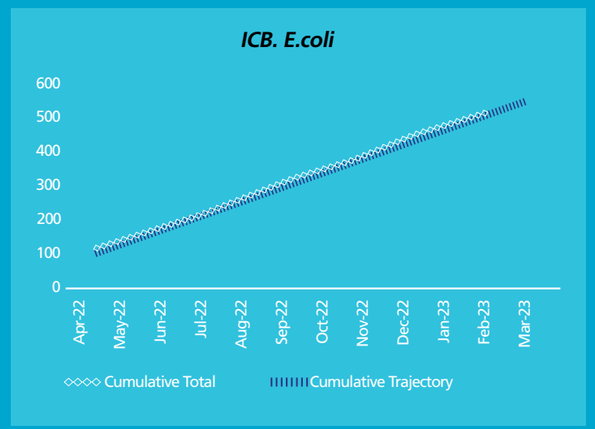
The available data (1st April 2022 to 28th February 2023) shows the system to be below trajectory for C.difficile by two cases to this point in time. For Gram negative organisms subject to mandatory reporting, E.coli are over trajectory (by nine cases); P. aeruginosa and Klebsiella species are both over trajectory by 20-30 cases. There has been nine MRSA bacteraemia cases during the 11-month period of reporting.

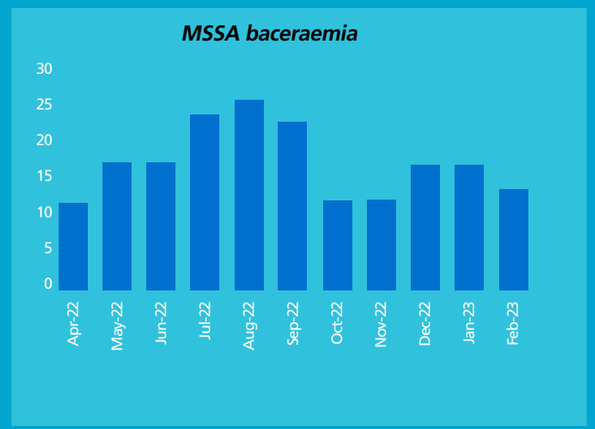
The Health Protection Team are reviewing all MRSA cases and a sample of Gram negative organisms that have occurred over the year to identify themes to share across the system. A system IPC subgroup has been established to co-ordinate a collaborative approach towards reducing Gram negative infections.

Organism	April 2022-Feb 2023 data			
	Cases/ Trajectory	Cases/ Trajectory	Cases/ Trajectory	Cases/ Trajectory
	Lincs ICB	ULHT	NWAFT	NLAG
C.difficile	134/136	57/53	85/105	18/20
E.coli	484/475	58/59	45/68	33/60
P.aeruginosa	83/60	12/12	14/15	7/7
Klebsiella pp.	170/142	29/34	21/33	17/23
MRSA	9	1	4	0
MSSA	179	25	18	18









Maternity

The Lincolnshire Local Maternity and Neonatal Service network (LMNS) is well established and continues to proactively work with system partners to drive forward improvements for Lincolnshire families. LMNS have a robust governance structure to ensure oversight and assurance of the quality, safety and transformation of local maternity and neonatal provision within Lincolnshire ICB. Further information is detailed under the section on Key Achievements.

ULHT has made positive improvement leading to CQC rating good for maternity and successfully now exited NHS England / Improvement Maternity Safety Support programme (MSSP). Good progress is demonstrated against the Ockenden Review recommendations. There is still work on-going with personalisation and coproduction of services with the Maternity Voices Partnership. Digital continues to be a significant challenge for Maternity, particularly with ascertaining data. ULHT is working towards procurement of a new maternity digital system supported by LMNS. There is a recruitment plan to appoint a digital matron to work across the LMNS to drive forward the strategy and the digital agenda.

ULHT has completed a piece of work benchmarking their position against the Ockenden Review 15 improvement Essential Actions and the East Kent Review recommendations. NHS England are due to publish a Single Maternity Plan to define the next improvement action requirements for LMNS partners, which has been delayed until April 2023. The Ockenden Insight Assurance visit for ULHT in 2023/24 will be LMNS system-led and took place in mid-June 2023.

Patient Safety

There has been continued commitment by the ICB, and providers of healthcare to Lincolnshire patients, to work as an ICS to review adverse incidents and serious incidents focusing on identifying and sharing learning, with a view to implementing sustained improvement in the care we commission and deliver. This work has provided the foundation for the implementation of the Patient Safety Incident Response Framework (PSIRF) published, by NHS England, in August 2022.

PSIRF defines the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents, for the purpose of learning and improving patient safety; and represents significant transformational change.

Within Lincolnshire a collaborative approach has been taken to the implementation of PSIRF. The ICB has developed a Lincolnshire-wide PSIRF Implementation Group with active engagement from key healthcare providers who are headquartered within the ICB footprint. Membership is also extended to key stakeholders including (but not limited to) the Local Maternity and Neonatal System (LMNS); Coroners and Healthwatch. The meeting aims to provide support to those organisations, within the ICB boundary, who are implementing PSIRF; to identify areas of good practice/learning and potential joint working and to identify any system risks associated with the delivery of PSIRF. Representatives from the ICB are also actively engaged with and attending the healthcare provider organisational PSIRF Implementation Meetings.

The ICB is also linking in with ICBs in neighbouring areas, where Lincolnshire patients are receiving care, to secure an insight into their implementation of PSIRF.

Through the involvement in the above, the ICB will be able to collaborate with providers in the development and sign off of the Provider Patient Safety Incident Response Policies and Plans; oversee and support effectiveness of systems to achieve improvement following patient safety incidents; support co-ordination of cross system learning responses and share insights and information across organisation/ services to improve patient safety.

Continuing Healthcare

The ICB Continuing healthcare (CHC) service has continued to maintain good performance on eligibility decisions being made within 28 days. There is also robust performance on Discharge to Assess for patients requiring CHC on hospital discharge, with the team joining daily discharge calls now as business as usual, to ensure any CHC service blocks are addressed for patients. There have been continued workforce challenges in the team due to illness and vacancies which have caused a backlog with annual reviews. To address this additional agency staffing cover has been maintained plus ongoing utilisation of an external provider to address priority reviews and ensure an acceptable trajectory for clearance of any outstanding reviews and workload management.

The CHC team has continued work to improve access to personal health budgets for all our patients. The clinical team have concentrated on ensuring packages of care are personalised for our patients, and that they are fully involved in decisions made about them (where possible). A full Personal Health Budget (PHB) roll out strategy is developed, informed by the June 2022 workshop that was held involving clinicians from across the health and care system. Priority areas for initiation of PHBs over the next year are identified. The ICB continue to achieve NHS targets set for numbers of PHBs in place.

Care Homes

Through the Enhanced Health in Care Homes programme, the ICB continued to work with the Local Authority, Lincolnshire Care Association (LINCA), Primary Care Networks (PCN) and all other relevant system partners to ensure a network of support is available for care homes and domiciliary care providers. ICB Safeguarding Leads also continued with their regular input to the Care Home & Domiciliary Service Quality Review Meeting led by the Local Authority with partner agencies, which considers in detail any specific provider concerns for follow up, to ensure appropriate support and improvement occurs. An additional Care Home and Home Care Quality Forum was also initiated in 2022/23 to provide a forum for health and care colleagues to share any concerns and initiatives relating to care homes and home care, and the intention is to develop this forum further in 2023/24 as a supportive community of practice/interest.

Primary Care Quality – General Practice

The Quality of General Practice provision has continued to be assured through the work of ICB Locality Primary Care Quality Assurance Groups and constituent ICB locality linked staff. There is then escalation reporting of any areas of concern to the Primary Care Quality Oversight Group and to the Primary Care Commissioning and Delegated Functions Committee. At these groups there is careful consideration for each practice of wide ranging quality indicators including any incidents, complaints, Healthwatch and regulator feedback. Any concerns are followed up directly with the practice for improvement action as needed. Increasingly this follow up is in conjunction with the associated Primary Care Network (as Primary Care Networks develop, they will gradually take greater staged responsibility for the quality of care delivery in their local area). The Quality Governance role development of Primary Care Networks is being supported by the aligned ICB Quality officers in conjunction with the ICB Primary Care Team.

Activity levels for general practice and primary care services in general have remained very significantly increased across 2022/23 with 'normal' workload, plus backlog after 'lockdowns, positive cases and long COVID patients needing on-going care, awaiting elective procedures, and because of the additional workload associated with delivery of the COVID-19 and influenza vaccination programmes.

General practice has continued to ensure safe service access by ensuring maintenance of safe Infection Prevention and Control practices and appropriate access routes, be this via telephone or video consultation routes or via face to face appointments where indicated.

Throughout the year COVID-19 prevalence in the community continued to present significant workforce pressures with staff illness or staff isolating. Several practices have been affected at some point in 2022/23 by staff absences either due to COVID or for other reasons. Where necessary business continuity plans have been activated in our practices to ensure safe staffing levels e.g. use of locums, sharing staff and facilities across practices as examples. ICB locality staff continue to monitor this situation on a daily basis, ensuring support is offered if required.

Patient feedback through Healthwatch has continued to raise some access concerns for some practices. Where several concerns are raised, these are followed up directly with the practice to ensure any improvements required. Regular communication is also being shared with the public regarding the different routes for service access, including virtual contact and consultations being undertaken routinely now by General Practice when it is appropriate to do so.

Four of our practices have had more intensive support from the ICB, Local Medical Committee and system partners this year due to quality concerns and adverse CQC ratings.

Hawthorn Practice, Skegness, and Branston Practice in Lincoln currently have inadequate ratings with the CQC following inspection visits in 2022. Both practices have been recently re-inspected by the CQC. These were focused inspections to review areas where warning notices had been put in place. Positively, both practices had worked hard on improvement actions required and therefore the warning notices were lifted. There are still areas where improvements need to be embedded and sustained, therefore the ICB and partners continue to work closely with these two practices to support. Both practices will have full CQC re-inspections in the spring/summer of 2023 where, with the sustained improvement work, they are undertaking should improve their CQC ratings.

We are pleased to report that Lakeside Practice in Stamford has progressed out of the CQC Special Measures regime consequent to a previous inadequate rating from the CQC, received in 2021. The practice has now received an overall requires improvement rating with improvement demonstrated across inspection domains. There are further improvements required and therefore the ICB team and partners will continue to support as is required by the practice.

Spalding Practice was closed in March 2023, prior to this there were sustainability and quality concerns, which the ICB team supported Lincolnshire Community Health Services (LCHS), as provider of the service, to address. At the end of contract, LCHS decided they no longer wished to continue as

provider of this service and post consultation and engagement, the patient list was dispersed to neighbouring practices. The ICB Primary Care and Quality Teams provided full support to this work.

ICB support to workforce development and additional roles within primary care and general practice has continued to ensure continued workforce sustainability, given the challenges previously outlined and to maintain good quality multi-disciplinary care provision.

Primary Care Quality for Pharmacy, Optometry & Dental

Pharmacy, Optometry and Dentistry Quality Assurance & Improvement will become the responsibility of the ICB from the 1st April 2023. There has therefore been a full transition programme of work in liaison with NHSE and Midlands ICBs to facilitate the arrangements for this. Lincolnshire ICB will work collaboratively with the other East Midlands ICBs and Nottingham & Nottinghamshire ICB will host the transferred staff from NHS England. These staff will fully transfer by June 2023.

The staff transferred include contracting and clinical advisor staff who will undertake the main operational quality assurance and improvement activity with Pharmacy, Optometry and Dental providers.

A Lincolnshire ICB Quality Team member will link into this operational function and ensure information/intelligence feeds through into our existing Primary Care Quality oversight function and committees. Committee membership will be amended to include representatives for Pharmacy, Dental and Optometry as appropriate.

There has been collaborative work and engagement across all stakeholders this year, including with Healthwatch on the new Dental Strategy for the county as difficulties with dentistry access is frequently raised as an area of concern by patients. Dentistry has significant recruitment and retention challenges akin to some of our other services, so this joint working on the strategy is vitally important important in working towards addressing the challenges faced.

Safeguarding

ICBs have a statutory responsibility, set out in primary legislation and statutory guidance, to safeguard adults, children, young people, and looked after children. The ICB is committed to promoting the safety of all at risk of abuse or neglect, employing a safeguarding team which comprises of specialist safeguarding practitioners and designated professionals, including medical, nursing, and administrative staff to support this function. The team works proactively to support local, regional, and national safeguarding priorities and responding to the ever-evolving safeguarding landscape, such as the implementation of the Domestic Abuse Act 2021 and the commencement of the Serious Violence Duty in January 2023.

Safeguarding is a collective responsibility, whilst individuals and organisations have distinct roles, the system cannot operate effectively unless individuals and organisations work together.

Oversight of local partnership safeguarding arrangements is provided by the Lincolnshire Safeguarding Adults Board, the Safer Lincolnshire Partnership, the Lincolnshire Domestic Abuse Partnership, and the Lincolnshire Safeguarding Children Partnership (LSCP). The ICB is represented at all levels of work within these, providing leadership for safeguarding through attendance to the strategic boards, and sharing specialist knowledge and expertise through the active participation of the ICB safeguarding team in sub-groups, audit processes, statutory reviews (Child Safeguarding Practice Reviews, Serious Adult Reviews and Domestic Homicide Reviews), and specific task and finish groups.

The ICB safeguarding team attend regional and national NHSE meetings and forums, disseminating learning, and considering the implications of findings for the Lincolnshire system. Work currently being undertaken includes identifying how health can most effectively share information at multi-agency meetings, which commenced in response to national reports published into the murders of Arthur Labinjo-Hughes and Star Hobson in 2022, and preparation for the implementation of the long-awaited Mental Capacity (Amendment) Act 2019 and Liberty Protection Safeguards. The safeguarding team has worked with Continuing Health Care and Local Authority colleagues to facilitate and plan for the anticipated changes.

The ICB safeguarding team provides level 3 safeguarding training to primary care staff, facilitates GP forums, and produces a bi-monthly safeguarding newsletter which is shared with all GP practices in the county. The newsletter enables current safeguarding information to be shared, the forums provide an opportunity for peer supervision and professional challenge.

Partners continued to work proactively in 2022-2023 towards safeguarding priorities. Examples of work relevant to Lincolnshire is provided below, this list is not exhaustive but evidences the broad spectrum of work undertaken to protect children and young people at risk of harm and abuse:

The ICB safeguarding team is leading on the implementation of ICON (which stands for I – Infant crying is normal; C – Comforting methods can help; O – It is OK to walk away; N – Never, ever shake a baby) across Lincolnshire. ICON is an evidence-based programme aimed at preventing abusive head trauma in babies. The team have worked closely with health and wider partners on its successful implementation with future work focusing on roll-out across the military, in view of the number of service personnel and their families living within the county.

The Designated Doctor chairs the LSCP Child Death Overview Panel (CDOP) which reviews the circumstances surrounding the deaths of children and young people under the age of 18 years. In 2022, following an increase in deaths of young people in Lincolnshire suspected to be suicides, CDOP completed a thematic review to recognise any themes which could help inform policymakers, commissioners, and those providing services to children and young people.

Research provides extensive evidence of the poorer health outcomes experienced by Looked After Children and Care Leavers when compared to their non-care experienced peers. The ICB continues to work in partnership with the local health system, the Local Authority and Barnardo's to support and improve services for this cohort of vulnerable children and young people. 2022-2023 saw reported positive progress for the completion of Initial Health Assessments for Looked After Children within statutory timescales, which is a national issue and has been a longstanding local concern. NHS Lincolnshire ICB has also agreed to fund pre-payment prescription certificates for Care Leavers aged 18 - 25 years who would otherwise not be entitled to free prescriptions.

As one of the three safeguarding partners, the ICB works in partnership with the police and the Local Authority to co-ordinate their safeguarding services: acting as a strategic leadership group in supporting and engaging others and implementing local and national learning including from serious child safeguarding incidents.

To demonstrate how the ICB has performed against this duty, and to see the LSCP priorities, please see link below to LSCP Annual Report, LSCP Constitution 2022 – 2023 and the LSCP Business Plan 2022 – 2025.

Local Resources (proceduresonline.com)

The Safeguarding Accountability and Assurance Framework (SAAF) identifies core duties across the lifespan of safeguarding for individuals working in providers of NHS-funded care settings and NHS commissioning organisations.

Responsibilities for safeguarding form part of the statutory functions for each organisation and its executive board must ensure effective discharge of this. The ICB has contractual requirements and assurance processes for safeguarding with all its providers, the safeguarding team are continually looking at ways to improve the quality of assurance methods to support providers, reduce replication and ensure the focus is on positive outcomes for patients and communities.

The ICB can confirm compliance to the statutory functions and assurance processes set out in the SAAF - legislation and mandatory reporting duties, roles and responsibilities of staff, and commissioning and assurance of NHS services.

In response to the increasing demands across the safeguarding agenda, in 2022 NHS Lincolnshire ICB reviewed the team structure and capacity of its safeguarding team. As a result, an additional post was created, an increase in sessions for the Designated Doctor agreed, and changes made to the team structure which enables the Designated professionals to fulfil the functions set out in the SAAF.

WORKING WITH PEOPLE AND COMMUNITIES

This section provides an overview of our activities – further details are available in the Lincolnshire ICB's People and Communities Involvement report 2022/23

Our engagement work is underpinned by the Lincolnshire ICB People and Communities Strategy

Our commitment

The Health and Care Act 2022 mobilises partners within ICSs to work together to improve physical and mental health outcomes. These new partnerships between the NHS, social care, local authorities and other organisations will only build better and more sustainable approaches if they are informed by the needs, experiences and aspirations of the people and communities they serve. The ICB is fully committed to involving patients, the public, partners and key stakeholders in the development of services and ensuring they are at the heart of everything we do. We understand that partnership working is key to empowering patients to have more choice and control over their own health. Through these partnerships, we can better understand the health needs of our population, resulting in improved health outcomes.

Legal Duty for Involvement

As outlined in section 14Z45 of the NHS Act 2006 as amended by The Health and Care Act 2022, the ICB has discharged its public involvement duty by having in place provisions for involving the public in the planning of commissioned services; and the development and consideration of proposals for changes in the commissioning arrangements which would have an impact on service delivery and decisions which would have an impact on services. By listening to local people and co-producing with those who represent them, we can improve the decisions we make and ensure we are considering the health needs of Lincolnshire residents. The ICB wants to continuously improve and develop how we can involve our communities. It is important to us that the public sees how their feedback has helped to shape local services and how much we value all feedback and engagement. How we do this is set out in our values, which are outlined in our Constitution, and the principles set out in our People and Communities Strategy, which explain how we will work with people and communities and continue to develop and strengthen this with our partner organisations and patient representatives.

Governance and assurance information

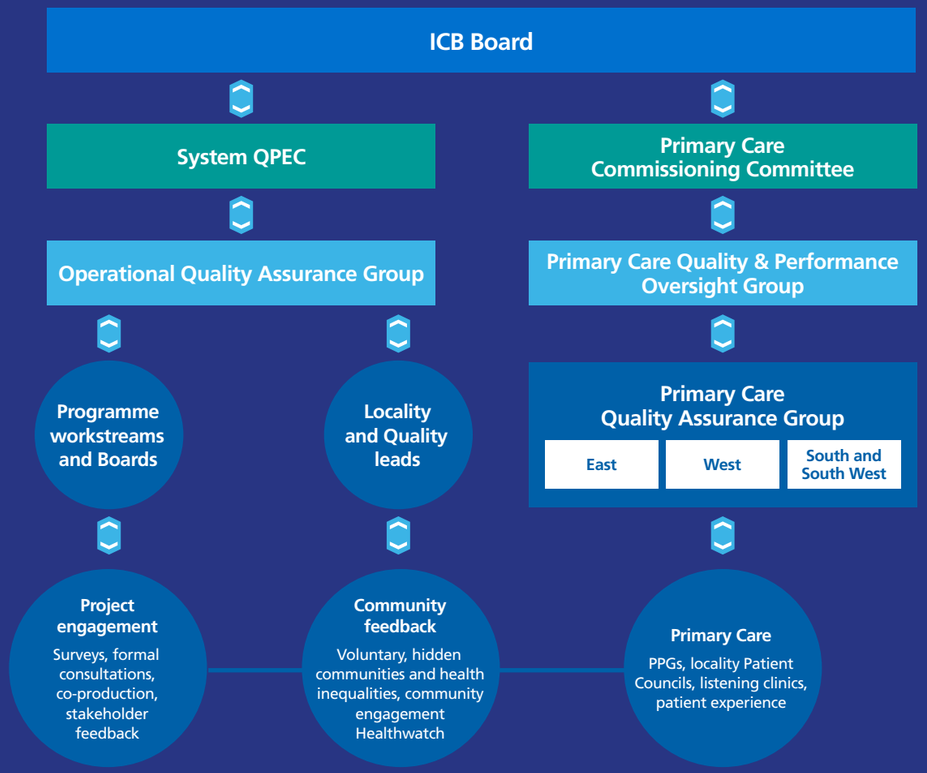
Timely and meaningful engagement is a priority for us, and a strong framework, with clear structures and assurance processes, plays a key role in making sure that patients and communities are central to our decision-making.

- Our ICB Constitution clearly states our guiding principles about public involvement and is available to view on our website.
- Our engagement function is part of the ICB's Strategic Planning, Integration and Partnerships team, ensuring patients and our communities are at the heart of service development, improvement, and transformation. Strong links are maintained with the ICB Nursing and Quality Team to align patient experience and engagement with quality and safety.
- Reports on our engagement and outcomes of this are reported to the ICB Operational Quality Assurance Group Meeting with escalation as required to the System Quality Committee and to our Primary Care Commissioning Committee (PCCC) if it is regarding a GP practice. Reports are also regularly shared with partners via our System Quality and Patient Experience Committee.

Feedback from programme specific engagement is also shared with our project leads to help shape and steer their programmes of work.

- Feedback from our engagements and consultations is also reported into our Board meetings to inform decision making on large projects.
- We have also established a dedicated communications and engagement team to focus solely on primary care, recognising the vast array of specific feedback we receive from patients and the public, and enabling us to ensure this reaches the teams developing primary care and its services in a timely manner for them to respond to.

The ICB's Continuous Listening Model demonstrates how all feedback is reported into the governance structures and evidences the difference it makes.



ICB Working with People and Communities Strategy in practice

Our strategy outlines our commitment to involving people and communities throughout Lincolnshire, highlighting the variety of ways we involve people and communities on an individual, group and community basis. We will ensure that our methods and approaches are inclusive and tailored to all the Lincolnshire population and stakeholders so they can have their say. To do this it is important that we recognise and understand who our stakeholders are and the most effective way to communicate and engage with them individually. This is supported by undertaking Equality and Health Inequality Impact Assessments to ensure that all voices in our community have an opportunity to be heard.

