NHS
Lincolnshire
Integrated Care Board

MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD TO BE HELD ON TUESDAY, 22nd NOVEMBER 2022 BRIDGE HOUSE, THE POINT, SLEAFORD at 9.00 AM

Definition of a conflict of interest:

'A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold'.

A conflict of interest may be:

Actual	Potential
There is a material conflict between one or more interests.	There is the possibility of a material conflict between one or more interests in the future.

Interests fall into the following categories:

Financial Interests	Non-financial professional Interests	Non-financial personal interests	Indirect interests
Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.	Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career	Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.	Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

- **Financial Interests**: Could include for example:
  - A director, including a non-executive director, or senior employee of a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model.
  - A shareholder (or similar ownership interests), a partner or owner of a private or not for profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
  - A management consultant for a provider or
  - A provider of clinical private practice.

  This could also include an individual being:

  - In employment outside of the organisation.
  - In receipt of secondary income.
  - In receipt of a grant from a provider.
  - In receipt of any payments for example honoraria, one-off payments, day allowances or travel and subsistence from a provider.
  - In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
  - Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

- **Non-Financial Professional Interests**: This may, for example, include situations where the individual is:
  - An advocate for a particular group of patients.
  - A GP with special interests e.g., in dermatology, acupuncture etc.
  - An active member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually in itself amount to an interest which needs to be declared).
  - An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE).
  - Engaged in a research role.
  - Development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or
  - GPs and Practice Managers, who are Members of the Board or Committees of the ICB, should declare details of their roles and responsibilities within their GP Practices.

- **Non-Financial Personal Interests**: This could include for example, where the individual is:
  - A voluntary sector champion for a provider.
  - A volunteer for a provider.
  - A member for a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation.
  - Suffering from a particular condition requiring individually funded treatment.
  - A member of a lobby or pressure group with an interest in health and care.

- **Indirect Interests**: (as those categories are described above) for example:
  - Spouse/Partner.
  - Close relative e.g., parent, grandparent, child, grandchild, or sibling.
  - Close friend; or
  - Business partner.

  A declaration of interest for a “business partner” in a GP Partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP Partners, rather than by repeating the same information verbatim).

NHS
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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 22nd November 2022
Time: 9.00 am
Location: Boardroom, Bridge House, Sleaford

AGENDA

ITEM NUMBER		ACTION	ENCLOSURE/ VERBAL	LEAD	TIME
1. INTRODUCTION					
i)	Welcome and Apologies		Verbal	Sir Andrew Cash	9.00
ii)	Declarations of Interest		Verbal	Sir Andrew Cash	
iii)	Minutes of Meeting held on 27th September 2022 and minutes of the Annual Public Meeting held on 27th September 2022	Approve	Enclosures	Sir Andrew Cash	
iv)	Matters Arising, including Action Log	Note	Enclosure	Sir Andrew Cash	
2. CHAIR AND CHIEF EXECUTIVE UPDATES					
i)	Chair • Update and Overview	Note	Verbal	Andrew Cash	9.10
ii)	Chief Executive • Update and Overview	Note	Verbal	John Turner	9.20
3. KEY UPDATES					
i)	Public Health	Note	Verbal	Derek Ward	9.40
ii)	Healthwatch	Note	Verbal	Sarah Fletcher	9.50
4. CORE PURPOSE 1: HEALTH INEQUALITIES (tackle inequalities in outcomes, experience and access)					
i)	• Equity and Equality Lincolnshire Maternity and Neonatal System (LMNS)	Note	Enclosure	Sandra Williamson/ Sue Jarvis	10.00
5. CORE PURPOSE 2: HEALTH OUTCOMES (improve outcomes in population health and healthcare)					
i)	• Integrated Performance Report • Winter Plan	Note	Enclosures	Clair Raybould	10.15
ii)	Quality Section	Note		Martin Fahy	10.25

ITEM NUMBER		ACTION	ENCLOSURE/ VERBAL	LEAD	TIME
BREAK 10.35-10.50					
6. CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY					
i)	Finance Report	Note	Enclosure	Matt Gaunt	10.50
7. CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE (help the NHS support broader social and economic development)					
i)	Lincolnshire System Greener NHS Plan	Consider	Enclosure	Sarah Connery	11.00
8. GOVERNANCE					
i)	Report from the System Quality and Patient Experience Committee meeting held on the 13th October 2022 - Approve the amended Terms of Reference	Receive	Enclosures	Jonathan Van-Tam	11.20
ii)	Report from the Service Delivery and Performance Committee meeting held on the 19th October 2022	Receive	Enclosure	Dawn Kenson	11.25
iii)	Report from the Primary Care Commissioning and Delegated Functions Committee meeting held on the 19th October 2022	Receive	Enclosure	Dr Gerry McSorley	11.30
iv)	Report from the Finance and Resource Committee meeting held on the 24th October 2022	Receive	Enclosure	Julie Pomeroy	11.35
v)	Report from the Audit and Risk Committee meeting held on 14th November 2022	Receive	Enclosure	Margaret Pratt	11.40
9. DATE, TIME AND VENUE OF NEXT MEETING					
	Tuesday, 20th December 2022 at 9.00 am at Bridge House, Sleaford	Note	Verbal	Sir Andrew Cash	11.45 close

Please send apologies to: Jules Ellis-Fenwick, ICB Board Secretary via email at: julieellis1@nhs.net

The items on this agenda are submitted to the Board for discussion, amendment and approval as appropriate. They should not be regarded, or published, as organisation policy until formally agreed at a Board meeting at which the press and public are entitled to attend. Papers are available on the ICB **website at** www.lincolnshire.icb.nhs.uk In case of difficulty accessing the papers, please contact **–** julieellis1@nhs.net

Special Resolution
The Board will be asked to consider the following resolution:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest' - (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)
Items in the private part of the meeting are either commercial in confidence or relate to individual staff and patients.