The ICB has adopted the ten principles set out by NHS England in the ICS design framework – these have been developed from work with systems across the country and, when embedded effectively, will create a golden thread running throughout the ICS, whether involvement takes place within neighbourhoods, in places or across the whole of Lincolnshire. Delivering our principles will demonstrate and evidence our commitment to the constitution. Our Lincolnshire ICB's People and Communities Involvement report 2022-23 details the work we have undertaken towards achieving these principles.

Using insight and data to inform our work

We recognise the differences in our communities from their health needs, ability to access services (both digitally and in person), and the ways they want to get involved. All of our commissioning and involvement activities are built on a solid understanding of our population, service users, their experiences and the people that support them. We utilise the knowledge, relationships, networks and strong links our partner organisations already have with our communities to ensure a fully holistic, system approach to involvement. We use existing and tested opportunities to engage and communicate, and seek to identify the best partner with the best relationship to lead the conversation. Working as partners strengthen our collective messages and involvement activities. As well as joining up care, we are joining up our engagement and experience work to capture and improve the patient journey and use this to empower joined up system working.

We support our programme teams to make these links and ensure Equality Impact Assessments, Quality Impact Assessments and Health Inequality Impact Assessments (HEAT) are undertaken to fully understand the people and communities we serve who may be impacted by any changes. The insights and diverse thinking of people and communities are essential to enabling the ICB to tackle health inequalities and the other challenges faced by health and care systems.

We have also developed an Insight Database, pulling together findings from engagement activities across the NHS and partner organisations to provide a solid base of intelligence and experiences which are shared to inform programmes of work and decision making.

How we reach diverse, potentially excluded and disadvantaged groups

The engagement team, previously working as key members within the Inclusion and Health Equalities Vaccination team, have continued to communicate and engage with the population of Lincolnshire in relation to COVID-19 vaccinations. This work has included targeting areas of the county with lower uptake of vaccinations and visiting local people in community venues. We continue to produce promotional material in a range of different languages and used methods including billboards, targeted fliers to households and businesses, videos and social media and work alongside key community leaders to share the messages. We continue to build on these relationships and utilise the links made in the community to involve the public in our engagements and consultations.

To help us involve people digitally we continue to recruit to our Citizen Panel, which now has over 800 members. The panel has been set up to be a group that is representative of our Lincolnshire population, allowing us to identify and target all demographics including those less likely to get involved, such as people with caring responsibilities, in fulltime employment and living in rural locations. The panel gives us an exciting opportunity to gain insight into our population's views on various topic and its aim is to research current services in Lincolnshire, test appetites for change and explore how the population feels about the current provision of services. The work of the Citizen Panel helped build the ICB's knowledge and confirm the approach with regards to on-going programmes of work, such as personalisation.

Our summer 2022 roadshow was a terrific opportunity to attend various local events and community groups, such as fun days, college fresher fayres and local networking events, reaching a wide range of people and potentially hidden communities. We shared a range of materials with people, enabling them to get directly involved in engagements the ICB or partners were undertaking, highlighting the different ways they could get involved, promotion of vaccinations and local communications messages, as well as partner services such as the Mental Health Helpline.

Our engagement materials have also been translated into the main languages in Lincolnshire and shared while we have been at events as well as via our social media and webpages. To support wider distribution of these we are currently developing a forward planner of activities, such as attendance at local factories with large Eastern European workforces. As well as providing opportunities to get directly involved with our programmes, we also signed thousands more people up to our fortnightly Engagement Bulletin. This is distributed to over 10,000 people to share ways they can get involved and highlight key news and projects in the ICB and partner organisations.

How we work with partner organisations

- Healthwatch are key partners and will act as a critical friend, as well as representing an independent view of the patient and public voice. Healthwatch will be integral members of Healthwatch is an integral member of the ICB Board and ICP Board as well as sit on various Committees.
- A representative of the Voluntary and Community Sector will also be an integral member of the of the ICB Board, an associate member on the ICP Board as well as sit on various Committees.
- Public Health and Local Authority representatives sit alongside our involvement board representative at every ICB board formally. This is supported by their membership of the ICS communications and involvement steering groups, to which members from across the system are invited to participate as collaborative leaders, to share best practice and leverage assets and networks to broader advantage.
- Our provider and primary care colleagues are part of our extended team and therefore are integral to the development and delivery of our shared strategic priorities.
- We will engage with our Health Overview and Scrutiny Committee on potential service changes, enabling them to consider whether it is a substantial and significant service change requiring consultation process. We will work to assure them that healthcare is planned and delivered in ways that reflect needs and aspirations of local communities, plans for substantial service changes are reasonable and that everyone has equal access to services.

Seeing the impact of participation

It is essential that our extensive engagement work is meaningful and impactful and that the public can see that their involvement is making a real difference. Some examples of our engagement activities over the last year include:

- Engagement to shape the principles of Community Diagnostic Centres and inform the development of our second CDC site as well as setting up a co-production group to 'walk through' the pathway and patient experiences, developing an action plan of improvements
- Engagement and patient experience on the new Hip and Knee pathway in the Musculoskeletal service. Co-production is a key element to inform the new pathways and communications requirements
- Supported the Ockenden Review Engagement to help improve and shape the future of maternity services by asking service users, families and carers to share their views and experiences.
- Engagement on prevention of and education for the diabetes service.
- Engagement to shape our bereavement support service, working with Lincolnshire County Council to understand experiences of those who have lost someone close to them to suicide.
- The Maternity Voices Partnership has also been gathering experiences of maternity care during the COVID-19 pandemic.
- Working with the Acute Hospital Trust and Maternity Services to engage on Tobacco Dependency Services.
- Widespread public, staff and stakeholder engagement to develop the Living with Cancer Strategy.
- Initial engagement in partnership with Healthwatch Lincolnshire to start the development of our Joint Forward Plan Five-year Strategy with the public, staff and clinicians. Future engagement plans are being developed to ensure further feedback shapes the strategy, overseen by the Steering Group with patient representation.
- We have held Listening Clinics in some of our GP practices as well as undertaken engagement and consultations on various changes to primary care including extended access at PCN level.
- Continued to develop and increase our stakeholder database contacts and strengthened our groups and meetings such as Patient Council, Involvement Champions, Citizen's Panel and other community groups and networks.
- Continued to grow our social media presence as well as getting out and about in our local communities through a series of events and roadshows.
- Commenced ongoing engagement on General Experiences of Care, asking for anyone who has recently used NHS services to share their experience with us.

How we enable and support those who want to get involved

The ICB has a number of ways to encourage involvement and our teams embedded within the ICB and ICS are supported by a strong network of people and community groups who initiate and contribute to our work. Our **Involvement Champions** are advocates for the groups and communities they represent. They will work with us to test our plans and strategies, monitor progress and evaluate outcomes. They support our engagement with local people and communities by sharing messages and gathering feedback to create a two-way communication process between the ICB and their communities.

Our **Citizen Panel** aims to be reflective of people and communities in Lincolnshire, taking part in surveys about planning and improving local health and care services. **Patient Participation Groups** - (PPGs) are designed to give patients and practice staff the opportunity to meet and discuss issues and opportunities, supporting their wider practice population to get involved and increase understanding in their healthcare services.

PPG representatives come together as a Lincolnshire Patient Council where they feed the views of their practice patients into the ICB and are involved in programmes and projects.

NHS Provider Organisations support **Patient Panels** and **Patient Experts** to regularly influence and shape the work of the system service developments and many of our programmes are embedding **co-production** groups of those with lived experience to put the patient at the heart of our services.

All opportunities are promoted on our social media and website, as well as circulated in our Engagement Bulletin. The Bulletin was developed to reduce engagement fatigue and to focus information in one place which is then sent fortnightly to our stakeholder and patient group database. This has gone from strength to strength and is now widely distributed, has increased participation in ICB engagement and shares information and involvement opportunities from across our provider Trusts and other partner and community organisations.

Our engagement activities are supported by strong social media promotion and the development of the Nextdoor platform as a key vehicle to share our events and opportunities to get involved. In addition, we have produced specially designed leaflets and pull-up display banners with our email address and QR codes to provide further opportunities at all events we attend for people to sign up to get involved in Lincolnshire ICB.

On a local level we continue to build strong relationships with our community groups and support organisations to help us reach individuals and communities. We work closely with groups and venues providing warm spaces, foodbanks, and services to our communities, as well as individuals such as Islamic leaders and social prescribers to draw on their wealth of experience and links to people we might not otherwise be able to reach. Our work with local and countywide partners is explained in more detail in our additional Lincolnshire ICB's People and Communities Involvement report 2022-23.

SOCIAL MEDIA AND ENGAGING WITH THE LOCAL POPULATION

Digital engagement with our local communities

The ICB strongly supports the use of social media as a positive communication channel, to provide members of the public, partners and other stakeholders with information about what we do and the services we commission.

We use social media to provide opportunities for genuine, open, honest and transparent engagement with stakeholders; giving them a chance to participate and influence decision making. Social media is a fantastic opportunity for us to listen and have conversations with a wide and diverse range of people, especially with hard to reach groups. It not only allows us to make announcements, e.g. health news, service information, upcoming events, it allows people to respond to whatever we post and encourage two-way conversation and feedback to improve the ongoing development of our services and to inform, engage, educate and inspire our local communities.

One of our key communication tools, which is often a first port of call for the public, is the ICB website. We launched a new website on 1st July to ensure that people can easily access information about the ICB, our system partners and programmes, latest news, events, engagement opportunities and the services available to them.

Between the 1st July 2022 and 31st March 2023 we had 64,380 users/visitors and 244,397 page views.

The most popular entrance to our site was via our homepage and our most popular pages were those with information about our vaccination programme in Lincolnshire and our community walk-in vaccination sessions.

The ICB social media channels saw an increase in reach, engagement, and new followers in this period. The ICB gained more than 1,241+ followers on all our accounts combined.

By using organic and paid promotions, the ICB's channels have seen a significant increase in reach, impressions and engagements such as shares, likes, link clicks, and inbound messages and comments from followers and members of local communities.

Our most engaging social media posts are those that are people-centred, stories and spotlights on our amazing teams working together to improve Lincolnshire's health and wellbeing. As part of our ongoing social media strategy, we will work on more people-centred content and grow our audience with the help of key stakeholders and influencers.

We are now working as a system across our local NHS and starting to look at how we can work better together in Lincolnshire to inform, engage and grow our audiences as an ICS.

ICB and Armed Forces Family

To those who proudly protect our nation, who do so with honour, courage, and commitment, the Armed Forces Covenant is the nation's commitment to you.

It is a pledge that together we acknowledge and understand that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives. The 2021 census data shows that over 89,000 adults residing in Lincolnshire have previously served in HM Forces and in 2022 there were just over 6,600 serving personnel plus their families.

In December 2022 the ICB signed the Armed Forces Covenant.

The NHS Constitution establishes the principles and values of the NHS in England and commits to ensuring that those in the Armed Forces, reservists, veterans and their families are not disadvantaged in accessing health services. The Armed Forces Forward View sets out nine Commitments that the NHS makes to the Armed Forces Family:

1. Working in partnership to commission safe, high-quality care for serving personnel and their families
2. Supporting families, carers, children and young people in the Armed Forces community
3. Helping the transition from the Armed Forces to civilian life
4. Identifying and supporting Armed Forces veterans
5. Improving veterans' and their families' mental health
6. Supporting veterans in the criminal justice system
7. Identifying and addressing inequalities in access to healthcare
8. Using data and technology to improve services
9. Driving research and innovation in Armed Forces healthcare

On 8th November 2022 new Statutory Guidance was published: Armed Forces Covenant Duty Statutory Guidance - GOV.UK (www.gov.uk). This is a new legal obligation placed on certain local public organisations, to require them to pay due regard to the Covenant and its principles, focussing on the key areas of healthcare, education and housing, which provide the basis of successful lives. This covers the settings of NHS primary care, secondary care and local authority delivered healthcare services and refers to the following functions: provision of services; planning and funding; and co-operation between bodies and professionals.

There is a Lincolnshire Armed Forces Covenant Partnership Board and the ICB is represented by the Programme Director for Strategic Estates, Partnerships and Planning.

The ICB has applied to become a bronze member of the Defence Employer Recognition scheme and is working towards its silver membership which will ensure parity with the other NHS organisations in Lincolnshire. Defence Employer Recognition Scheme - GOV.UK (www.gov.uk)

32 of our practices are accredited with RCGP Veterans Friendly GP Practice scheme.

IMPROVING HEALTH, REDUCING HEALTH INEQUALITIES AND PREVENTION

Reducing Health Inequalities

The Lincolnshire Integrated Care Board (ICB) has a legal duty under Section 14Z35 of the Health and Care Act (2022) to reduce inequalities between persons with respect to their ability to access health services; and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. The Act also places duties on the ICB to:

- have regard to the wider effects of decisions on inequalities.
- promote integration requires consideration of securing integrated provision across health, health-related and social services where this would reduce inequalities in access to services or outcomes achieved.

To do this effectively, the ICB works with its partner organisations to reduce health inequalities and embeds this requirement into its commissioning strategies and policies. Lincolnshire is deeply engaged in addressing health inequalities, through the local authority, NHS trusts and wider sector partners already being represented on both the Integrated Care Board (ICB) Board and the Integrated Care Partnership (ICP), with inequalities prominently identified as one of the key challenges for the health and care system and the population.

We have a shared Joint Health and Wellbeing Strategy in place informed by Lincolnshire Joint Strategic Needs assessment (JSNA) and Global Burden of Disease.

Our ambition for the Better Lives Lincolnshire by 2030 is 'for the people of Lincolnshire to have the best possible start in life, and be supported to live, age and die well'.

Lincolnshire has a challenging combination of rurality, coastal and urban deprivation, an ageing population, and a low-wage economy; this combination defines the difficulty of the mission to improve its population health.

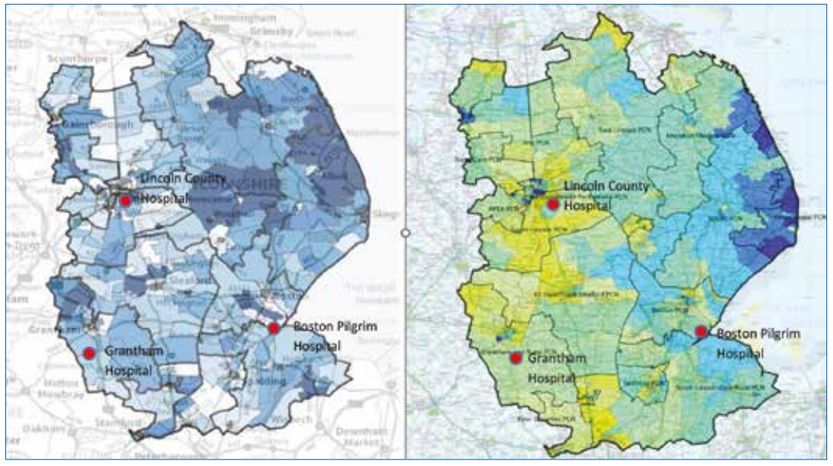
While most of our population enjoys good health and have better health outcomes compared with the rest of the country, we know that significant health inequalities exist and some of our residents are dying from illnesses such as circulatory diseases, cancer and respiratory diseases at a younger age than we would expect.

There is a stark 20-year difference in healthy life expectancy between the highest and lowest socio-economic deciles of the population – based on Index of Multiple Deprivation (IMD) quintiles.

- The Chief Medical Officer's annual report 2021: Health in Coastal Communities, elucidates these challenges and specifically references the east coast, for example, communities in Skegness and Mablethorpe. According to 'The Centre for Towns' measures these conurbations rank: 1st (Mablethorpe) & 4th (Skegness) in the 20 most deprived places in England and Wales (Combines economic and social isolation). Mablethorpe is fifth in the top 20 places for social isolation. It is already known that residents of such communities find access to healthcare problematic, face a declining bus network and experience poor broadband relative to the major cities/ urban areas.

The maps below show (left) the concentration of older adults in the Eastern parts of the county along with the large areas of socio-economic deprivation in the urban areas, in rural Eastern areas and along the coastal strip (right). This is a specific problem in Lincolnshire with two of its three major secondary care facilities (marked in red on the map) are located well away from the coast.

Our Health Inequalities (HI) Framework for action approach promotes primary and secondary preventative services and addresses the inequalities in access and uptake, alongside work led through the ICP which targets the wider determinants of health. Core20PLUS5 is embedded in our work.



Reducing health inequalities and improving health equity is everyone's business and will be a "golden thread" through all our work and at all levels from all partners. We need to think about health inequalities and shifting to equality of outcomes for all by connecting the dots between the wider determinants of health and the population's health outcomes e.g., impact of jobs or housing on people's health.

National

Nationally, the NHS England and NHS Improvement has outlined approach to support the reduction of health inequalities at both national and system level. Providing exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes. The approach described below – 'Core20PLUS5' defines a target population cohort and identifies '5' focus clinical areas for accelerated improvement. This approach has been embedded within our Health Inequalities and Prevention Programme.

Within Lincolnshire our Core 20Plus population are:

- The 20% most deprived communities as identified by the Index of Multiple Deprivation (IMD) – 120k patients, 15% of Lincolnshire population.
- Plus – People from a black, asian and ethnic minority communities (101k patients, 13% of Lincolnshire), with the largest ethnic minority group being "any other white background" (8.2%) - a significant proportion of this group is people from an Eastern European background.
- ICS locally determined population groups (evidence and insight based) experiencing poorer-than-average health access, experience, and/ or outcomes who may not be captured within the CORE20 alone and would be benefit from a tailored health care approach – key groups identified for Lincolnshire include travellers, people who are homeless, rural, and coastal communities, farming and military families.

The Five National Strategic Priorities for Health Inequalities Improvement are embedded with the Health Inequalities framework for action as defined below:

- **Priority 1: Restore NHS services inclusively**
  - o By understanding waiting lists, Did Not Attends (DNAs) and cancellations (all broken down by ethnicity and IMD quintiles)
- **Priority 2: Mitigate against digital exclusion**
  - o Ensuring providers offer face to face care to patients who cannot use remote services and assessment of the impact of digital consultation channels on patient access
- **Priority 3: Ensure datasets are completed and timely**
  - o By prioritising improved recording and collection of ethnicity data across all settings of clinical data
- **Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes**
  - o Through increased uptake of COVID and flu vaccinations, ongoing management of long-term conditions and Annual health checks for people with learning disabilities
- **Priority 5: Strengthen leadership and accountability**
  - o Systems and Providers should have a named executive for tackling health inequalities

The effectiveness of our response depends on a system approach, recognising the need for action by all partners across the whole range of factors that influence and determine inequalities. It will also depend on our ability to become increasingly sophisticated and systematic in the way that we use data and insight to build our understanding of our population's health and wellbeing needs – with a view to understanding how need varies between groups and at different levels of our system, as well as what groups and communities are impacted most by inequalities. With this in mind, we have in place a system-wide Health Inequalities and Prevention Programme Board between Lincolnshire's NHS and Local Authority with wider partners to reduce the avoidable inequity in people's health across the county.

Actions to address Health Inequalities

Vision:

- To increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county.

Approach:

- Tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire.

Ambition:

- A year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire.

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

- Implement the Core20PLUS5 programme and improve access, experience, and outcomes for our key vulnerable groups identified as being at risk of inequity in access and outcomes such as ethnic minority groups, those living in highest deprivation and ICS locally determined population groups
- Understand our local population and local health needs, through using the joint strategic needs assessments (JSNAs) and the collation of additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.
- We work in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we serve to improve health and healthcare for the local population.
- We seek the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, focus groups and Healthwatch.
- Enable co-production with people with lived experience to inform decision making.
- Improve health outcomes through embedding Population Health Management insights and intelligent evaluation

Working with partners to tackle Health Inequalities

We made good some progress on our approaches to addressing health inequalities, but recognise we have a great deal more work to do. We deepened our understanding of the current challenges and adopted more systematic ways to use data.

Insight from engagement with people and communities was a key influencer in the way we delivered the vaccination programme and supporting campaign. It also influenced many of the programmes and projects highlighted in this report.

Some examples from 2022/23 of projects and programmes aimed at reducing health inequalities are detailed in the section titled 'Key Achievements'.

Demonstrating due regard in decision making

This section explains how the ICB in 2022/23 discharged its duty under Section 14Z43 of the NHS Act 2006 (as amended) to have regard in decision making.

An Equality Impact Analysis (EIA) and Health Impact Assessment (HIA) is completed on all ICB commissioning decisions and policies to ensure access and inclusion for protected and marginalised groups and communities.

All service re-designs, business cases and project initiation documents (PIDs), new services and procurement exercises undergo a process of EIA. The use of Health Equity Assessment Template (HEAT) has been embedded within the Integrated Care System (ICS) planning processes, investment decisions and ICS governance arrangements in 2022/23.

Joint Strategic Needs Assessment

The Lincolnshire Health and Wellbeing Board is the forum where councillors, commissioners (ICB and Local Authority) and communities work together with other partners to improve the health and wellbeing of our local population and reduce health inequalities. Among its key responsibilities is the production of the local JSNA. The Joint Strategic Needs Assessment, or JSNA, provides a picture of current and future health and wellbeing needs of the local population, by collating a range of evidence in one place. It tells us about lifestyle behaviours, health conditions, the needs of vulnerable groups and the wider factors that impact on health and wellbeing, like transport, housing and employment. Information comes from a range of sources including national data sets, registrations of births and deaths, NHS and council services, and local surveys or consultation events.

This is achieved through action to address at three levels to have an influence on health outcomes:

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

The JSNA highlights who Lincolnshire's priority groups are in relation to health and social care need. The JSNA aims to establish a shared, evidence-based consensus on the key local priorities across health and social care.

The ICB and ICP are also required to take account of the JSNA in the planning of local health services and in the development of the Integrated Care Partnership Strategy. The JSNA has been used to inform the Lincolnshire interim ICP Strategy, which sets out the plans across four aims that set our strategic direction up to 2025.

These aims are:

- Have a focus on prevention and early intervention
- Tackle inequalities and equity of service provision to meet population needs
- Deliver transformational change in order to improve health and wellbeing
- Take collective action on health and wellbeing across a range of organisations

Better Lives Lincolnshire - ICP strategy January 2023

The Interim ICP Strategy shows the overall profile of the health and wellbeing of the Lincolnshire population, identifying those conditions that are causing the greatest ill health and mortality, for example, cardiovascular disease and musculoskeletal conditions. Deprivation and high disease prevalence, for example chronic respiratory disease and cardiovascular disease are recognised as key challenges affecting some of the ICB population as well as being one of the main risk factors.

In response to the NHS Long Term Plan, the ICB, along with system partners, set out plans last year to take a systematic population health approach to reducing health inequalities and addressing unwarranted variation in care.

Joint Local Health and Wellbeing Strategy (JHWS)

This section provides details on how the ICB in 2022/23 contributed to the delivery of the Lincolnshire Health and Wellbeing Strategy as required under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

For many years, the NHS and Local Authority have worked in close partnership with partners to tackle health inequalities. All organisations have an important role to play, whilst the ICB have a legal duty to respond to inequalities in the health of their populations, both in terms of access to services and outcomes on life expectancy. No one organisation can do this in isolation. The Health Inequalities programme will require involvement of all NHS organisations, Local Authority and wider partners to work together if we are to achieve real and lasting improvements for people living within Lincolnshire.

The JHWS for Lincolnshire aims to inform and influence decisions about the commissioning and delivery of health and care services in Lincolnshire so that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing.

The local authority Director of Public Health attends the ICB Board meetings and provide an update at each meeting. Through our work with them, and active engagement at the health and wellbeing boards, we have confirmed the ICB's contribution to the delivery of the joint health and wellbeing strategies.

EQUALITY, INCLUSION AND HUMAN RIGHTS (EHIR)

This section of the report highlights key areas of EIHR work achieved by LICB during April 2022 to March 2023 as part of the continuous implementation of the equality strategy objectives and the equality action plan 2020-23.

The information in the report demonstrates Lincolnshire Integrated Care Board (LICB) compliance to the Equality Act 2010, Public Sector Equality Duty (PSED) 2011 and how the ICB has, through the exercise of all its functions, given due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Three key examples of work that we focused on in 2022 include:

EIHR Training delivery

Delivery of the EIHR training programme for 2022-23 commenced in April 22 and the following courses were made available to all ICB staff:

o Equality Impact Assessment (EIA) Training

o Our Journey to Trans Inclusion

o EDI Refresher Training

o Tackling Bias and Discrimination in the Workplace

The programme was developed following the outcomes of a training needs analysis that was undertaken in 2021. The programme was the first of its kind for the ICB and all sessions were evaluated electronically by participants. A final evaluation report has been produced, which has shown good/excellent feedback from those who attended – some examples of what participants have said include:

'Enjoyed the interactive session, with the ability to work through the EIA form'

'Was very interactive and informative – thank you'

'I did find the training useful and recommend it to others'

The ICB has also enhanced support for staff through other methods: -

- Mandatory equality training for all staff.
- Systemwide Cultural Intelligence training for senior managers and leaders, provided by the Lincolnshire NHS Trusts.
- Providing information on professional development opportunities e.g., Mary Seacole leadership programme and Edward Jenner programmes.
- Health and wellbeing offers, including menopause and burn out/mental health workshops and resources through the employee assistance programme e.g. champion health app.

Equality Deliver System 2022 (EDS) pilot

The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England, in active conversations with patients, public, staff, staff networks, community groups and trade unions, to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.

There is an NHSE requirement for NHS Trusts and ICBs to pilot EDS and provide feedback of the process – a decision to focus on piloting domain two (Workforce health and well-being) was made by the ICB Equality Forum in October 2022 and as a result the following was achieved:

- Implementation plan was produced October 2022.
- Qualitative and quantitative evidence was collated for domain 2 during November/ December 22 and analysis took place January 2023.
- Peer review was undertaken with Staff Engagement Group (SEG) members February 2023.
- There was shared practice of EDS pilots with other ICS providers and other CSUs throughout the process.
- EDS report and action plan 2023-24 was produced with specific actions relating to EDS outcomes, which was taken to Senior Managers Operation Delivery Group (SMODG) for initial comments in February 2023 and then LICB executive committee for final approval on 23rd March 2023.
- Pilot report was published on the ICB website on 27 March 2023.

Systemwide Black Asian and Minority Ethnic (BAME) and Allies Staff Forum

Leadership commitment for the BAME and Allies forum has continued throughout 2022. Formation of the ICB in July 2022 and emphasis on collaborative working across the system required the forum to be a more prominent force to support partners to enable positive change for black, Asian and minority ethnic staff within the system. In view of this, backed by system leaders, the forum was relaunched in December 2022 in the form of two groups: -

- System network – This will continue as a support mechanism for black, Asian and minority ethnic staff and their allies, sharing experiences and ideas as well as networking opportunities.
- Leadership group - which will:
  - Have a Governance structure that feeds into People Board.
  - Have a reporting mechanism for regional workforce race equality data returns.
  - Be action driven in line with people plan priorities.
  - Be a training hub to improve progression for black, Asian and minority ethnic staff.
  - Be action driven in line with network ideas and experiences shared.

Work is being done to develop the terms of reference of both groups and the structure and actions of the leadership group so that both arms of this group can be fully functional from 2023 onwards. Much of this work has been linked to the systemwide Belonging strategy.

1. Other business as usual work activities during 2022 included:

- Submission of staff data for the Workforce Race Equality Standard (WRES), including development of WRES action plan 22-23
- Ongoing training and support to staff on conducting Equality Impact Assessments (EIA) to enable them to give due regard to equalities when assessing the impact of an activity, policy, or project either in its revision or developmental stage
- EIHR support in relation to procurement exercises
- Charter marks – LICB once again acquired Disability Confident – Employer Status in 2022 and has also achieved Mindful Employer and Carers Award
- Promoting the importance of Accessible Information Standard (AIS) to system provider organisations
- Ongoing monitoring of EIHR action plan outcomes through the LICB Equality Forum

For more information about our EIHR work please visit the equality webpage of the LICB Website: Commitment to Equality, Inclusion and Human Rights - Lincolnshire ICB

PRINCIPLES FOR REMEDY

The ICB continues to use the Principles for Remedy for NHS Complaints, as set out by the Parliamentary and Health Service Ombudsman (https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy).

This identifies good practice with regards to providing remedies for patients wishing to make a complaint and these are supported by the ICB:

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

The ICB has adopted all six principles of remedy in the development of our complaints handing procedure and they form a core part of the ICB's Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments.

The policy clearly sets out the organisation's process for handling complaints in order for the ICB to meet statutory requirements and how the ICB takes responsibility, acknowledges failures, provides an apology, and uses the learning from any complaint investigation to improve their services.

COMPLIMENTS, CONCERNS AND COMPLAINTS

Valuing Patient Experience

The ICB values the opportunity to hear what people think about the services we commission, and we use feedback to support decisions about services. We analyse complaints and monitor the themes and trends to promote learning. This information is reviewed in conjunction with other quality metrics to drive quality improvement and is used to further support the schedule of quality assurance visits which improves patient experience and patient outcomes.

Breakdown of Formal Complaints	
Quarter 2	19
Quarter 3	4
Quarter 4	18
Total	41

During July 2022 to March 2023, we received 243 informal concerns and 41 formal complaints, both directly from patients or their family, the public, and from Members of Parliament on behalf of their constituents.

The ICB views compliments, concerns, and complaints as a valuable source of information and we use this as part of our ongoing monitoring for services we commission.

We ensure that we acknowledge all feedback received, making sure that any concern or complaint response is dealt with compassionately, effectively and in a timely manner.

To prevent informal concerns escalating to formal complaints, we endeavour to resolve concerns by either providing the information needed or signposting the complainant to the appropriate department or organisation to enable direct contact and response.

Our responses to concerns and complaints are administered in line with the Local Authority Social Services and National Health Service (England) Regulations 2009.

By the end of the reporting period 1st July 2022 to 31st March 2023, of these 41 formal complaints, four were upheld, 18 were partially upheld, 12 were not upheld, two were closed as not pursued, which leaves a total of five being carried forward.

FREEDOM OF INFORMATION

The Freedom of Information Act 2000 (FOI) gives people a general right to access information held by or on behalf of public authorities. It is intended to promote a culture of openness and accountability among public sector bodies and to facilitate a better public understanding of how they carry out their duties, why they make the decisions they do and how they spend public money. Exemptions deal with instances where a public authority may withhold information under the FOI Act or Environmental Information Regulations.

Exemptions apply where releasing the information would not be in the public interest, for example, where it would affect law enforcement or harm commercial interests. Requests are handled in accordance with the terms of the FOI Act and in line with best practice guidelines from the Information Commissioner's Office and the Ministry of Justice.

In line with the requirements of the FOI Act, the ICB has a comprehensive Publication Scheme to make information about the ICB readily available to the public without the need for specific written requests. However, from the 1st July 2022 the ICB processed 179* requests covering the following work streams: Commissioning, Continuing Healthcare, Finance, Workforce, Medicines Management, Mental Health,

FINANCIAL SUMMARY

The annual accounts of the ICB have been prepared in accordance with the National Health Service Act 2006 (as amended) Directions by the NHS Commissioning Board, in respect of Integrated Care Boards' annual accounts. The accounts have been prepared on a 'going concern' basis to show the long-term commitment to healthcare services. This is described at note 1.1 to the accounts. The annual accounts are detailed in full from page 103 in this report.

The level of accuracy used in financial reporting for the ICB is informed by the materiality concept. A transaction can be considered to be material by the impact it has on the financial duties of the ICB, but also the reputational and legal implications for the ICB and its internal and external stakeholders. Where judgements and estimates have been made in the preparation of the financial statements, the concept of materiality has been used. However, it should be noted that the concept of materiality has not been applied to disclosures required by law and accounting guidance - precise figures have been used for these disclosures.

ICBs are set a Revenue Resource Limit (RRL) by NHS England that represents the maximum that can be spent in the year. This is used to inform the financial plan for the year. The ICB agreed a plan with NHS England to deliver a £3.75m under-spend against its in-year RRL. The actual outcome for the year was an £11.6m deficit at 31st March 2023, which equates to £15.3m adverse variance against the plan and 100.94% of the RRL.

The ICB therefore failed to meet its financial breakeven duty in 2022/23.

The total 2022/23 financial plan was for a £3.25m deficit when taking account of the £7.0m planned deficit relating to the former NHS Lincolnshire Clinical Commissioning Group for the period 1st April 2022 to 30th June 2022. Actual financial performance for the former NHS Lincolnshire Clinical Commissioning Group (CCG) for the period 1st April 2022 to 30th June was break-even therefore delivering a £7.0m favourable variance against plan.

Therefore for the period 1st April 2022 to 31st March 2023 the variance against the planned deficit of £3.25m for the former CCG and ICB combined was £8.3m adverse.

The wider Lincolnshire NHS system (including the ICB and NHS providers) made a deficit against allocation and income for the full year in 2022-23 of £16.8m.

The financial outlook for 2023-24 is challenging, and a recovery support programme is in place for the Lincolnshire system.

The ICB's plan for 2022/23 did not contain any planned capital resource use. The ICB had a capital allocation for Primary Care Services GP IT goods. Spend against this allocation is not recorded in the books of the ICB as all costs are reimbursed by NHS England and all assets are recorded in NHS England's accounts in line with their capital plan.

Summary Headline Financial Information

NHS Lincolnshire ICB's delivery of its financial targets for 2022/23 as follows:

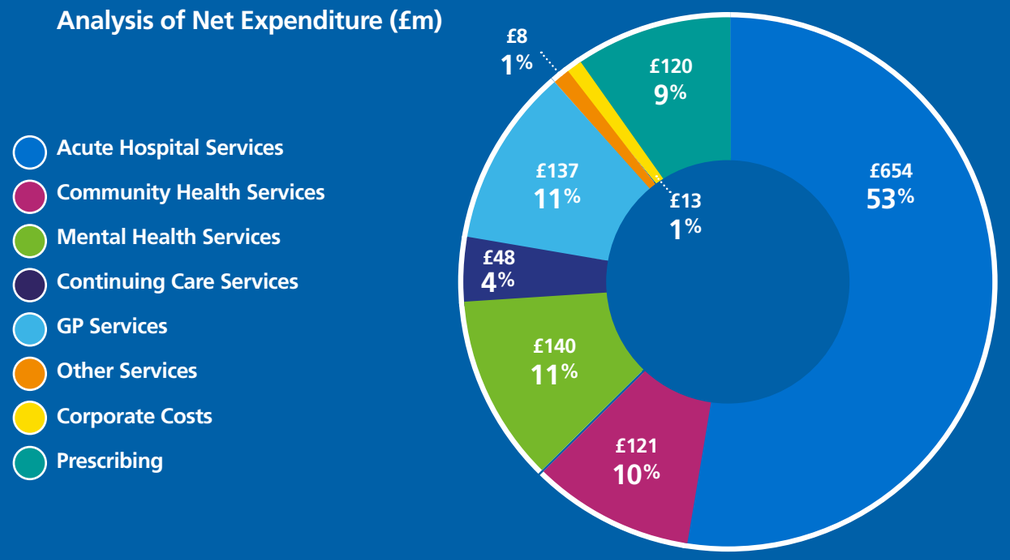
	CCG For the period 1 April 2022 to 30 June 2022 £m	ICB For the period 1 July 2022 to 31 March 2023 £m	Total Commissioner Full Year for the period 1 April 2022 to 31 March 2023 £m	Lincolnshire Provider Full Year for the period 1 April 2022 to 31 March 2023 £m	Total Lincolnshire Integrated Care Services Full Year for the period 1 April 2022 to 31 March 2023 £m
Revenue Resource Limit	£376.0	£1,229.7	£1,605.7	£1,055.2	£2,660.9
Net Operation Expenditure	£376.0	£1,241.2	£1,617.2	£1,060.4	£2,677.7
Suplus/(Deficit)	£0.0	-£11.6	-£11.6	-£5.3	-£16.8

The ICB managed its administration functions within the allocated Running Costs Allowance of £12.9 million.

Cash payments were also managed within the Maximum Cash Drawdown limit as allocated by NHS England.

The ICB is an approved signatory to the Prompt Payment Code. This initiative was devised by the Government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses.

Analysis of Net Expenditure (£m)



Mental Health

The Mental Health Investment Standard (MHIS), set by NHS England, requires all ICBs in England to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year.

In Lincolnshire, we are committed to improving the mental health and wellbeing of our local people. The Lincolnshire system has invested in improving mental health and learning disabilities facilities and services for several years which has resulted in some areas of expenditure reducing due to more efficient and effective services now being delivered in a more appropriate care setting. Including the quarter 1 contributions of the former CCG, for 2022/23 NHS Lincolnshire spent £134.4m equating to 10.9% of its programme allocation on Mental Health Services in 2022/23 which represented a 1.74% growth in expenditure on mental health services spend in Lincolnshire in 2021/22. The shortfall against the target was 5.09%.

Mental Health Spend (£m)	£134.4
ICB Programme Allocation (£m)	£1,228.7
Mental Health Spend as a proportion of ICB / CCG Programme Allocation	10.9%

Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute. Approved signatories undertake to:

- pay suppliers on time;
- give clear guidance to suppliers and resolve disputes as quickly as possible; and,
- encourage suppliers and customers to sign up to the code.

In the NHS, performance is measured by the Better Payment Practice Code which requires the ICB to pay at least 95% of valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The ICB is fully compliant with the code, with around 99% of non-NHS invoices paid within 30 days. Full details are given in Note 6 to the accounts.

The operating expenditure of the ICB can be split into two types:

- Programme – this is expenditure on the purchase of healthcare. The ICB overspent against its programme allocation. It spent 99.9% of its total resources on programme expenditure.
- Administration – costs that are not for the purchase of healthcare, but relate to the direct running costs of the ICB. The ICB underspent on its Running Costs allocation. The ICB spent 1.0% of its total resources on administration expenditure.

Mr John Turner
Chief Executive
(Accountable Officer)
28th July 2023

THE ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

The Members' Report has been prepared by the Board of the ICB.

The Board is responsible for ensuring the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the ICB's principles of good governance.

The ICB Board consists of the ICB Interim Chair, the Chief Executive, Director of Finance, Director of Nursing, Medical Director, five Non-Executive Directors, three partner members representing NHS and Foundation Trusts, Local Authority and Primary Medical Services, senior managerial support and representatives from Public Health, Healthwatch, Health and Wellbeing Board and Voluntary Sector.

Sir Andrew Cash was the Interim ICB Chair for the reporting period 1st July 2022 to 31st March 2023. Mr John Turner has been the Chief Executive (Accountable Officer) for the reporting period 1st July 2022 to 31st March 2023.

The composition of the Board and the Audit and Risk Committee through the year and up to the signing of the Annual Report and Accounts (including advisory and Non-Executive Directors) is outlined in this section. Details of members of other committees and sub-committees are set out in the Annual Governance Statement (AGS).

Board Members

Name	Role
Dr Dave Baker	Interim Partner Member, Primary Medical Services
Cllr Wendy Bowkett	Partner Member, Local Authority
Sir Andrew Cash	Interim ICB Chair
Mrs Sarah Connery	Executive Board Mental Health Member
Mr Matt Gaunt	Director of Finance
Mrs Maz Fosh	Partner Member, NHS & Foundation Trusts
Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee
Mr Martin Fahy	Director of Nursing
Dr Sunil Hindocha	Interim Medical Director
Dr Gerry McSorley	Non-Executive Member and Chair of the Primary Care and Delegated Functions Committee and Remuneration Committee and Deputy ICB Chair
Mr Pete Moore	Non-Executive Member, Chair of Audit and Risk Committee (up to 31st January 2023)
Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
Mrs Margaret Pratt	Non-Executive Director and Interim Chair of the Audit and Risk Committee (from 21st October 2022)
Mr John Turner	Chief Executive
Professor Sir Jonathan Van-Tam	Non-Executive Member and Chair of Quality and Patient Experience Committee

Name	Role
Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
Mr Simon Evans	System Director of Clinical Integration and Leadership Development
Mrs Sarah Fletcher	Healthwatch Representative
Mrs Michele Jolly	Voluntary and Care Sector Representative
Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
Mrs Clair Raybould	Director for System Delivery
Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
Professor Derek Ward	Public Health Representative
Cllr Sue Woolley	Chair of the Health and Wellbeing Board

Board Committees

In order to discharge its duties effectively, the Board has a number of formally constituted Committees as set out in the ICB Constitution and Corporate Governance Handbook, which includes the Scheme of Reservation and Delegation.

The ICB Board has two statutory Committees. They ensure the ICB is compliant with statutory responsibilities and functions.

- Audit and Risk Committee
- Remuneration Committee

The ICB has also established a further Committee to enable the members to make collective decisions on the review, planning commissioning and procurement of Primary Medical Services (PMS) within the ICS area under delegated authority from NHS England to ICBs.

- Primary Care Commissioning and Delegated Functions Committee

All three of these Committees are Chaired by an ICB Non-Executive Director.

The Board has also established three other Committees to assist it with the discharge of its functions. These Committees are set out below:

- Service Delivery and Performance (ICB Joint Committee)
- Quality (ICB Joint Committee)
- Finance (ICB Joint Committee)

These Committees are ICB Joint Committees with the three provider partner organisations in Lincolnshire. They are Chaired by an ICB Non-Executive Director and include Non-Executive Director representation from each of the three provider partner organisations – Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust.

At the Board's first meeting held on the 1st July 2022 a paper was presented on the ICB Board Committees and the membership for the six ICB Board Committees which was discussed and agreed as detailed below:

Committees and NEMs	Gerry McSorley (GM)	Dawn Kenson (DK)	Jonathan Van-Tam (JVT)	Julie Pomeroy (JP)	Pete Moore (PM)/ Margaret Pratt (MP)
Audit and Risk		X		X	X (Chair)
Remuneration	X (Chair)	X	X	X	X
Primary Care Commissioning and Delegated Functions Committee	X (Chair)		X	X	
Service Delivery and Performance		X (Chair)			
Quality and Patient Experience			X (Chair)		
Finance and Resource Committee				X (Chair)	

The membership was amended during 2022 to reflect temporary changes to the Chair of the Audit and Risk Committee to reflect necessary cover arrangements for Mr Pete Moore, Non-Executive Director who was on long term sick leave from April 2022 through to January 2023.

Audit and Risk Committee – Acting Chair, Mrs Julie Pomeroy (Non-Executive Director) from 1st July 2022 through to 20th October 2022), Acting Chair, Mrs Margaret Pratt (Non-Executive Director) from 21st October 2022)

The Audit and Risk Committee is chaired by the Non-Executive Director with lead responsibility for governance. The Committee has met four times during the period 1st July 2022 to 31st March 2023 and has had 93% attendance from Non-Executive Directors. All meetings were quorate.

The Audit and Risk Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across all activities that support the ICB in achieving its objectives.

A key purpose of the Audit and Risk Committee is to monitor the integrity of the ICB's financial statements and assure itself that relevant risks, particularly financial, are appropriately identified and managed within a robust system of internal control. The Audit and Risk Committee is also responsible for seeking appropriate assurance on arrangements for counter-fraud and audit work programmes.

The Audit and Risk Committee has been attended by, and updates have been received from, the ICB's Internal and External auditors as well as its Counter Fraud Service at each meeting along with updates on Information Governance. The Audit and Risk Committee has also received regular updates on the development of risk management systems for the ICB including the development and establishment of the Board Assurance Framework in line with the ICB Strategic Risks.

During the period 1st July 2022 to the 31st March 2023 the Committee has regularly provided reports to the ICB Board and has produced its Annual Report covering the period 1st July 2022 through to 31st March 2023 and a Self-Assessment of its performance. These documents were presented to the ICB Board at its meeting held on the 30th May 2023.

The membership of the Audit and Risk Committee for the period 1st July 2022 to 31st March 2023 comprised:

Name	Role
Mr Pete Moore	Non-Executive Director – Chair of the Audit and Risk Committee (unavailable from the 1st July 2022 and left the ICB on the 31st January 2023)
Mrs Julie Pomeroy	Non-Executive Director – Acting Chair of the Audit and Risk Committee from the 1st July 2022 through to 20th October 2022)
Mrs Margaret Pratt	Non-Executive Director – Acting Chair of the Audit and Risk Committee from the 21st October 2022 through to 31st March 2023
Mrs Dawn Kenson	Non-Executive Director

The following people are also in attendance:

Mr Matt Gaunt, Director of Finance and Contracting

Mrs Julie Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance

Internal Audit representatives, PwC

Ernst and Young, External Audit representatives

Local Counter Fraud Specialist, PricewaterhouseCoopers (PwC)

Remuneration Committee – Chair, Dr Gerry McSorley

All ICBs were required to hold a Remuneration Panel meeting on the 1st July 2022 to confirm the pay for the ICB Non-Executive Members. This took place as required and the meeting of the Panel was immediately followed by the first formal Remuneration Committee meeting.

The Remuneration Committee met as required throughout the year and is chaired by one of the ICB Non-Executive Directors.

The Committee's main role is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B of the NHS Act 2006, which in summary is to:

- Confirm the ICB Pay Policy including adoptions of any pay frameworks for all employees including senior managers/directors (including Board Members) and Non-Executive Directors.

The Remuneration Committee has produced its Annual Report covering the period 1st July 2022 through to 31ST March 2023 and a Self-Assessment of its performance. These documents were presented to the ICB Board at its private meeting held on the 30th May 2023).

Further information on the membership and attendance by the Non-Executive Directors of the Remuneration Committee is detailed on page 90.

Primary Care Commissioning and Delegated Functions Committee – Chair, Dr Gerry McSorley

The Primary Care Commissioning Committee (PCCC) is Chaired by one of the ICB Non-Executive Directors. The Committee was established to enable the members to make collective decisions on the review, planning, commissioning and procurement of primary medical services within the ICS area under delegated authority from NHS England.

The Committee has met three times in public during the period 1st July 2022 to 31st March 2023 and has had 50% attendance from the Non-Executive Directors. All meetings were quorate.

The Primary Care Commissioning Committee has also held three Development Sessions during the period 1st July 2022 to 31st March 2023 which has covered the following topics:

- November 2022 - Primary Care Network Maturity
- January 2023 - Informal Review of the Committee to date
- March 2023 - Role of the Committee going forward following delegation of commissioning and oversight of POD activity.

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

During the period 1st July 2022 to the 31st March 2023 the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

Finance and Resource Committee – Chair, Mrs Julie Pomeroy

The Finance and Performance Committee is Chaired by one of the ICB Non-Executive Directors. The Committee has met eight times during the period 1st July 2022 to 31st March 2023 and has had 75% attendance from Non-Executive Directors. The meeting was quorate.

The Committee was established to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- Financial performance of the ICB;
- Financial performance of NHS organisations within the ICB footprint.

During the period 1st July 2022 to the 31st March 2023 the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

Quality and Patient Experience Committee – Chair, Professor Sir Jonathan Van-Tam

The Quality and Patient Experience Committee (QPEC) was chaired by one of the ICB Non-Executive Directors.

The Committee has met two times during the period 1st July 2022 to 31st March 2023 and has had 75% attendance from Non-Executive Directors. All meetings were quorate.

The Quality and Patient Experience Committee was established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Social Care Act 2022. This includes the inequalities in the quality of care.

During the period 1st July 2022 to the 31st March 2023, the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

Service Delivery and Performance Committee – Chair, Mrs Dawn Kenson

The Service Delivery and Performance Committee (SD&P) was chaired by one of the Non-Executive Directors.

The Committee has met seven times during the period 1st July 2022 to 31st March 2022 and has had 88% attendance from Non-Executive Directors. All meetings were quorate.

The Committee was established to provide leadership and direction in supporting the Lincolnshire NHS system to drive forward the delivery of the agreed strategic priorities, monitor the impact of their delivery and provide oversight to the systems approach to planning. The key focus of the Committee is on progress and delivery of the Lincolnshire NHS System Strategic priorities and operational plan'; this being a subset of the broader Integrated Care Strategy.

During the period 1st July 2022 to the 31st March 2023 the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

As referred to in the Annual Governance Statement, after each Board Committee meeting an assurance report is prepared and presented to the Board for consideration. This includes a summary of items discussed and any areas for escalation. The presentation of these reports ensures the Board receive timely information rather than waiting for the presentation of full minutes.

Conflicts of Interest

The ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure and be able to evidence that these decisions secure the best possible services for the population it serves, the ICB must demonstrate accountability to relevant stakeholders, particularly the public, and probity and transparency in the decision-making process.

Register of Interests

As required by section 14Z30 of the NHS 2006 Act, the ICB has made arrangements to manage any actual or potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

The ICB has established a Standards of Business Conduct and Conflicts of Interest Policy, which was approved by the ICB Board at its first meeting held on the 1st July 2022. This policy sets out clear procedures to deal with situations where an officer/member has a conflict of interest and is included in the ICB Governance Handbook available here: www.lincolnshire.icb.nhs.uk

In accordance with section 14Z30(2) of the NHS Act 2006 registers of interest are recorded in the ICB Registers of Interests which is published on the ICB website and is shared and considered by the ICB Audit and Risk Committee at each meeting.

One of the requirements of the statutory requirements for an ICB is to identify a Conflicts of Interest Guardian. At the ICB's first Board meeting held on the 1st July 2022 the ICB's Conflict of Interest Guardian was confirmed as Mrs Julie Pomeroy, Non-Executive Director.

The Conflicts of Interest Guardian is responsible for:

being a safe point of contact for employees or workers of the ICB to raise any concerns in relation to the policy.

acting as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns regarding conflicts of interest.

providing support, independent advice and judgment on non-publication of conflicts and minimising risks.

providing advice on minimising the risk of conflicts of interest.

Personal data related incidents

There have been no serious incidents in 2022/23 relating to loss of personal data. Further details of the ICB's Information Governance arrangements can be found within the Annual Governance Statement.

Modern Slavery Act

NHS Lincolnshire ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Mr John Turner
Chief Executive
(Accountable Officer)
28th July 2023

STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Lincolnshire Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed Mr John Turner to be the Accountable Officer of NHS Lincolnshire Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Lincolnshire Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Ernst and Young auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Mr John Turner
Chief Executive
(Accountable Officer)
28th July 2023

ANNUAL GOVERNANCE STATEMENT
1st July 2022 to 31st March 2023

Lincolnshire ICB - QJM

Introduction and context

NHS Lincolnshire Integrated Care Board is a body corporate established by NHS England on 1st July 2022 under the National Health Service Act 2006 (as amended).

The Integrated Care Board's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

Between the 1st July 2022 and 31st March 2023, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Lincolnshire Integrated Care Board's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Lincolnshire Integrated Care Board's Accountable Officer Appointment Letter.

I am responsible for ensuring that the Lincolnshire Integrated Care Board is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Integrated Care Board as set out in this governance statement.

Governance arrangements and Effectiveness

The principal function of the Integrated Care Board is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The governance framework of the Integrated Care Board is detailed in the ICB's Constitution and Corporate Governance Handbook.

The Constitution sets out the details of the ICB Board Membership and also reflects the mission, values, function and duties of the ICB and refers to the key governance documents that the ICB has produced – Standing Orders, Functions and Decisions Map, Standing Financial Instructions, Scheme of Reservation and Delegation including Delegated Financial Authority Limits, Financial Authority Limits and Corporate Governance Handbook. Work is also underway to develop further key governance documents, such as the Board Assurance Framework (further details are set out on pages 81 and 82).

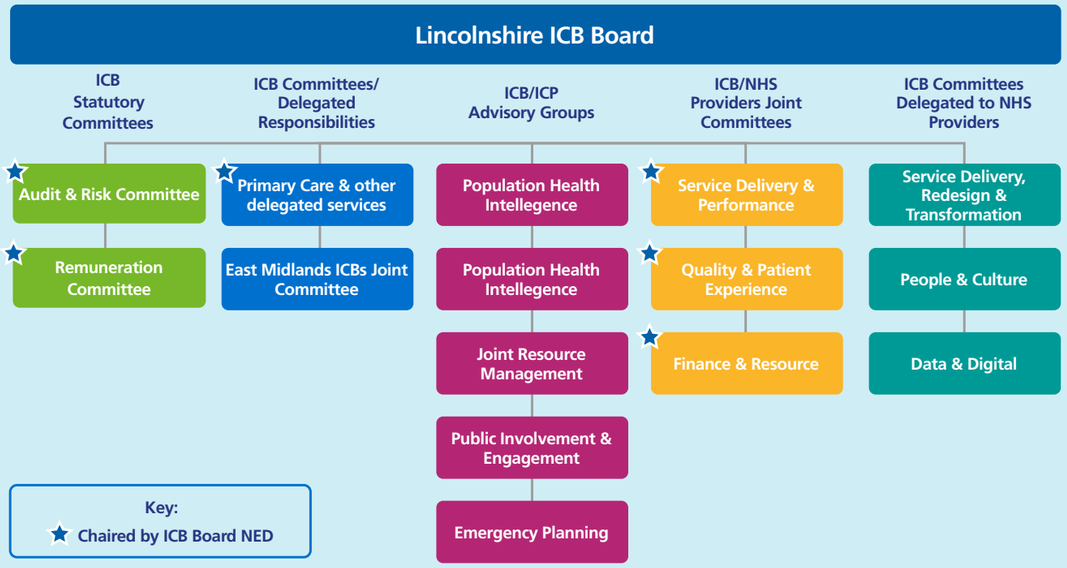
The ICB Constitution and other key governance documents were produced in line with NHSE national templates provided to support the establishment of ICB's and utilising examples of best practice adopted by partner organisations.

The Corporate Governance Handbook brings together all the ICB's governance documents including those documents referred to above along with Terms of Reference for all the ICB Board Committees, Delegation Arrangements for all instances where ICB functions are delegated and where ICB functions are delegated and list of all eligible providers of Primary Medical Services. The ICB Governance Structure is supported by the ICB Functions and Decisions Map which is a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decisions Map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

The ICB Governance Structure and ICB Function Map are detailed below and on the following page.

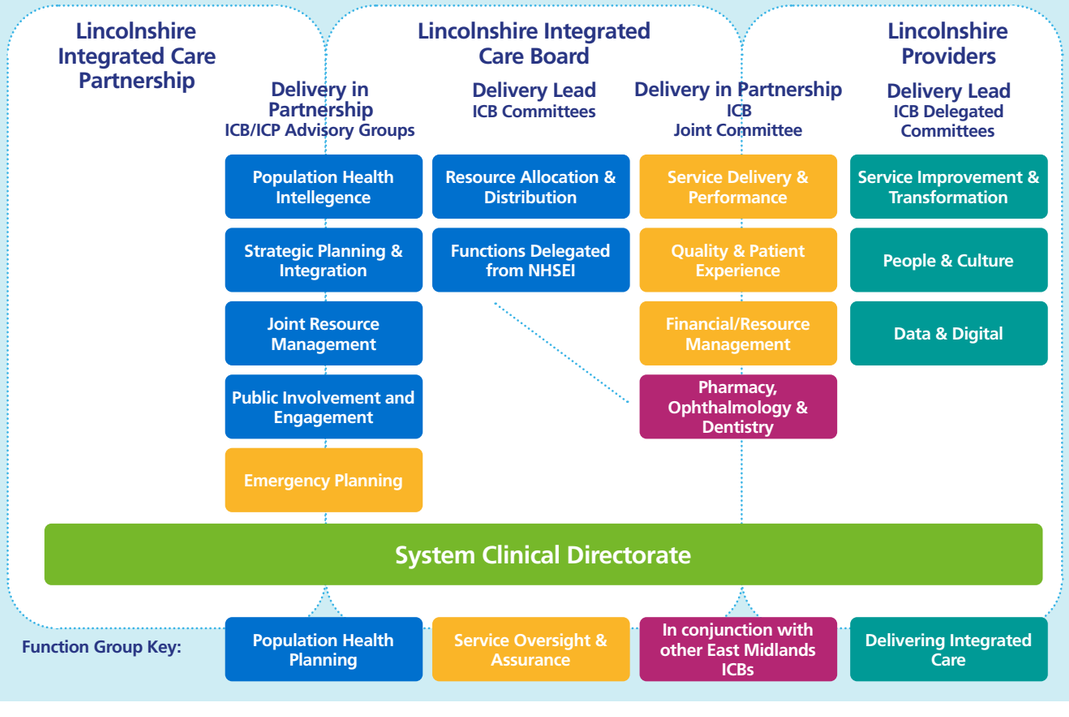
ICB Governance Structure

The diagram below highlights how ICB Board Members and Participans/Observers link to the wider system governance.



ICB Function Map

Taking the functions groupings described earlier and applying the principles for how the Lincolnshire ICBs functions should be delivered, a high level function map has been produced:



The ICB's Committee structure supports the ICB's governance processes and ensures that there is effective monitoring and accountability arrangements for the systems of internal control. The Terms of Reference for these Committees have been reviewed during the year to ensure robust governance and assurance arrangements are in place and are appropriate for the requirements of Lincolnshire ICB.

Board – Chaired by Sir Andrew Cash, Interim ICB Chair

In line with requirements, on the 1st July 2022, the ICB held its first Board meeting to approve key governance documents. This Board meeting was preceded by an Establishment Committee to confirm the appointment of the ICB Chief Executive and then in turn approve the appointment of the Non-Executive and Executive Directors, Partner Members and Executive Member for Mental Health. This was actioned as required and in line with the ICB Constitution (section 3.15.4).

The Board has met six times in public with meetings held on a bi-monthly basis. The public meetings have been held as both on a face to face basis and through 'Live Events' through Microsoft Teams. The Board had 92% attendance from all Members. All meetings between July 2022 to March 2023 were quorate.

The role of the ICB is to allocate the NHS budget and commission services for the population, taking over the functions previously held by Clinical Commissioning Groups (CCGs) and some of the direct commissioning functions of NHS England. The ICB is directly accountable to NHS England for NHS spend and performance within the system.

The ICB is directly accountable to NHS England for NHS spend and performance within the system. Its role is therefore both strategic (and in the case of primary care commissioning) the oversight of the operational management of direct provision.

The Board exists to:

- Ensure good governance.
- Monitor quality, safety, risk and progress.
- Ensure safeguarding compliance.
- Manage conflict of interest issues according to guidance and
- Monitor statutory duties.

The Board receives monthly updates on quality, finance, risk and performance through its formal meetings and Development Sessions. Updates are provided by Executive Directors as required and there is good attendance at the Lincolnshire system-wide Non-Executive Director Forum.

The Board has performed effectively throughout the period 1st July 2022 to 31st March 2023 in ensuring good governance around the ICB's decision making processes and in setting up a robust Committee structure to manage areas of risk and priority for the ICB. In making this statement, my sources of evidence and assurance are demonstrated through having the right skill mix and experience of Board Members with clearly defined roles and responsibilities (both as individuals and as a unitary Board), and careful forward planning of Board business with the agendas aligned to the four core purposes of the ICB. The agendas also include timings for the presentation of each item which ensures the meetings finish on time, whilst ensuring sufficient consideration and challenge is given to the papers presented. The ICB Executive Team who produce the majority of Board papers have carried out a review in 2023 to ensure their paper are short, effective and include all key information and facts and any actions required are clearly identified. This ensures effective decision-making in the meetings.

The membership of the Board is detailed under the Corporate Governance Report on page 51.

Board Performance and Development

The ICB Board is committed to reviewing and ensuring that it is as effective as it can be. The Board engaged IMPOWER, a specialist consultancy to support the ICB Board in its development and priorities, to support the ICB Board in its development and priorities.

The Board held its first Board Development Session on the 23rd August 2022 to:

1. Understand the Lincolnshire context and discuss an emerging vision for the Lincolnshire Integrated Care System.
2. Understand how this correlates to where we want to be by March 2023, 2025, and 2030.
3. Understand and agree the role and purpose of the ICB, including the focus of activities required now and the relationship with the Lincolnshire ICP and the Lincolnshire Provider Collaborative.
4. Plan and agree ways of working as a Board and across the ICS, including to evaluate and agree the Board Development requirements for the operational year.

The Board also discussed and agreed the structure of the formal Board meeting agendas going forward, which were subsequently revised to reflect the four core ICS purposes. The Board held a further Development Session on the 1st November 2022 to consider a summary of discussions from the ICB Board Development Session that took place on 23rd August 2022. The output from these discussions have been refined at future sessions and have informed the development of amongst other things the Board Assurance Framework and the draft Interim Care Partnership Strategy.

The Board agreed the next steps for ICB establishment from that point until March 2023 which in turn provided a basis for the completion of the ICB strategy for the system. Further information on the development of Lincolnshire's Interim Integrated Care Strategy is detailed in the Chair and Chief Executive Foreword on pages six to nine. I have taken assurance from these developments and the good governance that the processes demonstrate.

The Board has held further Development Sessions in November, December and February 2023 and considered a number of topics to provide assurance about the developing governance arrangements of the ICB.

Annual Assessment of Integrated Care Boards

NHS England has a statutory duty to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year and publish a summary of these assessments. The ICB Annual Assessment will consider whether the ICB has met the 8 statutory requirements across 5 domains, using several Key Lines of Enquiry (KLOEs).

NHS England wrote to all ICBs in April 2023 setting out the requirements of the 2022/23 ICB Annual Assessment, which the ICB was expected to respond to by Friday, 5th May 2023. This was completed. NHS England will publish a summary of the outcomes of all ICB performance assessments as part of its 2022/23 Annual Report and Accounts.

Board Committees

Information on the Board Committees, including their key responsibilities, membership, attendance records and highlights of their work during the period 1st July 2022 to 31st March 2023 is detailed in the Members' report. All Board Committees have benefitted from the active engagement and involvement of Board Members from partner organisations within the ICS.

All Board Committees at the end of each meeting are asked to review how effective the meeting was and to decide whether anything should be escalated to the Board. The Board then receives an assurance report following each Committee meeting, presented by the respective Non-Executive Director Chairs. This report details items of particular note, areas of risk and points of escalation for consideration.

Board Committees Review

In early 2023 a review of the Board and Committee structures via the ICB was encouraged to assess:

1. Opportunities to improve Committee working, e.g are the Terms of Reference correct, is the membership correct, what suggestions there are for improvements etc.
2. How the other Committees work and interact.

This review will be completed in the Autumn 2023.

UK Corporate Governance Code

Whilst NHS Bodies are not required to comply with the UK Code of Corporate Governance, for the period 1st July 2022 to 31st March 2023, the ICB has applied the principles of the UK Code of Corporate Governance as considered relevant to the ICB including drawing on other best practice available. As Chief Executive I believe this is important context for my assessment of the governance of the ICB.

The Annual Governance Statement demonstrates how the ICB has regard to the principles set out in the Code.

Discharge of Statutory Functions

The NHS Lincolnshire Integrated Care Board has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I confirm that the Integrated Care Board is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the Integrated Care Board's statutory duties.

Risk management arrangements and effectiveness

The development of the ICB's integrated risk management system has been on-going since its inception in July 2022.

The Risk Management system includes: Risk Management Framework, Strategy and Policy, newly formatted Board Assurance Framework and revised Corporate Risk Register. It enables the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the ICB objectives.

This Framework establishes a structure for the effective and systematic management of strategic and operational risks (as per the diagram on the next page). It enables the ICB to have a clear view of the risks affecting each area of their activity, how those risks are managed, the likelihood of occurrence and their potential impact on the successful achievement of the corporate objectives.

The policy is in line with and has adopted the following principles of risk management as set out in guidance provided by ISO 31000: 2018 standard.

The Risk Management Framework, Strategy and Policy applies to all employees of the ICB, the Board Executive Team and all senior managers to ensure that risk management is a fundamental part of the ICB's approach to the governance of the organisation and all its activities.

Following a Board workshop held in November 2022 on Strategic Risk Management, seven strategic risks were agreed. These were considered by the ICB Executive Team in February 2023 when the risks was reviewed, revised and reduced to six. An Executive Lead was agreed for each of these and through which Committee they will be managed.

The six strategic risks and associated Executive leads are listed below:

Risk 1: The ICB is unable to improve the quality of services to increase population health and well-being and consequently healthy life expectancy does not improve for Lincolnshire residents – **Director of Health Inequalities, Prevention and Regional Collaboration**

Risk 2: The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county – **Director of Strategic Planning, Integration and Partnerships**

Risk 3: The ICB is unable to create and implement a workforce strategy, so services continu to operate unsustainably with significant fragility in day to day operation – **Director of Nursing**

Risk 4: The ICB is unable to devise and implement a sustainable service improvement and financial recovery plan to remove unwarranted variation and consequently continues to operate without full autonomy – **Director of Finance**

Risk 5: The ICB fails to exit the RSP and segment four of the NHS Oversight Framework within the agreed timeframe (I recognise this may not absolutely be the right wording) – **Director Finance**

Risk 6: The ICB fails to deliver against key performance targets/indicators as identified in the operational planning guidance – **Director of System Delivery**

The new format for the BAF has been populated with the six strategic objectives. Work is being undertaken with each Executive Lead to ensure the associated mitigations are identified. The populated BAF will then be regularly reviewed through the Risk Management Group with oversight through Audit and Risk Committee.

Stakeholder Involvement in managing risks

In carrying out its functions, NHS Lincolnshire ICB is committed to having due regard to Section 149 of the Equality Act 2010 (the Public Sector Equality Duty). An Equality Impact Assessment is appended to the Risk Management Strategy, Framework and Policy.

As a key partner of the ICS and ICB, Healthwatch provide a representative voice of patients from the many diverse communities in Lincolnshire into our risk management processes. Their involvement in the ICB structure includes membership of the System Quality and Patient Experience which reviews 'quality' in respect of patient safety, clinical effectiveness and patient experience of the services we commission.

A Healthwatch representative sits on the Primary Care Commissioning and Delegated Functions Committee, and reviews Primary Care risks. As referred to previously under the Performance section of this report, the Chief Executive of Healthwatch is a regular participant on the ICB Board and is actively involved in discussions on risk.

Prevention and deterrence of risk

The ICB has established processes to assist in the identification and mitigation of risks arising. All reports to the Board and its Committees have mandatory sections on the assessment of health inequalities impact, equality and diversity impact and risk and assurance.

The Board continually keeps up to date on matters of strategic risk and controls related to challenges within the local health economy and changes to national policy.

Capacity to Handle Risk

The Accountable Officer has overall responsibility for the management of risk by the ICB. All employees have a responsibility to identify and manage risk appropriate to their own role in the organisation.

The role of each senior officer is to ensure that appropriate arrangements are in place for the identification and elimination or reduction of risk to an acceptable level. Officers must also ensure compliance with policies, procedures and statutory requirements.

The ICB Board has a duty to assure itself that the organisation has properly identified the risks it faces, processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The accountabilities, roles and responsibilities for Risk Management are detailed within the ICB Risk Management Framework, Strategy and Policy as per the table below:

ROLES	RESPONSIBILITIES
Integrated Care Board	The Board has overall responsibility for risk management and needs to be satisfied that appropriate arrangements are in place and that internal control systems are functioning effectively. The Board determines the ICB's risk appetite and risk tolerance levels and is also responsible for establishing the risk culture.
Audit & Risk Committee	The Audit and Risk Committee provides the Board with assurance on the effectiveness of the Board Assurance Framework (BAF) and the robustness of the ICB's operational risk management processes. The Committee's role is not to 'manage risks' but to ensure that the approach to risks is effective and meaningful. The Committee supports the Board by obtaining assurances that controls are working as they should, seeking assurance about the underlying data upon which assurances are based and challenging relevant managers when controls are not working, or data is unreliable.
Operational/delivery/ transformation Boards	All operational groups are responsible for working with System Partners and monitoring risks associated to the delivery of their duties and/or objectives. This will include ensuring risk logs are in place and risks are escalated to the ICB's Corporate Risk Register as and when it is appropriate to do so.
Chief Executive	The Chief Executive will have responsibility for maintaining a sound system of internal controls that support the achievement of the ICB's policies, aims and objectives, whilst safeguarding public funds and assets.
Director of Finance	The Director of Finance is the executive lead for corporate governance and risk and assurance systems across the ICB. This includes promoting the ICB's risk culture within the Executive Team, wider directorates and across system partners.
Director of Nursing	The Director of Nursing is the Chair for the Risk Management Group. This includes promoting the ICB's risk culture within the Executive Team, wider directorates and across system partners.
ICB Non-Executive Directors	As members of the Board and Committees, the Non-Executive Directors will ensure an impartial approach to the ICB's risk management activities and should satisfy themselves that the system of risk management is robust. The Non-Executive Directors also provide oversight and assurance through their respective Board Committees.
Executive Directors	Executive Directors are responsible for ensuring effective systems of risk management are in place and commensurate with this policy, within their respective directorates. This includes promoting the ICB's risk culture and ensuring all senior leaders, within their directorates, have a robust understanding of the risk management arrangements.
Senior Information Risk Owner (SIRO)	The SIRO takes ownership of the ICB's information risks and acts as advocate for information risk on the ICB.
Risk Owner	Risk owners are responsible for ensuring robust mitigating actions are identified and implemented for their assigned risks.
Individuals	All individuals are responsible for complying with the arrangements set out thin this policy and are expected to: • Routinely consider risks when developing business cases, commencing procurements or any other activity which could be impacted by unexpected events • Ensure that any operational risks that they are aware of are captured on the Corporate

Risks to the ICB are reported, discussed and challenged at the bi-monthly Board meetings. Communication is two-way, with the Committees escalating concerns to the Board and the Board delegating actions to the responsible Committee where appropriate.

In conjunction with the development of the ICB's integrated risk management systems a training suite on risk management has been produced. During 2023/24 all appropriate staff will be provided with training in the principles of risk management and assessment in order for them to manage and treat appropriate levels of risk within their designated authority and day to day duties. Detailed procedures and guidelines are set out in the ICB's Risk Management Framework, Strategy and Policy which provides executives, managers and staff with the appropriate tools to identify, score and treat risk properly.

Risk Assessment

Risk identification, assessment and monitoring is a continuous structured process in ensuring that the ICB works within the legal and regulatory framework, identifying and assessing possible risks facing the organisation, and planning to prevent and respond to these.

As part of the transition process from the former NHS Lincolnshire CCG to the ICB it was agreed to continue with the CCG's Risk Management Group (RMG) which had been reinstated in 2021. The key forums for the management of risk in the ICB are outlined below:

Risk Management Group

- Has delegated duties as the 'gatekeeper' for escalation and de-escalation of any key risks
- Has responsibility for the management of risk monitoring and action
- Will report to the Senior Management Operational Delivery Group on a monthly basis
- Will report to the Audit & Risk Committee on a quarterly basis

Senior Management Operational Delivery Group

- Has oversight of the Risk Management Group
- Will receive a monthly report

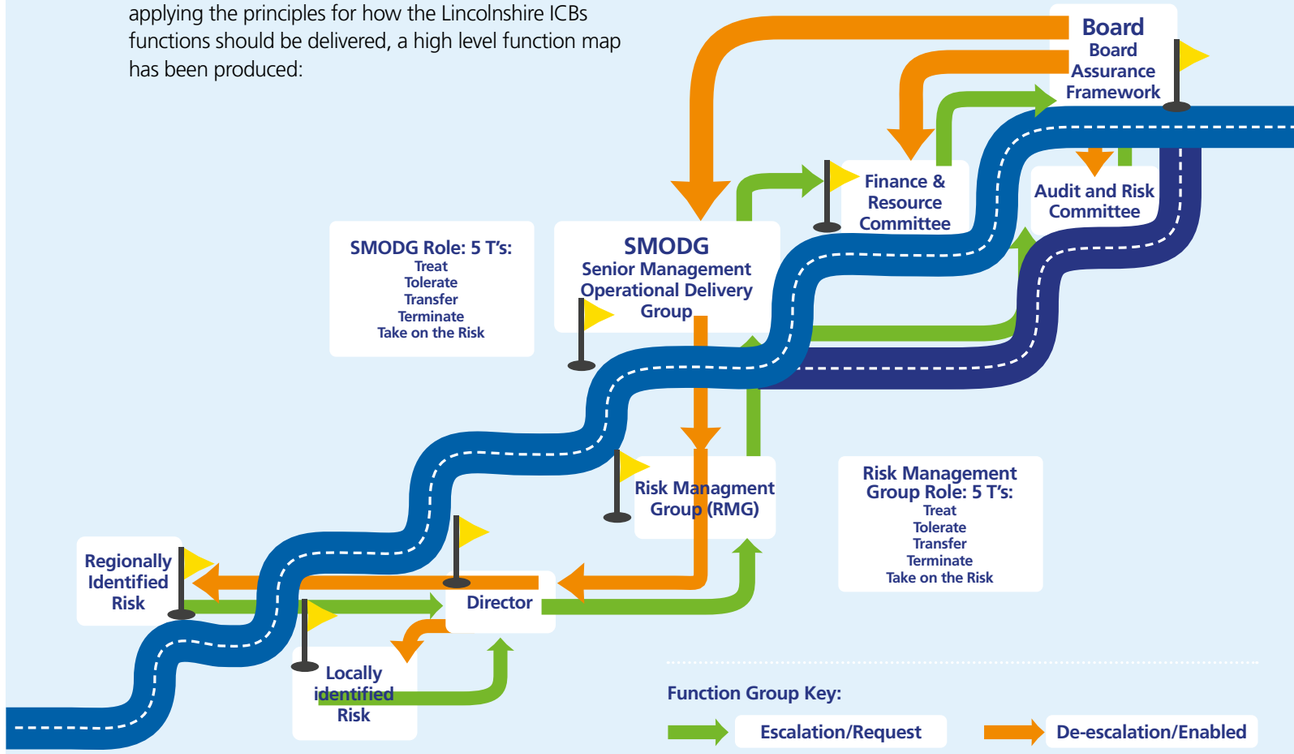
Audit & Risk Committee

- Is responsible for seeking assurance for the Board in order that the systems of internal control are managing risk is appropriate
- Receive a report of risks from the Risk Management Group on a quarterly basis

The ICB escalates risk for two reasons. Firstly, for information, and secondly when a risk requires action or resource/authority to proceed from an authorised source.

Risk Escalation/De-escalation Road Map

Taking the functions groupings described earlier and applying the principles for how the Lincolnshire ICBs functions should be delivered, a high level function map has been produced:



Risk Register

Building on the work carried out thus far by the ICB, the Corporate Risk Register (CRR) has been further refined and the format updated as a number of the items included were 'legacy risks' from the previous CCG and have therefore been removed.

The presentation of the CRR will also be refreshed and refined in early 2023/24.

The ICB risk scoring matrix is detailed below:

01-03	Very low risk
04-06	Low risk
08-12	Medium risk
15-25	High risk

In conclusion - NHS England (NHSE) has confirmed that there are no identified risks to compliance with the ICB licence.

Commissioning Support Unit

The ICB purchases the majority of its commissioning support services from Arden & GEM Commissioning Support Unit Commissioning Support Unit (CSU). This includes the following:

- Provider Management
- Business Intelligence
- Human Resources
- Information Governance
- Equality and Diversity
- Health and Safety
- Business Continuity
- Freedom of Information

The ICB relies on CSU governance and assurance for the probity and stewardship of services provided.

The ICB keeps all contracts under review in order to ensure efficiency and value for money. The ICB also receives Service Auditor Reports which provide assurance about the operation of their internal controls, and which are detailed later in the Annual Governance Statement along with other sources of assurance, such as from Internal Audit.

Other sources of assurance

Internal Control Framework

A system of internal control is in place in the Integrated Care Board to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The ICB demonstrates internal control by a variety of mechanisms. The ICB Committee structure as described earlier in the report ensures that a systematic and controlled process is in place to review and approve relevant policy documentation and ensure robust governance is in place.

The Audit and Risk Committee has specific responsibility for reviewing, managing and reporting risk to the Board. There are financial controls in place to comply with good practice and these are audited by internal and external auditors each year.

The internal audit programme is extensive and covers key areas of the ICB business to review the ICB's compliance with policies and procedures and to recommend strengthening where appropriate. In 2022/23 the Head of Internal Audits opinion on the efficacy of the operation of internal controls is referred to on page 89.

Where internal audit assess that controls require improvement; or where compliance with agreed controls need to be strengthened, management agree the actions to be taken and are then held accountable for delivering the agreed improvements. The Audit and Risk Committee monitor the delivery of agreed improvements against the timescales agreed by management.

Annual audit of conflicts of interest management

The ICB's internal auditors carried out a Conflicts of Interest (CoI) audit during the period 1st July 2022 to 31st March 2023 with two low risk rating actions identified. These actions have already been addressed as of 31st March 2023.

Data Quality

The data used by the Board is based on the NHS national data sets. All data is checked for accuracy and is automated to avoid errors and inconsistency. To ensure consistency procedures are documented and regularly reviewed.

There have been no data quality issues reported between the period 1st July 2022 to 31st March 2023.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information, and special category data. This framework is supported by NHS Digital's Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the Integrated Care Board, other organisations and to individuals, that personal information is safeguarded securely and used properly in line with National Data Guardian requirements. The ICB is not required to submit its DSPT until 30th June 2023.

There are processes in place for incident reporting and investigation of serious incidents. The ICB has not had any personal data related incidents in year that have met the criteria for external reporting to the Information Commissioner's Office. We have developed data protection impact assessments (DPIAs) and management procedures to embed an information risk culture throughout the organisation against identified risks.

The ICB purchases its Information Governance services and its Data Protection Officer service from Arden & GEM CSU.

Business Critical Models

The ICB does not use any business critical models at this time and will continue to review any models that it uses in the future to ensure quality assurance of such models.

Third party assurances

The ICB receives assurance through reports from audits performed on other organisations that provide services to the ICB:

For the period 1st July 2022 to 31st March 2023 the ICB has received reports relating to:

- Arden and Greater East Midlands Commissioning Support Unit (finance and payroll)
- NHS Shared Business Services (SBS) Limited (employment services)
- Capita Business Services (primary care support England)
- NHS Business Service authority-Electronic staff record.
- NHS Business Services Authority (prescription payments to pharmacists and student bursaries)
- NHS England (processing of General Practitioner Data Services)

In reviewing the above reports, I have noted that, with the exception of the audit of Arden and Greater East Midlands Commissioning Support Unit and NHS Business Services Authority (student bursaries), qualified opinions have been provided by the service auditors. However, consideration of the reports' findings has identified that the opinions have been qualified on the basis of a relatively small number of exceptions when testing the operation of controls. The majority of these exceptions have already been actioned or plans put in place to rectify these.

Overall, the ICB is satisfied with the management responses provided in relation to these exceptions and the actions being implemented to address them.

Control Issues

The ICB has implemented governance, risk management and internal control processes and subjected them to scrutiny through the various Committees of the Board.

In the Month Nine Governance Statement some control issues were highlighted in relation to the financial position and key quality and performance targets. Oversight and management of these has been primarily through the Board, its Committees and supporting governance structure which includes representatives from partners across the ICS. These have been primarily managed through the Board Committees - such as Finance and Resource and Service Delivery and Performance.

Information on the ICB year end financial position and performance in relation to the key constitutional targets and standard are detailed under the Performance and Finance Sections of the Annual Report and include the actions taken to resolve or mitigate against these areas.

Review of economy, efficiency & effectiveness of the use of resources

The ICB Board has overarching responsibility for ensuring there are appropriate arrangements in place to exercise CCG functions effectively, and economically. The ICB sets a Financial Plan at the beginning of the year which is agreed by the ICB Board. The Plan is monitored on a monthly basis and reported to the Board.

The ICB also uses non-financial measures to manage its day-to-day business and to give a comprehensive and balanced view of performance. The Board reviews the performance report on a bi-monthly basis.

In April 2022 the CCG was required to submit a draft financial plan covering the time-period 1st April 2022 to 31st March 2023 in line with national requirements. This covered the quarter one period for the CCG (1st April 2022 to 30th June 2022 and nine months of the ICB (1st July 2022 to 30th March 2023).

A separate Annual Report for the CCG for the period 1st April 2022 to 30th June 2022 has been produced.

An update on the financial position was provided to the ICB Board at its meeting held on the 26th July 2022.

The ICB has regular and open dialogue with NHS England regarding its operations and deliverables against targets. The Lincolnshire system has gone through a rigorous process with open dialogue with NHSE to enact the NHSE Reforecasting protocol to report variance to plan.

The Lincolnshire ICB System entered the NHS Oversight Framework (NOF) Four in July 2021 due to financial concerns and was due to exit the due to exit the NOF4 at the end of Quarter Four 2022/23. at the end of Quarter Four 2022/23. Although the System has made good progress in past 12 months, it did not meet all NOF4 conditions and therefore the NOF4 has been extended by 12 months and the NOF4 conditions remain the same.

The exit conditions are as follows:

1. ULHT to demonstrate sufficient progress to exit NOF4 – this condition has been met.
2. The system to agree a consolidated system strategic delivery plan ("SDP") that underpins the financial improvement plan. The SDP has a clinical sign off and has been approved by the System Leaders Board – the condition has been met.
3. The system approved and delivered Financial Recovery Plan (FRP) (which underpins the SDP that contains a deficit reduction plan. The system can clearly evidence a financial governance and joined approach to shared risk management. The FRP governance and reporting has been approved and implemented and the FRP Board is being on a weekly basis. The risk share agreement agreed in 2022/23 remains in place. The System put in place clear oversight arrangements (these need to include oversight from NHSE/I Finance Team) and the FRP is delivered for two consecutive quarters. The Lincolnshire Leaders Group (LLG) approve the 2023/24 Financial Recovery Plan (FRP) on the 22nd March 2023. The FRP states that the System will deliver £55m of savings. The monthly phasing was agreed with NHSE on Monday 27th March 2023. The system is aiming to meet this condition by end of Quarter Two and therefore apply for an early release from NOF4.
4. The system can demonstrate a clear pipeline for future improvement plans contributing towards financial balance. The system is setting up a task and finish group that will identify new opportunities and creates a sustainable pipeline of projects for 2023/24 and beyond; this pipeline will be linked to annual planning process and will be closely aligned to the system's strategy.

Delegation of functions

The ICB received delegated authority for Primary Care Commissioning budgets when it was established on 1st July 2022.

These consisted of GP contract budgets, and related areas of expenditure. To assure itself of the effective use of resources for delegated budgets the ICB accesses monthly payment information, which is reviewed and challenged for understanding and further information if required. A financial report is taken bi-monthly to the Primary Care Commissioning and Delegated Functions Committee of the ICB which allows review and challenge by Non-Executive Directors.

There is a risk register covering Primary Care risks and emerging risks. This is reviewed by the Primary Care Commissioning and Delegated Functions Committee at each meeting.

Escalation reports from the Primary Care Commissioning and Delegated Functions Committee are reviewed at the Board, and the delegated budgets form part of the overall financial report of the ICB.

Counter fraud arrangements

The ICB is compliant with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption. There has been no requirement to re-submit the CFFSR following the creation of the ICB, with the next submission of the final CFFSR set as 31st May 2023.Preparations are well underway for the annual Counter Fraud Functional Standard Return (CFFSR).

The ICB contracted with PwC for an accredited Counter Fraud Specialist (CFS) service to undertake counter fraud work.

The executive lead role for Anti-Fraud and Anti-Bribery and Corruption sits with the Director of Finance (as a member of the ICB Board). The CFS attends the regular meetings of the Audit and Risk Committee, providing formal updates against an agreed annual programme of activities.

All new counter fraud referrals received from July 2022 to March 2023 were investigated and closed by 31st March 2023.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the Integrated Care Board the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Integrated Care Board's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

"Our opinion is as follows:

Generally satisfactory with some improvements required.

Governance, risk management and control in relation to ICB critical areas is generally satisfactory. However, there are some areas of weakness in the framework of governance, risk management and control which potentially put the achievement of objectives at risk.

Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control: Two high risk areas were identified:

Personal Health Budget (PHB) Approval - For each PHB, a proforma is established, which has all relevant documents embedded. This means that the budget costings, Care and Support Plan and Care Needs Portrait are all provided in order for the budget to be approved. We completed sample testing of 20 PHBs, and noted several errors in the processing of each sample.

PHB s75 agreements - We completed sample testing over twenty Section 75 PHBs, to review what evidence was provided to the ICB from the LCC. There was very little evidence available, only the Care Needs Portraits and some review documentation on the care plan. Three out of 20 Care Needs Portraits had not been completed by a nurse, which is a requirement of the national framework for NHS Continuing Healthcare.

Corporate Governance: **System Quality and Patient Experience Committee (SQPEC)** –the Terms of Reference for the SQPEC suggests 'the Quality Committee shall meet formally a minimum of eight times per year, along with two development sessions'. However, only two meetings have occurred to date in October and December 2022. Across both of these meetings, a number of concerns/areas for clarification were raised by members. It was agreed in the December 2022 meeting that a development session would be held in January 2023 to discuss and resolve the items but this meeting has been deferred until 21 April 2023 and no meetings of the SQPEC have occurred in between.

In summary, our opinion is based on the following:

- Medium risk rated weaknesses identified in individual assignments that are not significant in aggregate to the system of internal control.
- High risk rated weaknesses identified in individual assignments that are isolated to specific systems or processes; and
- None of the individual assignment reports have an overall classification of critical risk."

The Audit and Risk Committee approved the Internal Audit plan that had been developed in conjunction with the ICB Executive Team.

During the period 1st July 2022 to 31st March 2023, Internal Audit issued the following audit reports:

TITLE	RATING
Conflicts of Interest	Low
Key Financial Controls	Medium
PHB CHC Review	High
Primary Care	Medium
Corporate Governance	High
DSPT	Medium

Internal Audit also issued some advisory reports (as in not risk rated) during the year which were noted by the Audit and Risk Committee.

These are as follows:

• Business Continuity and EPRR

• Review of the HFMA Checklist

The Audit and Risk Committee acknowledged the risks identified in the reports presented. For the period July 2022 to March 2023 all audit actions were monitored and updated via the PwC Internal Audit TRAC system. A report was provided to each meeting of the Audit and Risk Committee on the actions that remained outstanding, and the progress made to date.Where there had been little evidence of progress against the agreed actions, the lead individual was invited to attend the Audit and Risk Committee meetings to provide an update in person.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the Integrated Care Board who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Integrated Care Board achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by the:

- Board
- Audit and Risk Committee
- Primary Care Commissioning and Delegated Functions Committee
- Finance and Resource Committee
- Quality and Patient Experience Committee
- Service Delivery and Performance Committee

I have also been provided with assurance through the Executive Team meetings, Board and Board Development Sessions that the necessary plans and governance arrangements are in place for the satisfactory delegation of Pharmacy, Optometry and Dental services to the ICB from the 1st April 2023.

A plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

Improvement and strengthening of financial controls were undertaken following a review in the early part of the year. During the year, the ICB has developed and strengthened its governance arrangements.

The work that is underway on the development of the Board Assurance Framework will be finalised in the early part of 2023/24 in line with comments received from the ICB's external auditors as part of their Value for Money exception reporting. The BAF is a key document to ensure the Board receives assurance that the ICB's controls to manage strategic risks are assessed and continuously improved.

Mr John Turner
Chief Executive
(Accountable Officer)
28th July 2023

REMUNERATION AND STAFF REPORT

Remuneration Report

The ICB has prepared a Remuneration Report containing information about director's remuneration. This report is in respect of the senior managers of the ICB.

Some of the information in the report is part of the annual audit of the accounts, and this is indicated when it applies in the title of each section.

The definition of "senior managers" is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Integrated Care Board. This means those who influence the decisions of the ICB as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.'

The tables on subsequent pages of this report summarise the remuneration (excluding National Insurance contributions) and pension status of the ICB's Board members and other senior managers for the period 1 July 2022 to 31 March 2023. Prior year comparators are not required as the ICB was only established on 1st July 2022.

The ICB's Remuneration Committee, which is a Committee of the Board, ensures that remuneration is both equitable and fair throughout the organisation. The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17-19 of Schedule 1B to the NHS Act 2006, i.e., to confirm the ICB Pay Policy, including adoption of any pay frameworks for all employees including senior managers/directors (including Board Members) and Non-Executive Directors. It also ensures that the ICB's most senior managers are appropriately and fairly rewarded for their contributions, conforming to the ICB's probity and financial integrity as part of the corporate governance arrangements.

Remuneration Committee

The membership of the Remuneration Committee and their attendance at meetings throughout the period July 2022 to March 2023 was as follows:

Dr Gerry McSorley	Chair of the Remuneration Committee and Non-Executive Director
Sir Andrew Cash	Interim ICB Chair
Mrs Dawn Kenson	Non-Executive Director
Mrs Julie Pomeroy	Non-Executive Director
Professor Sir Jonathan Van-Tam	Non-Executive Director

There were four meetings of the Remuneration Committee held between 1st July 2022 and 31st March 2023 and further information on attendance is included in the Annual Governance Statement.

Arden & GEM are contracted by the ICB to provide professional Human Resource advice to the ICB. Although Arden & GEM was paid for the advice as part of their overall contract, no fee or other payment was made to any individual employed by Arden & GEM CSU.

Policy on the Remuneration of Senior Managers

The Remuneration Committee is responsible for determining the remuneration of all individuals who are non-employees and engaged under Contracts for Services. Remuneration for these positions is informed by local and national pay benchmarking. Their remuneration is reviewed periodically to ensure that it keeps pace with increasing demands on the time of the individuals in those positions.

Duties of the Remuneration Committee

For the Chief Executive, Directors, and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, pensions, and cars.
- Determine arrangements for termination of employment and other contractual and non-contractual terms.

For all staff (including senior managers):

- Determine the ICB Pay policy (including adoption of pay frameworks such as Agenda for Change).
- Oversee contractual arrangements.
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of national guidance.

To avoid any conflict of interest in respect of Non-Executive Directors who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by a Remuneration Panel – the details and membership of the Panel are set out in the ICB Governance Handbook. The Non-Executive Directors are not part of this process.

The notice period for executive directors is six months and the arrangements for compensation payments for early termination of contract will comply with NHS regulations. The remuneration for executive directors does not include any performance related bonuses and none of the executives receive personal pension contributions other than their entitlement under the NHS Pension Scheme.

Remuneration of Very Senior Managers

Employment terms for a Very Senior Manager (VSM) or member of the ICB's Executive Team are determined separately and where appropriate the principles of Agenda for Change are applied to these employees to ensure equity across the ICB. Remuneration for VSM employees is informed by the ICB Executive Pay Framework. When the VSM Pay Framework is published it will also be used, but until then there is a robust process in place within the ICB. The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Non-Executive Directors from the Board and their decisions are informed by independent, local and national benchmarking to ensure the best use of public funds and to help with recruitment and retention. Their decisions also take into consideration annual VSM pay review guidance from NHS England and annual Agenda for Change pay circulars to ensure parity where appropriate.

Use of prior year comparators in the Remuneration Report

Although normally expected, prior year comparators do not appear in this report as this is the first year of the ICB.

Salaries and Allowances [Audited]

Salaries and allowances for the senior managers of the ICB for July 2022 to March 2023 are shown in Table 1 below. The notes describe principles which support the figures in the table. Pension related benefits shown below are pro rata apportionments of the full year April 2022 to March 2023 in line with NHS Business Services Authority guidance. This was necessary as pensions data is only provided on an annual basis.

Salaries and Allowances Notes

1. Total remuneration includes salary and non-consolidated performance-related pay as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
2. None of the ICB's senior employees are entitled to performance related bonuses.
3. The Interim Medical Director was engaged through an off-payroll engagement with a GP practice.
4. There were no payments or awards made to past senior managers, payments made for loss of office during the periods shown or payments to anyone who was not a senior manager but has previously been a senior manager at any time.
5. All pension related benefits show the increase in 'lifetime' pension which have arisen in the year 2022/23. The sum reported reflects the amount by which the annual pension received on retirement age has increased in the year multiplied by 20 (the average number of years a pension is paid to members of the NHS pension scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
6. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000, they would be shown in the salary band (£'000) 45-50.
7. Where an employee has been in post for part of the year, their pay and pension amount are time apportioned to reflect their time in post with the ICB. Any start and end dates are shown in the notes.
8. The calculation of pension related benefits includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial period.

Table 1: Salaries and Allowances for the period July 2022 to March 2023

Name and title	July 2022 to March 2023					
	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	80-85	0	0	0	20-22.5	100-105
Mr Andrew Cash, Chair	45-50	0	0	0	0	45-50
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	25-30	0	0	0	0	25-30
Mr Martin Fahy, Director of Nursing	100-105	0	0	0	85-87.5	185-190
Mr Matt Gaunt, Director of Finance	120-125	0	0	0	60-62.5	185-190
Dr Sunil Hindocha, Interim Medical Director	95-100	0	0	0	0	95-100
Mrs Dawn Kenson, Non-Executive Director	10-15	500	0	0	0	10-15
Mr Gerry McSorley, Non-Executive Director	10-15	0	0	0	0	10-15
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	80-85	0	0	0	22.5-25	105-110
Mr Peter Moore, Non-Executive Director	5-10	0	0	0	0	5-10
Professor Sir Jonathan Van-Tam, Non-Executive Director	10-15	0	0	0	0	10-15
Mrs Julie Pomeroy, Non-Executive Director	10-15	0	0	0	0	10-15
Mrs Margaret Pratt, Non-Executive Director	5-10	0	0	0	0	5-10
Mrs Clair Raybould, Director for System Delivery	85-90	0	0	0	22.5-25	110-115
Mr John Turner, Chief Executive	135-140	0	0	0	0	135-140
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	80-85	0	0	0	22.5-25	105-110

Notes to Table 1 The ICB has been unable to appoint a permanent medical director until approval of the terms and conditions for the post are received from NHS England. Dr Sunil Hindocha has been working with the ICB on an interim basis in this role through an off-payroll engagement with the Heart of Lincoln GP practice. The value reflected in the above table was the amount paid or payable to the Heart of Lincoln GP practice between July 2022 and March 2023.

All postholders reported above were in post for the full year with exception to the following:

- Mr Peter Moore, Non-Executive Director – left the ICB on 31 January 2023.

- Mrs Margaret Pratt, Non-Executive Director – in post from 21 October 2022

- Mr Simon Evans, Non-Executive Director – in post from 3 January 2023.

- Dr Sunil Hindocha, Interim Medical Director - started working with the ICB on 1 July 2022.

The expenses shown relate to travel costs which were outside the normal limits for non-taxable refund.

Non-cash remuneration: benefits in kind

Employees can receive non-cash benefits which must be reported to HMRC each year on a P11D form. These include discounted services or goods, vouchers (including childcare vouchers), living accommodation, travel allowances, company cars, vans, bikes or other vehicles available for private use, low-cost loans, private insurance, professional fees and subscriptions.

None of the senior managers received benefits in kind during the period July 2022 to March 2023.

Pensions benefits [Audited]

Most of the senior managers do not have pensionable pay, either because (for the medical staff) they are part of a GP pension scheme or because (for non-executive directors) their engagement does not qualify as pensionable pay. The notes describe principles which support the figures in Table 2.

Pension Benefit Notes

1. The below information is based on data provided by the NHS Pensions Agency.
2. The employer's contribution rate to pension benefits was 20.68% of pensionable pay throughout 2022/23.
3. Pension figures included in the table below are for senior managers that have pensions paid directly by the ICB and include all of their NHS service, not just pension payments that related to the year in question.
4. Where an employee has been in post for part of the year their pension amount is time apportioned to reflect their time in post.
5. Staff are able to make additional voluntary contributions alongside their regular contributions.
6. The calculation of the real increase in Cash Equivalent Transfer Value includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial period.
7. The benefits and corresponding Cash Equivalent Transfer Value disclosed in Table 2 below does not allow for any potential adjustment in relation to the McCloud judgement.
8. Table 2 covers the period July 2022 to March 2023. Data provided by the NHS Pensions Agency for the full year 2022/23 has been apportioned to give the figures shown.

Table 2: Pension Benefits for the period ending 31 March 2023

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 July 2022	Employer's contribution to stakeholsder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnership	0-2.5	0	35-40	0	409	13	442	0
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	0	0-2.5	25-30	50-55	375	0	388	0
Mr Martin Fahy, Director of Nursing	2.5-5	7.5-10	65-70	165-170	1,238	90	1,369	0
Mr Matt Gaunt, Director of Finance	2.5-5	0	35-40	0	474	50	552	0
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	0-2.5	0-2.5	50-55	110-115	1,043	33	1,111	0
Mrs Clair Raybould, Director for System Delivery	0-2.5	0-2.5	30-35	50-55	492	19	534	0
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	0-2.5	0-2.5	40-45	80-85	703	23	753	0

The Department of Health and Social Care Group Accounting Manual confirms that where a senior manager has opted out of the pension arrangements for the whole of the year, no pension figures should be reported. This guidance has been applied to Table 2 for Mr John Turner, who chose not to be covered by the pension arrangements during the reporting period.

Pension information as at 1 July 2022 was not available from the NHS Pensions Agency and so had to be estimated from the full year figures. This was done by:

- Starting with the opening figures as at 1 April 2022.
- Uplifting the opening figures in line with the HM Treasury price increase tables (taking 25% of the annual uplift to estimate the increase from April to June).
- Adding an estimate of the real increase in pensions from April to June by apportioning the annual increase across the year.

The same apportionment principles apply to the disclosures for Mr Simon Evans. He started with the ICB on 3 January 2023. Increases to pension benefits are shown in proportion to his working time with the ICB, and the increase in Cash Equivalent Transfer Value was spread across the year to calculate the 1 July 2022 CETV.

The following definitions are provided for the pension tables above.

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 2024 CETV figures.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

There have been no compensation payments for early retirement or for loss of office during the period July 2022 to March 2023.

Payments to past directors

There have been no payments to past directors.

Fair pay disclosures [Audited]

Percentage change in remuneration of highest paid director

Entities are required to disclose pay ratio information and detail concerning the percentage change in remuneration for the highest paid director. However, as this is the first year of the organisation there are no changes to report.

Pay ratio information

As at 31 March 2023, remuneration ranged from £2,500 to £182,500 using midpoints of the bands based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration of Lincolnshire ICB staff shown in the table below:

Pay ratio analysis for all staff (in £5,000 pay bands)	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
As at 31 March 2023	25- 30	40 - 45	50 - 55

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director against the 25th percentile, median and 75th percentile of remuneration of the ICB's workforce. (Salary is the only component, so no further breakdown is presented.) The banded remuneration of the highest paid member of the Board in the Integrated Care Board in the period July 2022 to March 2023 was annualised full time equivalent remuneration of £180-£185,000 based upon gross earnings in March 2023. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2022-23	7.11	4.27	3.59

In 2022/23 no employees received remuneration in excess of the highest-paid director.

The midpoint of the banded remuneration for the highest paid member of the Board was 4.27 times the median remuneration of the workforce, which was £40 - £45,000.

Exit Packages for the period July 2022 to March 2023 [Audited]

There were no exit packages agreed in the period July 2022 to March 2023.

Table 1: Exit Packages for the period July 2022 to March 2023

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
More than £200,000	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0

Reporting of redundancy and other departure costs is in accordance with the provisions of the Agenda for Change redundancy policy. Exit costs in this note are accounted for in full in the year of departure. Where the ICB has agreed early retirements, the additional costs are met by the ICB and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Other Departures

There have been no other departures in the period July 2022 to March 2023.

Table 1: Other Agreed Departures for the period July 2022 to March 2023

As a single exit package can be made up of several components (each of which will be counted separately in this Note) the total number above will not necessarily match the total numbers in Note 4.4 Exit Packages which will be the number of individuals.

* Any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below.

**Includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.

There were no non-contractual payments (£0) made to individuals where the payment value was more than 12 months of their annual salary.

STAFF REPORT

Staff Engagement

July 2022 ushered in a new chapter for the staff from the former NHS Lincolnshire Clinical Commissioning Group who transferred across to NHS Lincolnshire Integrated Care Board from 1st July. The transfer to the ICB followed an extensive consultation exercise with staff.

As a newly formed organisation, the ICB wanted to immediately ensure that all its teams felt they were an integral part of the new organisation.

To support this the ICB agreed to continue with the previously established Staff Engagement Group (SEG) which meets on a monthly basis.

The chair of the group is elected from the group membership who represent teams across the ICB. Staff can find out more about the work of SEG via our intranet where they have a dedicated page.

Under the guidance of the Director of Nursing, the ICB has developed initiatives based on best practice and continued with activity that had been previously established by the former CCG. This included charity events, the development of the staff recognition scheme and input into proposed staff benefits in line with Lincolnshire system partners. Equally important is the SEG role who continue to support dialogue between staff and the senior team. As we move forward the group aims to have representation across across all areas of the ICB and has recently undertaken a successful recruitment drive to help achieve this.

To ensure that we continually improved as an organisation we continued to engage with staff on a weekly basis through our hosted Team Talk Live Event, where members of the executive team update staff on a wide range of topics including our regular business activities, staff development and employee wellbeing initiatives.

The introduction of a regular guest speaker slot enabled staff to meet colleagues virtually from other areas of the ICB, our Non-Executive team and individuals from across the wider Lincolnshire Integrated Care System, which now forms an essential part of the new national statutory arrangements for health and social care. Our weekly teams briefing is supplemented by Team Talk News, the weekly newsletter that is sent out to all staff.

October also saw the transfer of our vaccination teams to our provider trust Lincolnshire Community Health Services NHS Trust, who took over responsibility for the vaccination programme.

Staff Survey

In October 2022, the ICB encouraged staff to participate in the NHS annual staff survey. This renowned national survey is completed anonymously by staff who are asked to answer questions on communication, engagement, line management, equality and, more importantly, how the organisation is run and led by our senior team.

The Staff Survey was launched in October 2022 and 263 staff completed questionnaires. In March 2022 the results were released and in its first year of operation Lincolnshire ICB was placed a commendable 3rd place in the NHS annual staff survey for all Integrated Care Boards across England. The survey completion rate was 77% which was slightly above similar sized organisations where the rate was identified as 76%. This was a significant achievement and reflected the hard work of both staff and managers to make the Lincolnshire Integrated Care Board one of the best places to work across our local system and nationally. Our aim is to continue to build on our strengths and learn from our weaknesses, to ensure that we continue our successful journey in the coming months and years.

We want to take this opportunity to thank all our staff in the ICB for all their hard work who have helped make the first nine months of the ICB a successful one for Lincolnshire and its population.

Staff Composition

We monitor a number of human resource indicators, including staff sickness rates, vacancy rates and staff turnover. This allows us to explore further management of such issues and to gain assurance around the proactive support offered to staff regarding their health and wellbeing.

We are pleased to report that our cumulative sickness absence has reduced from 4.69 % in July 2022, to 3.82% in March 2023. This downward trend is welcome and positive given that our staff have had to deal with some challenging workloads both pre and post pandemic. As a new organisation we will continue to monitor absence and address any trends.

Staff Turnover

The turnover rate for the ICB staff in for the period 1st July 2022 to 31st March 2023 was an average of 33.10% which is higher than normal due to the transfer of staff members to other public sector organisations. The ICB uses a variety of source documents including exit interview data and feedback from the NHS staff survey to identify what steps it needs to take to reduce turnover. The results of these surveys are analysed at regular intervals and any specific trends or concerns will be reviewed by the ICBs senior management team who will ensure that any recommendations are implemented accordingly.

Staff Composition Table

Staff (as at 31st March 2023)			
Payscale	Gender	Permanent/ Fixed Term staff (WTE)	Bank staff (Headcount only)*
Band 2	Female	6.60	1
	Male	7.00	
Band 3	Female	29.37	
	Male	10.00	
Band 4	Female	41.28	
	Male	3.00	
Band 5	Female	26.33	1
	Male	6.00	
Band 6	Female	35.94	
	Male	15.00	
Band 7	Female	46.61	
	Male	13.00	
Band 8a	Female	38.91	
	Male	16.00	1
Band 8b	Female	22.71	1
	Male	7.00	
Band 8c	Female	13.60	1
	Male	4.00	
Band 8d	Female	4.00	
	Male	3.56	
Band 9	Female	4.00	
	Male	3.00	1
VSM	Female	4.00	
	Male	1.80	
GP's/ Clinical Advisors	Female	0.40	
	Male	2.32	
Board Members	Female	0.00	
	Male	3.00	

Sickness Absence Table

Sickness Absence Data	
	Jul 22-Mar 23
Total days lost	1964
Total staff years	252
Average working days lost	7.7

Number of Senior Managers Table

	Female		Male		Total	
	Headcount	% of workforce	Headcount	% of workforce	Headcount	% of workforce
Board Members	0	0.00%	3	0.74%	3	0.74%
Senior Managers (Band 8c and above)	27	6.68%	14	3.47%	41	10.15%
Other Members of staff	272	67.33%	88	21.78%	360	89.11%
Total	299	74.01%	105	25.99%	404	100.00%

Staff Policies

Throughout 2022 we established a set of policies for the ICB which are based on best practice. We will continue to develop further policies as the need arises. In addition, we have established an online induction programme for new starters and developed guidance for managers to hep induct new starters. We also began to use our newly created intranet page to share guidance with staff in an easily accessible way.

Our staff intranet is regularly updated and includes a dedicated HR page which provides support and guidance for all our staff including a comprehensive wellbeing offer to staff to make sure that they are fully supported in both their physical and mental health. We regularly review this offer with our partner organisations to make sure our support is aligned with the wider Lincolnshire System and the NHS People Plan

We continue to support disabled people and we are a Disability Confident Employer. We are committed to:

- inclusive and accessible recruitment
- communicating vacancies
- offering an interview to disabled people
- providing reasonable adjustments
- supporting existing employees

Our equality information is available on our website. This information is part our public commitment to meeting the equality duties placed upon us by legislation and we pledge to update this regularly. For further specific information on equalities and diversity please see pages 63 to 65 of this report.

Our staff can meet with their line manager to have regular a one-to-one discussion. Additionally, wehave in place an annual appraisal where more in depth discussions can take place to enable managers and employees to discuss performance wellbeing and career development.

Throughout the year our OD team have focused on development of a wide range of initiatives to support the further development of our staff including coaching and mentoring as well as supporting our wider discussions with staff through our planned whole team staff events.

As part of the ICB's commitment to ensure it looks after the mental health of its employees the ICB has applied for and received the Mindful Employer standard.

Lincolnshire ICB works with its partners across Lincolnshire and has an agreed Lincolnshire People Plan which supports the key pillars including, Looking after its People, New Ways of Delivering Care and Growing for the Future.

How well has the ICB looked after its people?

Lincolnshire ICB places significant emphasis on making sure that the wellbeing of its staff is placed at the heart of everything we do. In addition to our established occupational health and employee assistance programme, the ICB offers its staff a wide range of wellbeing support from the wider Lincolnshire ICS system for both physical and mental health (recent initiatives include the launch of the Shiny Mind and Champion Health apps as well as access to our more established Lincolnshire system services such as Steps to Change). We have also recently aligned our benefits offer to staff to ensure that the ICB remains an employer of choice within the Lincolnshire System.

Any new wellbeing initiatives are announced at our weekly briefing and further detail is provided on our wellbeing hub on our HR intranet page which is accessible to all staff. Further support to staff is available from our HR team and we encourage all our managers to have conversations with staff as part of their one to one and appraisal process. Staff who have been absent through ill-health have a return-to-work interview with their manager to identify any concerns and ensure that any additional support that may be required is provided.

Throughout the period of this reporting year our HR & OD teams have supported both managers and staff through face-to-face coaching and mentoring sessions with specific tailored support being provided to teams across the ICB. In addition, our HR Business Partner team have supported the delivery and engagement of staff events including the launch of the staff survey which has been articulated on page **X** of this report.

The welfare of our staff is of paramount importance to us and when staff are absent, they will be supported by our Occupational Health Service and our Employee Assistance Programme in addition to locally and nationally agreed support packages.

Our managers conduct return to work interviews with staff who have returned after a period of absence. This helps identify any particular issues and support packages that need to be put in place.

How has the ICB promoted new ways of working and delivering care?/ How has the ICB contributed to growing the NHS workforce?

Since the pandemic the ICB has adopted a new, agile approach to office working which where business reasons permit gives staff the flexibility to work part of the work from home and part of the week in the office. This blended approach to working has been regularly reviewed since the start of the pandemic and has been adjusted to take account of covid restrictions in order to keep our staff and residents safe. The ICB has reviewed its flexible working policy to ensure that the right to request flexible working is a day one right which was an integral part of the 2020 NHS People Plan.

The ICB has recognised the need for staff to become multiskilled and where possible operate a matrix working model which recognises the diverse range of talents across the organisation. This has enabled us to provide opportunities for our staff to support essential work across the Lincolnshire system and in particular support the delivery of national NHS requirements including the launch of our System Control Centre in November 2023. This built on our work supporting our partner organisations with specific project around the delivery of key targets which are detailed under the Performance section of this report.

The ICB recognises that in order for the NHS to meet its further workforce challenges it has to regularly review how it recruits and retains staff ensuring that it both meets the needs and desires of its workforce while meeting the operational needs of the service. In 2022 the ICB embarked on the launch of a pilot apprenticeship programme with a local training provider. These apprenticeships focussed on finance and mental health which have traditionally been difficult to fill areas. As part of this programme the ICB is looking at how the apprenticeship levy any be utilised across the organisation to support the upskilling of staff so that this can be done withing an agreed financial envelope which is what the apprenticeship levy is there to support.

Off Payroll Engagements

Table 1: Length of all highly paid off-payroll engagements

For all highly paid off-payroll engagements as of 31 March 2023, greater than £245 per day:

	Number
Number of existing engagements as of 31 March 2023	1
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

Note: the £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: New Off Payroll engagements

For all off-payroll appointments engaged at any point between 1 July 2022 and 31 March 2023, greater than £245 per day:

	Number
Number of off-payroll workers engagemed between July 2022 and March 2023	6
Of which	
The number not subject to off-payroll legislation	0
The number subject to off-payroll legislation and determined as in-scope of IR35	2
The number subject to off-payroll legislation and determined as out-of-scope of IR35	4
The number of engagements reassessed for compliance or assurance purposes during the year	0
of which the number of engagements that saw a change to IR35 status following review	0

Note: A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

The ICB confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 3: Off Payroll board members/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023.

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officals with significant financial responsibility", during the financial year.	16

The welfare of our staff is of paramount importance to us and when staff are absent, they will be supported by our Occupational Health Service and our Employee Assistance Programme in addition to locally and nationally agreed support packages.

Our managers conduct return to work interviews with staff who have returned after a period of absence. This helps identify any particular issues and support packages that need to be put in place.

Freedom to Speak Up Guardian

Our Freedom to Speak up Guardian is Mr Martin Fahy who is our Director of Nursing. He is supported by Mrs Vanessa Wort who is the ICBs Freedom to Speak up Lead and our Associate Director of Nursing.

During 2022 the ICB refreshed its Freedom to Speak Up Policy to ensure that it meets national guidelines for Freedom to Speak Up. The launch of our new policy in 2023 celebrated the appointment of four Freedom to Speak Up Champions and a new area for Freedom to Speak Up information on our staff intranet. This enables our staff to know how and who to speak up to and what will happen when they do.

Our policy is designed to be inclusive and support resolution by managers wherever possible but provides formal routes for escalation where this has proved not possible.

Trade Union Facility Time

The ICB does not have any designated trade union representatives and is reporting a nil return under the Trade Union (Facility time Publication's requirements) regulations 2017.

Expenditure on Consultancy

Consultancy spend for July 2022 to March 2023 was £587,042.

Conclusion

This staff report provides a most appropriate space to give heartfelt thanks to all those staff involved in the vaccination programme, including our vaccinators, nurses, doctors and support staff for their incredible work and dedication during the COVID-19 pandemic, to ensure that our residents and communities remained safe. We are for ever grateful for their work, and we wish them all well in their future endeavours.

Parliamentary Accountability and Audit report

The ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report starting on the next page. An audit certificate and report is also included in this Annual Report.

Mr John Turner
Chief Executive
(Accountable Officer)
28th July 2023

Entity name:	NHS Lincolnshire Integrated Care Board
This year	for the period 9 months ending 31 March 2023
This year ended	31 March 2023
Last year ended	30 June 2022
This year commencing:	01-July-2022

CONTENTS

NHS Lincolnshire Integrated Care Board - Annual Accounts for the period 9 months ending 31 March 2023

Explanatory Foreword to the Accounts

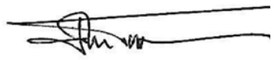
In accordance with the Department of Health and Social Care Group Accounting Manual 2022-23 the Integrated Care Board has accounted for transfers of function from the predecessor Lincolnshire Clinical Commissioning Group (CCG) as a transfer by absorption. As an organisation that was established on 1st July 2022 prior year comparator information is not included, with exception to the Statement of Financial Position and related notes. The accounts and associated notes that follow refer to the 9 month period from the 1st July 2022 to the 31st March 2023.

The NHS Lincolnshire Integrated Care Board (ICB) received an in-year Revenue Resource Limit (allocation) of £1,229,678,000 in 2022-23 for the period 1st July 2022 to 31st March 2023. The plan for the period was to deliver a surplus of £3,754,214. When combined with the former Lincolnshire CCG plan for the period 1st April 2022 to 30th June 2022 of £7,003,000 deficit this created a full year plan for a deficit of £3,248,786.

As set out in these accounts, the ICB incurred net operating expenditure of £1,241,234,036 during 2022-23 which exceeded the ICB's Revenue Resource Limit by £11,556,036 (as demonstrated in Note 41 to the accounts). Therefore there was an adverse variance against the full year plan of £8,306,250.

The ICB continued to host the Lincolnshire Covid-19 vaccination programme up to 30th September 2022. All the associated expenditure has been refunded to the ICB by NHS England. The ICB used a large number of agency and interim staff in order to deliver this service, which can be seen in some of the notes to the accounts and the analysis of staff costs.

As at 31 March 2023 the ICB had net liabilities of £88,709,054. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. There is no reason to believe that sufficient funding will not be made available to the ICB in the 12 months from the date of approval of these Financial Statements. As such these Financial Statements have been prepared on a going concern basis.



Mr John Turner
Accountable Officer
(Chief Executive)
28th July 2023

Statement of Comprehensive Net Expenditure for the period ended 31 March 2023

	Note	9 months to 31 March 2023 £'000
Income from sale of goods and services	2	(3,545)
Other operating income	2	(158)
Total operating income		**(3,703)**
Staff costs	4	16,332
Purchase of goods and services	5	1,229,323
Depreciation and impairment charges	5	50
Provision expense	5	(1,078)
Other Operating Expenditure	5	301
Total operating expenditure		**1,244,928**
Net Operating Expenditure		**1,241,225**
Finance expense		11
Net expenditure for the Period		**1,241,236**
Net Gain on Transfer by Absorption		(56,430)
Total Net Expenditure for the Financial Period		**1,184,806**
Other Comprehensive Expenditure		
Total other comprehensive net expenditure		**-**
Comprehensive Expenditure for the period		**1,184,806**

Revenue does not include allocation or cash received from NHS England. This is drawn down directly into the bank account of the Integrated Care Board and credited to the General Fund. The cash available in year from NHS England was £1,225,924,000 and the in year Revenue Resource Limit (allocation) was £1,229,678,000.

Notes 1 to 43 form part of this statement.

Statement of Financial Position as at 31 March 2023

	Note	9 months to 31 March 2023 £'000	3 months to 30 June 2022 £'000
Non-current assets:			
Right-of-use assets	13a	351	401
Total non-current assets		**351**	401
Current assets:			
Trade and other receivables	17	9,117	12,090
Cash and cash equivalents	20	1	1
Total current assets		**9,118**	**12,091**
Total current assets		**9,118**	12,091
Total assets		**9,469**	12,492
Current liabilities			
Trade and other payables	23	(95,059)	(64,648)
Lease liabilities	13a	(56)	(60)
Provisions	30	(2,754)	(3,830)
Total current liabilities		**(97,870)**	(68,538)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(88,401)**	(56,046)
Non-current liabilities			
Lease liabilities	13a	(301)	(343)
Provisions	30	(8)	(39)
Total non-current liabilities		**(309)**	**(382)**
Assets less Liabilities		**(88,710)**	(56,428)
Financed by Taxpayers' Equity			
General fund		(88,710)	(56,428)
Total taxpayers' equity:		**(88,710)**	(56,428)

Notes 1 to 43 form part of this statement.

The financial statements on pages 106 to 109 were approved by the Governing Body on 19th July 2023 and signed on its behalf by:

Mr John Turner
Chief Executive
(Accountable Officer)
28th July 2023

NHS Lincolnshire Integrated Care Board - Annual Accounts for the period 9 months ending 31 March 2023

Statement of Changes In Taxpayers Equity for the 9 months ended 31 March 2023

	Note	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 9 months ended 31 March 2023			
Balance at 01 July 2022		-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies under absorption costing		(56,430)	**(56,430)**
Adjusted balance at 1 July 2022		**(56,430)**	**(56,430)**
Changes in NHS Integrated Care Board taxpayers' equity for 9 months ended 31 March 2023			
Total transition adjustment for initial application of IFRS 16		-	**-**
Net operating expenditure for the financial year	SOCNE	(1,241,234)	(1,241,234)
Total revaluations against revaluation reserve			**-**
Net Recognised NHS Integrated Care Board Expenditure for the Financial year		**(1,241,234)**	**(1,241,234)**
Net funding		1,208,954	1,208,954
Balance at 31 March 2023		**(88,710)**	**(88,710)**

Notes 1 to 43 form part of this statement.

NHS Lincolnshire Integrated Care Board - Annual Accounts for the period 9 months ending 31 March 2023

Statement of Cash Flows for the period ended 31 March 2023

	Note	9 months to 31 March 2023 £'000
Cash Flows from Operating Activities		(1,241,234)
Net operating expenditure for the financial year	5	50
Depreciation and amortisation	11	(52,557)
Movement due to transfer by Absorption		11
Interest paid	17	(9,117)
Increase in trade & other receivables	23	95,059
Increase in trade & other payables	30	(30)
Provisions utilised	30	(1,078)
Decrease in provisions		**(1,208,896)**
Net Outflow from Operating Activities		**-**
Net Cash Inflow/(Outflow) from Investing Activities		**(1,208,896)**
Net Outflow before Financing		
Cash Flows from Financing Activities		1,208,954
Net Funding Received		(56)
Repayment of lease liabilities		**1,208,898**
Net Cash Outflow from Financing Activities		
Net Increase in Cash & Cash Equivalents	20	**1**
Cash & Cash Equivalents at the End of the Financial Year		**1**

Notes 1 to 43 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Integrated Care Board for the purpose of giving a true and fair view has been selected. The policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014. The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICBs) across England and abolished Clinical Commissioning Groups (CCG). Integrated Care Boards took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an Integrated Care Board on 1 July 2022.

As at 31 March 2023 the ICB had net liabilities of £88,709,054. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. There is no reason to believe that sufficient funding will not be made available to the ICB in the 12 months from the date of approval of these Financial Statements. As such these Financial Statements have been prepared on a going concern basis.

It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2023/24 and Integrated Care Board published allocations can be found on the NHS England website for 2023/24. The commissioning of health services (continuation of service) will continue after 31 March 2023.

Our considerations cover the period 12 months beyond the date of authorisation of issue of these financial statements. Taking into account the information summarised above, the Board have a reasonable expectation that the Integrated Care Board will have adequate resources to continue in operational existence for the foreseeable future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Due to rounding of transactions, in some places, there may be minor rounding differences in relation to casting/cross-casting in these accounts.

Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint arrangements

Arrangements over which the Integrated Care Board has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Integrated Care Board is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 Pooled Budgets

The Integrated Care Board has entered into a pooled budget arrangement with Lincolnshire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Learning Disabilities, Child and Adolescent Mental Health, Community Equipment and Proactive Care in the Community. Note 35 to the accounts provides details of the income and expenditure.

The pool is hosted by Lincolnshire County Council. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The Integrated Care Board reviews the Section 75 agreements to determine which party has control over the services being delivered, in accordance with IFRS 11 and the accounting policy at 1.4 for joint arrangements.

The Integrated Care Board has considered the NHS lead commissioning arrangement under IFRS 15 Revenue from Contracts with Customers for all elements contained within the individual section 75's and has concluded that the Integrated Care Board is acting as both the 'principal' and the 'agent' for different parts of the arrangement and should therefore account for gross expenditure and income arising from the arrangement within the financial statements and the net expenditure and income arising from the agreement respectively.

1.6 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board. NHS Lincolnshire Integrated Care Board considers it has only one operating segment, that is commissioning of healthcare services.

Notes to the financial statements

1.7 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard, the Integrated Care Board will not disclose information regarding performance obligations relating to part of a contract that has an original expected duration of one year or less,
• The Integrated Care Board is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Integrated Care Board to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Integrated Care Board is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Integrated Care Board accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Integrated Care Board commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:
• It is held for use in delivering services or for administrative purposes;
• It is probable that future economic benefits will flow to, or service potential will be supplied to, the Integrated Care Board;
• It is expected to be used for more than one financial year;
• The cost of the item can be measured reliably; and,
• The item has a cost of at least £5,000; or,
• Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
• Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.
Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
• Land and non-specialised buildings – market value for existing use; and,
• Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Integrated Care Board's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the Integrated Care Board;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the Integrated Care Board checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 The Integrated Care Board as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease. The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments. The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement of the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

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Notes to the financial statements

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of, or modification made, to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.13.2 The Integrated Care Board as Lessor

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. When the group is an intermediate lessor, it accounts for the head lease and the sub-lease as two separate contracts. The sub-lease classification is assessed with reference to the right-of-use asset arising from the head lease.

Amounts due from lessees under finance leases are recognised as receivables at the amount of the group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the net investment in the lease.
Rental income from operating leases is recognised on a straight-line basis over the term of the relevant lease.

1.14 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Integrated Care Board's cash management.

1.15 Provisions

Provisions are recognised when the Integrated Care Board has a present legal or constructive obligation as a result of a past event, it is probable that the Integrated Care Board will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 3.27% for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 3.20% for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 3.51% for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 3.00% for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Integrated Care Board has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.16 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the Integrated Care Board pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with Integrated Care Board.

1.17 Non-clinical Risk Pooling

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 Carbon Reduction Commitment Scheme
The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Integrated Care Board does not meet the qualification criteria for this scheme.

1.19 Contingent liabilities and contingent assets
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.20 Financial Assets
Financial assets are recognised when the Integrated Care Board becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:
• Financial assets at amortised cost;
• Financial assets at fair value through other comprehensive income and ;
• Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.20.1 Financial Assets at Amortised cost
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.20.2 Financial assets at fair value through other comprehensive income
Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.20.3 Financial assets at fair value through profit and loss
Financial assets measured at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.20.4 Impairment
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Integrated Care Board recognises a loss allowance representing the expected credit losses on the financial asset.

The Integrated Care Board adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Integrated Care Board therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Integrated Care Board does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.21 Financial Liabilities
Financial liabilities are recognised on the statement of financial position when the Integrated Care Board becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.21.1 Financial Guarantee Contract Liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:
• The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
• The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.21.2 Financial Liabilities at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Integrated Care Board's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

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1.21.3 Other Financial Liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 Value Added Tax
Most of the activities of the Integrated Care Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 Foreign Currencies
The Integrated Care Board's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Integrated Care Board's surplus/deficit in the period in which they arise.

1.24 Losses & Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Integrated Care Board not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.25 Critical accounting judgements and key sources of estimation uncertainty
In the application of the Integrated Care Board's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.25.1 Critical accounting judgements in applying accounting policies
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the Integrated Care Board's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

• It is appropriate to prepare the accounts on a 'going concern' basis;

• Continuing healthcare claims (CHC) prior to 31 March 2013 and which relate to the population of the Integrated Care Board are not directly recognised in the accounts. Rather, they are managed via a national risk pool. There is no contribution to the risk pool by Integrated Care Board in 2022-23. Payments for claims from NHS Lincolnshire Integrated Care Board residents are made by the Integrated Care Board but are recharged to the central NHS England risk pool;

• That all arrangements containing leases have been correctly identified in accordance with the relevant interpretation issued by the International Financial Reporting Standard (IFRS 16);

• The Better Care Fund reporting has been agreed with Lincolnshire County Council. This is shown on a net accounting basis in the accounts. Note 35 Pooled Budgets provides further detail.

1.25.2 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In the application of the Integrated Care Board's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily available from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions used are continually reviewed. Revisions to accounting estimates are recognised in the period from which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The most significant area of estimation uncertainty relates to the estimation of accruals for healthcare in the latter months of the year for which actual data was not received prior to the closure of the accounts. The material accruals relate to the provision of healthcare by the private sector mainly relating to the provision of Continuing Healthcare and Mental Health complex case provision where the BroadCare system is used to inform forecasts for contracts at individual patient level. In addition the estimation of accruals for Primary Care Prescribing relies on the forecasting methodology of the Business Services Authority (BSA).

Provisions have been made for the Integrated Care Board's liability for Continuing Healthcare for nursing care provided after 1 April 2013. Claims have been made by the public where they have borne the nursing costs but believe that there was a health need which should have been met by the Integrated Care Board. Each case has its own set of circumstances and appeals can be made against the initial ruling.

1.26 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.27 Adoption of new standards
There were no new International Financial Reporting Standards that impacted on the 9 months ended 31 March 2023 for NHS Lincolnshire Integrated Care Board.

Notes to the financial statements

1.28 New and revised IFRS Standards in issue but not yet effective

The Department of Health and Social Care Group Accounting Manual does not require the following IFRS Standards and Interpretations to be applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption and still subject to HM Treasury consideration.

• IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
• IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

The application of IFRS 14 and IFRS 17 would not have a material impact on the accounts for 2022-23, were they applied in that year.

2. Other Operating Revenue

	9 months to 31 March 2023 Total £'000
Income from Sale of Goods and Services (Contracts)	
Non-patient care services to other bodies	17
Prescription fees and charges	1,236
Other Contract income	2,131
Recoveries in respect of employee benefits	161
Total Income from Sale of Goods and Services	**3,545**
Other Operating Income	
Other non contract revenue	158
Total Other Operating Income	**158**
Total Operating Income	**3,703**

Revenue does not include allocation or cash received from NHS England. This is drawn down directly into the bank account of the Integrated Care Board and credited to the General Fund.

3. Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000	9 months to 31 March 2023 Total £'000
Source of Revenue					
NHS	17	-	1,554	161	1,732
Non NHS	-	1,236	577	-	1,813
Total	**17**	**1,236**	**2,131**	**161**	**3,545**

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000	9 months to 31 March 2023 Total £'000
Timing of Revenue					
Point in time	17	-	1,554	-	1,571
Over time	-	1,236	577	161	1,974
Total	**17**	**1,236**	**2,131**	**161**	**3,545**

Integrated Care Board revenue is entirely from the supply of services. NHS Lincolnshire Integrated Care Board receives no revenue from the sale of goods.

The contract income that has been recognised was not included within the opening balances of contract liabilities and contract income has not been recognised in the reporting period from performance obligations satisfied in the former NHS Lincolnshire Clinical Commissioning Group.

There is no contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	9 months to 31 March 2023		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	12,564	243	**12,807**
Social security costs	1,320	-	**1,320**
Employer Contributions to NHS Pension scheme	2,154	-	**2,154**
Apprenticeship Levy	51	-	**51**
Gross employee benefits expenditure	**16,089**	**243**	**16,332**
Less recoveries in respect of employee benefits (note 4.1.2)	(161)	-	**(161)**
Total - Net admin employee benefits including capitalised costs	**15,928**	**243**	**16,171**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**15,928**	**243**	**16,171**

4.1.2 Recoveries in respect of employee benefits

	9 months to 31 March 2023		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(132)	-	(132)
Social security costs	(17)	-	(17)
Employer contributions to the NHS Pension Scheme	(13)	-	(13)
Total recoveries in respect of employee benefits	**(161)**	**-**	**(161)**

4.2 Average number of people employed

	9 months to 31 March 2023		
	Permanently employed Number	Other Number	Total Number
Total	**308.14**	**58.93**	**367.07**
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

NHS Lincolnshire Integrated Care Board agreed no exit packages, that being compulsory redundancies and other, or non-compulsory, departures for the financial year ending 31 March 2023.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where the Integrated Care Board has agreed early retirements, the additional costs are met by the organisation and not by the NHS Pension Scheme. Ill health retirement costs are met by the NHS Pension Scheme and would not be included as an exit package agreed in the year.

Zero non-contractual payments (£0) were made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report; this was nil for the 9 months ending 31 March 2023.

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	9 months to 31 March 2023 Total £'000
Purchase of goods and services	
Services from other ICBs, CCGs and NHS England	4,978
Services from foundation trusts	214,372
Services from other NHS trusts	567,157
Services from Other WGA bodies	21
Purchase of healthcare from non-NHS bodies	180,898
Prescribing costs	123,171
General Ophthalmic services	51
GPMS/APMS and PCTMS	124,587
Supplies and services – clinical	1
Supplies and services – general	1,175
Consultancy services	587
Establishment	2,270
Transport	6,713
Premises	2,130
Audit fees	457
Other services	(10)
Internal Audit Services	109
Other professional fees	464
Legal fees	81
Education, training and conferences	111
Total Purchase of goods and services	**1,229,323**
Depreciation and impairment charges	
Depreciation	50
Total Depreciation and impairment charges	**50**
Provision expense	
Provisions	(1,078)
Total Provision expense	**(1,078)**
Other Operating Expenditure	
Chair and Non Executive Members	164
Clinical negligence	8
Research and development (excluding staff costs)	31
Expected credit loss on receivables	88
Other expenditure	10
Total Other Operating Expenditure	**301**
Total operating expenditure	**1,228,596**

Statutory Audit is provided by Ernst & Young LLP. The fees, inclusive of non-recoverable VAT, for the period reported was £237,600. In addition to the £237,600 (inclusive of VAT) recognised in these financial statements, there are additional costs relating to the 2021-22 audit of £35,642 (inclusive of VAT). In addition, due to the timing of and agreement of fees for Q1 CCG audit, £183,600 (inclusive of VAT) is reflected under 'audit fees' above related to the CCG audit fees which have been accounted for and paid by the ICB.

The Integrated Care Board contracts with its auditors provides for a limitation of the auditor's liability of £2,000,000.

Internal audit services are provided by PricewaterhouseCoopers LLP, fees for the 9 months reported were £109,470.

6.1 Better Payment Practice Code

Measure of compliance	9 months to 31 March 2023 Number	9 months to 31 March 2023 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	37,356	373,569
Total Non-NHS Trade Invoices paid within target	37,058	366,481
Percentage of Non-NHS Trade invoices paid within target	**99.20%**	**98.10%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,232	774,880
Total NHS Trade Invoices Paid within target	1,222	774,704
Percentage of NHS Trade Invoices paid within target	**99.19%**	**99.98%**

The NHS aims to pay at least 95% of all NHS and non-NHS invoices within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The performance for 2022-23 demonstrates this was achieved.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	9 months to 31 March 2023 £'000
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	**-**

The Integrated Care Board did not incur any interest charges from the late payment of commercial debts during 2022-23.

7. Income Generation Activities

The Integrated Care Board did not undertake any income generation activities where full cost exceeds £1 million or services were otherwise material in the accounts for the 9 months ending 31 March 2023.

8. Investment revenue

The Integrated Care Board received no investment revenue for the 9 months ending 31 March 2023.

9. Other gains and losses

Other gains and losses are largely associated with the disposal of fixed assets, and changes in the value of financial assets and liabilities. The Integrated Care Board had no such gains or losses for the 9 months ending 31 March 2023.

10. Finance costs

Finance costs are principally associated with interest charges on loans, PFI contracts and LIFT contracts. The Integrated Care Board doesn't have any of these arrangements. The Integrated Care Board has finance costs relating to interest expense on lease liabilities associated with rental of premises for the 9 months ending 31 March 2023.

	9 months to 31 March 2023 £'000
Interest on lease liabilities	11
Total finance costs	**11**

11. Net gain/(loss) on transfer by absorption

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021 that allowed for the establishment of Integrated Care Boards across England and abolished Clinical Commissioning Groups. Integrated Care Boards took on the commissioning functions of Clinical Commissioning Groups. NHS Lincolnshire Clinical Commissioning Group transitioned into NHS Lincolnshire Integrated Care Board on 1st July 2022.

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

	Total	NHS England Group Entities (non parent)
	9 months to 31 March 2023	9 months to 31 March 2023
	£'000	£'000
Transfer of Right of Use assets	401	401
Transfer of cash and cash equivalents	1	1
Transfer of receivables	12,090	12,090
Transfer of payables	(64,648)	(64,648)
Transfer of provisions	(3,870)	(3,870)
Transfer of Right Of Use liabilities	(403)	(403)
Net loss on transfers by absorption	**(56,429)**	**(56,429)**

12. Property, plant and equipment

The Integrated Care Board did not own any property, plant or equipment for the year ended 31 March 2023.

13a Leases

13a.1 Right-of-use assets

	9 months ending 31 March 2023		3 months ending 30 June 2022	
	Buildings excluding dwellings	Total	Buildings excluding dwellings	Total
	£'000	£'000	£'000	£'000
Opening cost or valuation	-	-		
IFRS 16 Transition Adjustment	-	-	418	418
Transfer from other public sector body	418	418	-	-
Closing Cost/Valuation	**418**	**418**	**418**	**418**
Opening Depreciation	-	-	-	-
Transfer from other public sector body	17	17	-	-
Charged during the year	50	50	17	17
Closing Depreciation	**67**	**67**	**17**	**17**
Closing Net Book Value	**351**	**351**	**401**	**401**

The right-of-use asset reported above relates to one building that is leased from within the NHS England Group, from NHS Property Services Ltd.

13a.2 Lease liabilities

	9 months to 31 March 2023	3 months to 30 June 2022
	£'000	£'000
Opening Lease liabilities	-	-
IFRS 16 Transition Adjustment	-	(418)
Transfer from other public sector body	(403)	
Interest expense relating to lease liabilities	(11)	(4)
Repayment of lease liabilities (including interest)	56	19
Closing Lease liabilities	**(358)**	**(403)**

13a Leases cont'd

13a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	9 months to 31 March 2023	Of which: leased from DHSC group bodies	3 months to 30 June 2022	Of which: leased from DHSC group bodies
	£'000	£000	£'000	£000
Within one year	(75)	(75)	(75)	(75)
Between one and five years	(300)	(300)	(300)	(300)
After five years	(25)	(25)	(81)	(81)
Balance at 31 March 2023	**(400)**	**(400)**	**(456)**	**(456)**
Effect of Discounting	43		53	
Included in:				
Current lease liabilities	(57)		(60)	
Non-current lease liabilities	(301)		(343)	
Total	**(358)**		**(403)**	
Balance by counterparty				
Leased from the NHS England Group		(400)		(456)
Balance as at 31 March 2023		**(400)**		**(456)**

There are no future cash outflows that the Integrated Care Board is exposed that are not recognised in the lease liabilities.

13a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	9 months to 31 March 2023	3 months to 30 June 2022
	£'000	£'000
Depreciation expense on right-of-use assets	50	17
Interest expense on lease liabilities	11	4
Expense relating to short-term leases	(19)	69

13a.5 Amounts recognised in Statement of Cash Flows

Total cash outflow on leases under IFRS 16	56	19

There are no restrictions or covenants imposed by the lease agreement and there are no sale and leaseback transactions for the financial year 2022-23.

14 Intangible non-current assets

The Integrated Care Board did not hold any intangible non-current assets for the 9 months ending 31 March 2023.

15 Investment property

The Integrated Care Board did not hold any investment property for the 9 months ending 31 March 2023.

16 Inventories

The Integrated Care Board had no inventories for the 9 months ending 31 March 2023.

17.1 Trade and other receivables

	Current	Non-current	Current	Non-current
	9 months to 31 March 2023	**9 months to 31 March 2023**	3 months to 30 June 2022	3 months to 30 June 2022
	£'000	**£'000**	£'000	£'000
NHS receivables: Revenue	357	-	2,898	-
NHS prepayments	-	-	1,123	-
NHS accrued income	3,293	-	85	-
Non-NHS and Other WGA receivables: Revenue	1,476	-	782	-
Non-NHS and Other WGA prepayments	2,010	-	2,775	-
Non-NHS and Other WGA accrued income	1,511	-	4,297	-
Expected credit loss allowance-receivables	(11)	-	(186)	-
VAT	401	-	314	-
Other receivables and accruals	80	-	4	-
Total Trade & other receivables	**9,117**	**-**	**12,090**	**-**
Total current and non current	**9,117**		**12,090**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	DHSC Group Bodies	Non DHSC Group Bodies	DHSC Group Bodies	Non DHSC Group Bodies
	9 months to 31 March 2023	**9 months to 31 March 2023**	3 months to 30 June 2022	3 months to 30 June 2022
	£'000	**£'000**	£'000	£'000
By up to three months	69	249	348	68
By three to six months	-	1	14	14
By more than six months	-	22	175	15
Total	**69**	**272**	**536**	**98**

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Other financial assets	Total
	£'000	**£'000**	**£'000**
Balance at 01 July 2022	(185)	**-**	**(185)**
Amounts written off	90	-	**90**
Other changes	84	-	**84**
Total	**(11)**	**-**	**(11)**

18 Other financial assets

The Integrated Care Board had no other financial assets for the 9 months ending 31 March 2023.

19 Other current assets

The Integrated Care Board had no other current assets for the 9 months ending 31 March 2023.

20 Cash and cash equivalents

	9 months to 31 March 2023	3 months to 30 June 2022
	£'000	£'000
Balance at 01 July 2022	1	5
Net change in the reported period	(0)	(3)
Balance at 31 March 2023	**1**	**1**
Made up of:		
Cash with the Government Banking Service	1	1
Cash and cash equivalents as in statement of financial position	**1**	**1**
Total bank overdrafts	**-**	**-**
Balance at 31 March 2023	**1**	**1**
Patients' money held by the clinical commissioning group, not included above	-	-

21 Non-current assets held for sale

The Integrated Care Board has no non-current assets held for sale to disclose for the 9 months ending 31 March 2023.

22 Analysis of impairments and reversals

The Integrated Care Board had no property, plant or equipment, intangible assets, inventories or financial assets during 2022-23. There were no impairments or reversals for the 9 months ending 31 March 2023.

23 Trade and other payables

	Current	Non-current	Current	Non-current
	9 months to 31 March 2023	**9 months to 31 March 2023**	3 months to 30 June 2022	3 months to 30 June 2022
	£'000	**£'000**	£'000	£'000
NHS payables: Revenue	5,425	-	170	-
NHS accruals	24,000	-	8,962	-
Non-NHS and Other WGA payables: Revenue	12,268	-	4,495	-
Non-NHS and Other WGA accruals	29,409	-	33,567	-
Non-NHS and Other WGA deferred income	25	-	53	-
Social security costs	237	-	263	-
Tax	203	-	197	-
Other payables and accruals	23,492	-	16,942	-
Total Trade & Other Payables	**95,059**	**-**	**64,648**	**-**
Total current and non-current	**95,059**		**64,648**	

Included above are liabilities of £0, for people, due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £1,049,113 outstanding pension contributions at 31 March 2023. This includes amounts related to GP pensions (£748,040) and outstanding contributions to the NHS Pension Scheme (£299,668) and NEST scheme contributions (£1,405).

24 Other financial liabilities

The Integrated Care Board had no other financial liabilities for the 9 months ending 31 March 2023.

25 Other liabilities

The Integrated Care Board had no other liabilities for the 9 months ending 31 March 2023.

26 Borrowings

The Integrated Care Board had no borrowings for the 9 months ending 31 March 2023.

27. Private finance initiative, LIFT and other service concession arrangements

The Integrated Care Board had no private finance initiative, LIFT and other service concession arrangements for the 9 months ending 31 March 2023.

28. Finance lease obligations

The Integrated Care Board had no finance lease obligations for the 9 months ending 31 March 2023.

29. Finance lease receivables

The Integrated Care Board had no finance lease receivables for the 9 months ending 31 March 2023.

30 Provisions

	Current	**Non-current**	Current	Non-current
	9 months to 31 March 2023	**9 months to 31 March 2023**	3 months to 30 June 2022	3 months to 30 June 2022
	£'000	**£'000**	£'000	£'000
Redundancy	-	-	118	
Continuing care	2,294	8	3,430	10
Other	460	-	283	29
Total	**2,754**	**8**	**3,830**	**39**
Total current and non-current	**2,762**		**3,870**	

	Redundancy	**Continuing Care**	**Other**	**Total**
	9 months to 31 March 2023 £'000	**9 months to 31 March 2023 £'000**	**9 months to 31 March 2023 £'000**	**9 months to 31 March 2023 £'000**
Balance at 01 July 2022	**-**	**-**	**-**	**-**
Transfer from other public sector body under absorption	118	3,440	312	**3,870**
Arising during the period	-	102	329	**431**
Utilised during the period	-	(29)	(1)	**(30)**
Reversed unused	(118)	(1,211)	(179)	**(1,508)**
Balance at 31 March 2023	**-**	**2,302**	**461**	**2,763**
Expected timing of cash flows:				
Within one year	-	2,294	461	**2,755**
Between one and five years	-	8	-	**8**
After five years	-	-	-	**-**
Balance at 31 March 2023	**-**	**2,302**	**461**	**2,763**

Continuing Care

The Integrated Care Board is responsible for liabilities, legal and financial elements relating to NHS Continuing Healthcare claims connecting to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups (1 April 2013). The total value of NHS Continuing Healthcare provision at 31 March 2023 is based on live claim cases, including appeals, and has been evaluated based on historical experience of claim success rates and average rates within the Integrated Care Board and legacy Clinical Commissioning Groups and is £31,189.

Under the accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the former Clinical Commissioning Groups. The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare claims relating to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups.

A provision has been included for Learning Disabilities Responsible Commissioner due to the unexpected and backdated costs. This assessment is based on historical experience and an average cost of a patient has been used to identify a provision value. It is estimated that £889,207 will be paid in less than a year.

The Integrated Care Board included a provision for Funded Nursing Care Continuing Healthcare as an estimate of likely costs of outcomes of Decision Support Tools. The historic success rate for each type of Continuing Health Care care been used alongside average costs of that care to identify a provision value. This previous provision was unused and was therefore reversed as it was no longer required by the Integrated Care Board.

A further provision of £1,381,302 has arisen in respect of historical VAT charges (2019 to 2021) relating to a key care provider that based on risk of these charges being settled has been provided for.

Other

A provision became arising of £290,000 due to the potential costs with vacating the Cross O' Cliff site. This includes removal fees and possible deep cleaning charges.

Other provisions include building works at primary care premises and contract challenges.

31 Contingencies

	9 months to 31 March 2023 £'000
Contingent liabilities	
Continuing Healthcare	160
Net value of contingent liabilities	**160**

The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare (CHC) claims for periods of care since the establishment of the Integrated Care Board and former Clinical Commissioning Groups. The Integrated Care Board has provided for the anticipated costs of continuing care claims (see Note 30 Provisions above) where it is probable that it will incur costs. Note 31 Contingencies discloses the difference between the estimated value of claims and the recorded provisions as £160,196 as at 31 March 2023.

Contingent assets

The Integrated Care Board had no contingent assets as at 31 March 2023.

32 Commitments

The Integrated Care Board had no capital or other financial commitments for the 9 months ending 31 March 2023.

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Integrated Care Board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Integrated Care Board and internal auditors.

33.1.1 Currency risk

The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Integrated Care Board has no overseas operations. The Integrated Care Board and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the Integrated Care Board and revenue comes parliamentary funding, the Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33 Financial instruments cont'd

33.1.4 Liquidity risk

The Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, as the need arises. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

33.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33.2 Financial assets

	9 months to 31 March 2023 Financial Assets measured at amortised cost £'000	3 months to 30 June 2022 Financial Assets measured at amortised cost £'000
Trade and other receivables with NHSE bodies	2,883	736
Trade and other receivables with other DHSC group bodies	2,267	6,473
Trade and other receivables with external bodies	1,568	855
Cash and cash equivalents	1	1
Total at 31 March 2023	**6,719**	8,066

33.3 Financial liabilities

	9 months to 31 March 2023 Financial Liabilities measured at amortised cost £'000	3 months to 30 June 2022 Financial Liabilities measured at amortised cost £'000
Loans with group bodies	-	-
Loans with external bodies	-	-
Trade and other payables with NHSE bodies	980	502
Trade and other payables with other DHSC group bodies	28,446	8,742
Trade and other payables with external bodies	65,527	55,295
Other financial liabilities	-	-
Private Finance Initiative and finance lease obligations	-	-
Total at 31 March 2023	**94,953**	64,539

33.4 Maturity of Financial Liabilities

For the 9 months ending 31 March 2023	Payable to Department of Health and Social Care Group £'000	Payable to Other Bodies £'000	Total £'000
In one year or less	29,426	65,527	94,953
In more than one year but not more than two years	-	-	-
In more than two years but not more than five years	-	-	-
In more than five years	-	-	-
Total at 31 March 2023	**29,426**	**65,527**	**94,953**

34 Operating segments

NHS Lincolnshire Integrated Care Board considers it has only one operating segment: commissioning of healthcare services

35 Joint arrangements - interests in joint operations

Information is disclosed in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

The 2022-23 pooled budgets are for Learning Disabilities, Child and Adolescent Mental Health Services (CaMHS), Proactive Care and Integrated Community Equipment Services (ICES). These budgets are predominantly hosted and managed on a day to day basis by Lincolnshire County Council, in instances where this is not the case the Integrated Care Board jointly host and manage. As a commissioner of healthcare services, the Integrated Care Board makes a contribution to the pool which is then used to purchase healthcare services. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement in line with the 2022-23 Group Accounting Manual and as defined in IFRS 11.

The pooled budget represents contributions to the areas of identified spend; it is quite likely that the respective organisations have spend relating to the schemes over and above these contributions.

All cash is transacted by all parties in the month concerned. There are no outstanding cash balances or liabilities at each period end for all organisations concerned.

Lincolnshire County Council is responsible for the production of memorandum accounts for the pooled budget. These will not be produced until after the publication of the Integrated Care Board's accounts.

The Integrated Care Board's share of the income and expenditure as handled by the pooled budgets for the 9 months ending 31 March 2023 were:

	NHS Lincolnshire Integrated Care Board	Lincolnshire County Council	Total Pooled Budget
	£'000	£'000	£'000
Income			
Section 75 - Proactive Care	-	(10,106)	(10,106)
Section 75 - Integrated Community Equipment Services	-	(3,242)	(3,242)
Section 75 - Learning Disabilities	-	(21,128)	(21,128)
Section 75 - Child and Adolescent Mental Health	-	(10,552)	(10,552)
Partnership Framework	-	(225)	(225)
	-	**(45,253)**	**(45,253)**
Expenditure			
Section 75 - Proactive Care	20,991	38,982	59,973
Section 75 - Integrated Community Equipment Services	3,242	2,994	6,236
Section 75 - Learning Disabilities	21,128	45,933	67,061
Section 75 - Child and Adolescent Mental Health	10,552	543	11,095
Partnership Framework	225	56	281
	56,138	**88,508**	**144,646**
Assets	**-**	**-**	**-**
Liabilities	**-**	**-**	**-**
Grand Total	**56,138**	**43,255**	**99,393**

36 NHS Lift investments

The Integrated Care Board had no Lift investments for the 9 months ending 31 March 2023.

37 Related party transactions

During the reported period none of the Governing Body Members or parties related to them have undertaken any material transactions with NHS Lincolnshire Integrated Care Board, other than those set out below (transactions identified were not with the member but between the Integrated Care Board and the related party).

Details of related party transactions with individuals for the 9 months ending 31 March 2023 are as follows:

Board Member	Related Party Name	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Dr James Howarth	Spilsby Surgery	1,750	-	-	-
Dr Majid Akram	The Deepings Practice	1,563	-	55	-
Dr David Baker	Vine Street Surgery	827	-	-	-
Dr Sunil Hindocha	Heart of Lincoln Medical Group	2,726	-	1	-
Total at 31 March 2023		6,866	-	56	-

The Department of Health & Social Care is regarded as a related party. During the reported period the Integrated Care Board had a significant number of material transactions with entities for which the Department of Health is regarded as the parent. For example:

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Arden and Greater East Midlands Commissioning Support Unit

Details of such organisations with whom the Integrated Care Board had contracts for the 9 months ending 31 March 2023 with are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Cambridge University Hospitals NHS Foundation Trust	3,332	35	3	-
Cambridge And Peterborough NHS Foundation Trust	985	-	15	-
Doncaster And Bassetlaw Hospitals NHS Foundation Trust	1,322	-	-	-
East Midlands Ambulance Service NHS Trust	27,564	-	32	-
Hull University Teaching Hospital NHS Trust	2,649	-	-	-
Lincolnshire Partnership NHS Foundation Trust	81,163	-	7	-
Lincs Community Health Services NHS Trust	82,603	265	391	145
NHS Arden And GEM CSU	6,557	-	10	-
NHS England	65	3,361	-	62
Norfolk & Norwich University Hospitals NHS Foundation Trust	769	-	-	-
North West Anglia NHS Foundation Trust	59,708	-	-	-
Northern Lincolnshire And Goole Hospitals NHS Foundation Trust	42,461	-	-	-
Nottingham University Hospitals NHS Trust	15,970	3	2	-
Nottinghamshire Healthcare NHS Foundation Trust	380	48	-	5
Royal Papworth Hospital NHS Foundation Trust	1,404	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	1,903	-	-	-
Sherwood Forest Hospitals NHS Foundation Trust	4,304	-	-	-
United Lincolnshire Hospitals NHS Trust	415,673	452	41	92
University College London Hospitals NHS Foundation Trust	622	-	-	-
University Hospitals Of Derby & Burton NHS Foundation Trust	2,039	-	-	-
University Hospitals Of Leicester NHS Trust	4,145	7	-	7
Total at 31 March 2023	**755,619**	**4,171**	**500**	**311**

In addition, the Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies, namely Lincolnshire County Council.

NHS Lincolnshire Integrated Care Board also has material transactions with all the GP Practices within its locality and membership.

The Integrated Care Board has not made any provision for doubtful debts for any of the above related parties.

38 Events after the end of the reporting period

There have been no post Statement of Financial position events which have had a material effect on these financial statements.

39 Losses and special payments

39.1 Losses

The total number of NHS Integrated Care Board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases	Total Value of Cases
	9 months to 31 March 2023	9 months to 31 March 2023
	Number	£'000
Administrative write-offs	2	90
Total Losses for the financial year	2	90

39.2 Special payments

The Integrated Care Board did not have any special payments during the 9 months ending 31 March 2023

40 Third party assets

The Integrated Care Board did not hold any third party assets during the 9 months ending 31 March 2023

41 Financial performance targets

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
NHS Lincolnshire Integrated Care Boards performance against those duties for the 9 months ending 31 March 2023 was as follows:

	9 months to 31 March 2023 Target £'000	9 months to 31 March 2023 Performance £'000	Duty Achieved?
Expenditure not to exceed income	1,233,381	1,244,937	No
Capital resource use does not exceed the amount specified in Directions	-	-	-
Revenue resource use does not exceed the amount specified in Directions	1,229,678	1,241,234	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	12,900	12,515	Yes

42 Impact of International Financial Reporting Standards

Please see Note 1.27

43 Analysis of charitable reserves

The Integrated Care Board did not hold any third party assets during the 9 months ending 31 March 2023.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Lincolnshire Integrated Care Board ("the ICB") for the nine-month period ended 31 March 2023 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 43, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023, and the Accounts Direction issued by NHS England in accordance with the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Lincolnshire Integrated Care Board as at 31 March 2023 and of its net expenditure for the nine-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Social Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the ICB's ability to continue as a going concern.

Other information

The other information comprises the information included in the Annual Report and Accounts for the period 1 July 2022 to 31 March 2023**,** other than the financial statements and our auditor's report

thereon. The Accountable Officer is responsible for the other information contained within the Annual Report and Accounts for the period 1 July 2022 to 31 March 2023

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2022 to 2023; or
- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the ICB under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended).

We have nothing to report in these respects.

In respect of the following, we have matters to report by exception:

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) ("the 2014 Act")

Under section 223GC(1) of the National Health Service Act 2006, an Integrated Care Board must ensure that expenditure incurred by the board in a financial year does not exceed the sums received by it in that year. For the purposes of our responsibilities under the 2014 Act, we have considered the ICBs statutory financial duties for the nine-month period to 31 March 2023.

NHS Lincolnshire ICB has reported a deficit of £11,556,000 against its Revenue allocation for the nine-month period to 31 March 2023.

We referred a matter to the Secretary of State under section 30 of the 2014 Act because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

Report on the ICB's proper arrangements for securing economy, efficiency and effectiveness in the use of resources

We report to you, if we are not satisfied that the ICB has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the nine-month period ended 31 March 2023.

On the basis of our work, having regard to the Code of Audit Practice 2020 and guidance issued by the Comptroller and Auditor General in January 2023, we have identified the following significant weakness in the ICB's arrangements for the nine-month period ended 31 March 2023.

Significant weaknesses in arrangements – Governance:

Issue

Through our attendance at Audit and Risk Committee, review of minutes and internal audit reports, we have identified that the ICB has not had a fully populated and functioning Board Assurance Framework in operation throughout the nine-month period to 31 March 2023.

Whilst it is acknowledged that as a newly formed organisation the ICB need to establish themselves and their views on risk, a populated BAF is a key document outlined in their governance and risk management arrangements to assess and consider the strategic risks, the sources of assurance, control gaps and mitigations to ensure they are making informed decisions.

Impact

We have identified that there is evidence to demonstrate that the ICB has had discussions on risk management and actions to respond to specific risks throughout the nine-month period.

However, in the absence of the Board Assurance Framework, the ICB has not been able to provide robust evidence to demonstrate that there is a framework in place to enable:

a. the Audit and Risk Committee to provide the Board with assurance on the effectiveness of the Board Assurance Framework; and
b. the Board to form a holistic view to assess and consider the strategic risks, the sources of assurance, control gaps and mitigations to ensure they are making informed decisions.

Action required to address the weakness

We recommend that the Board formalise the assurance processes by completing and approving the Board Assurance Framework for full implementation as a matter of priority.

Conclusion

This issue is evidence of weaknesses in proper arrangements for Governance;

- How the body monitors and assesses risk and how the body gains assurances over the effective operation of internal control, including arrangements to prevent and detect fraud; and
- How the body ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee.

We will report the outcome of our work on the ICB's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any further matters which we are required to report by exception.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on page 76, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant are the National Health Service Act 2006, Health and Social Care Act 2012 and Health and Care Act 2022, and other legislation governing NHS ICBs, as well as relevant employment laws of the United Kingdom. In addition, the ICB has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

- We understood how NHS Lincolnshire Integrated Care Board is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, head of internal audit, those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. This includes appropriate oversight of those charged with governance, a culture of honesty and ethical behaviour and placing an emphasis on fraud prevention, to reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment. We corroborated this through review of the ICB's board and committee meeting minutes, through enquiry of management, those charged with governance and employee's, review of the ICB's policies and through inspection of other information.

- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the ICB is engaging in any transactions outside the usual course of business. We also assessed the susceptibility of the ICB's financial statements to material misstatement in relation to the risk of fraud in expenditure recognition, specifically those entries and adjustments that over or under state expenditure accruals and prepayments balances at the period end.

- Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with governance, reading and reviewing relevant meeting minutes of those charged with

governance and the Board and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

- We addressed our fraud risk related to the overstatement/understatement of expenditure accruals and prepayments by undertaking testing to gain assurance over the completeness, existence and valuation of a sample of manual accruals raised outside the purchase order system and prepayments. We checked that criteria for recognition had been met and the estimate of the value was supportable with reference to underlying evidence. We also performed sample testing of expenditure cut-off and unrecorded liabilities to ensure that transactions had been recorded in the correct financial period.

- We addressed our fraud risk related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions. This included testing postings in the general ledger that fell outside of the standard transactions process flow.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in January 2023 as to whether the ICB had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the ICB put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the nine-month period ended 31 March 2023.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the ICB had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Qualified opinion in regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them, except for the incurrence of expenditure in excess of the specified revenue resource limit as set out in Note 40 to the financial statements.

The ICB has reported a deficit of £11,556,000 for the nine-month period to 31 March 2023.

We referred this matter to the Secretary of State on 28 July 2023 under section 30 of the Local Audit and Accountability Act 2014.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the nine-month period ended 31 March 2023. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the members of the Board of NHS Lincolnshire Integrated Care Board in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Ernst & Young LLP

Hayley Clark (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Birmingham

Date: 28 July 2023

Documents are available in different formats
e.g. large print, audio CD and other languages.

NHS Lincolnshire ICB
Bridge House
The Point
Lions Way
Sleaford
NG34 8GG

Telephone: 01522 573939

Follow us on Twitter
@NHSLincsICB

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www.lincolnshire.icb.nhs.uk

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