NHS
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MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD MEETING HELD ON TUESDAY 27TH SEPTEMBER 2022 AT 9.00 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Sir Andrew Cash	Interim ICB Chair
	Dr Dave Baker	Interim Partner Member, Primary Medical Services
	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mrs Sarah Connery	Executive Board Mental Health Member
	Mrs Maz Fosh	Partner Member, NHS & Foundation Trusts
	Mrs Dawn Kenson	Non-Executive Member, Chair of Service Delivery and Performance Committee
	Mr Martin Fahy	Director of Nursing
	Dr Gerry McSorley	Non-Executive Member, Chair of Primary Care and Delegated Functions Committee and Remuneration Committee
	Mrs Julie Pomeroy	Non-Executive Member, Chair of Finance and Resource Committee
	Mrs Emma Rhodes	Associate Director of Finance (Deputising for Mr Gaunt)
	Mr John Turner	Chief Executive
IN ATTENDANCE:	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mr Steve Clapton	Locality Lead – Vaccination Programme
	Mr Andy Fox	Public Health Representative
	Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mr Dean O'Dell	Healthwatch Representative
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
APOLOGIES:	Mrs Sarah Fletcher	Healthwatch Representative
	Mr Matt Gaunt	Director of Finance
	Dr Sunil Hindocha	Interim Medical Director
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mr Pete Moore	Non-Executive Member, Chair of Audit and Risk Committee
	Professor Sir Jonathan Van-Tam	Non-Executive Member, Chair of Quality Committee
	Professor Derek Ward	Public Health Representative
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board

22/25 WELCOME AND INTRODUCTIONS

Sir Andrew Cash welcomed all those present to the NHS Lincolnshire Integrated Care Board and confirmed the meeting was quorate.

Sir Andrew Cash emphasised that whilst the meeting was being held in public it was not a public meeting.

The meeting was being held both on a face to face basis and via Microsoft Teams as a Live Event. This arrangement had been put in place to enable members of the public or staff to either attend and observe the meeting in person or digitally through MS Teams.

Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma which was published on the website. The Questions and Answers facility had also been made available during the Board meeting as part of the live event.

Any questions submitted would be responded to after the meeting subject to inclusion of name and contact details. Questions will be published on the ICB website in future along with the response in terms of being open and transparent.

It was noted that one question had been received prior to today's meeting and that would be responded to by Mr Turner as part of his briefing.

The Board agreed to:

- **Note the briefing.**

22/26 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

Sir Andrew Cash reminded the Board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB.

Declarations made by members of the Board are listed in the ICB's Register of Interests. The Register is available either via the ICB Board Secretary or the ICB website.

Declaration of Interest from Committees:
No items declared.

Declarations of Interest from today's meeting:
No items declared.

The Board agreed to:

- **Note no interests were declared.**

22/27 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 26th July 2022 and agreed to:

- **Approve the minutes as a true and accurate reflection of the meeting.**

22/28 MATTER ARISING

Sir Andrew Cash presented the Action Log as included in the pack of papers. There was one action which was identified as delivered.

The Board agreed to:

- **Note the action log.**

22/29 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Sir Andrew Cash advised that the Chair and Chief Executive update and overview would be reflective of current national, regional and Lincolnshire viewpoints. The following points were highlighted:

- Following the sad death of Queen Elizabeth II, Her Majesty's funeral was marked by a public holiday in the form of a Day of National Mourning, as a mark of respect which took place on Monday, 19th September 2022. Sir Andrew Cash expressed his appreciation to those staff members who maintained services over the over the bank holiday.

- The country has a new Prime Minister and Secretary of State for Health, namely Liz Truss and Terese Coffey. They have both given an indication of their emerging priorities and further detail would be provided by Mr Turner under his briefing.
- The first Lincolnshire quarterly Non-Executive Directors meeting involving the ICB, and provider organisations was held on 26th September 2022 and was well attended. The key purpose of these events is to provide an open forum whereby views can be expressed, debated and aligned on system priorities. Deep dives into specific subjects will form part of the agenda going forward. Mrs Elaine Baylis, ULHT/LCHS Joint Chair had agreed to produce a paper setting out how the ICB and provider NEDs will work together going forward. Chief Executive colleagues also joined the meeting and will continue to do so going forward.
- The NHS Lincolnshire CCG final Annual Public Meeting was held on the 26th September 2022. Sir Andrew Cash expressed his appreciation to the former Lincolnshire CCG Board Members, some of whom who have gone forward with the ICB including Dr Gerry McSorley. Appreciation was also expressed to the CCG staff.
- Sir Andrew Cash would be Chairing the next meeting of the Lincolnshire Leaders Group, which was scheduled to take place on Wednesday, 28th September 2022. There would be a discussion on system priorities.
- Sir Andrew Cash and Mr Turner had received a letter from senior primary care colleagues on the 31st August 2022 about completing the establishment of the new clinical leadership arrangements. The letter has been responded to and various meetings have taken place and there are now actions in place to get those clinical leadership arrangements resolved in the immediate future.
- The Lincolnshire Civic Day was scheduled to take place on the 30th September 2022 at Lincoln Cathedral, which Mrs Dawn Kenson, Non-Executive Member will be attending on behalf of the ICB Board.

There were no questions received so Sir Andrew Cash moved to the Chief Executive update and overview.

Chief Executive update

Mr Turner advised that he had a number of points to highlight as followed:

In her first interview as the new Secretary of State for Health and Social Care, Terese Coffey detailed the 'Plan for Patients' which set out a number of measures relating to the ABCD approach which are four priority areas of focus

- Ambulances - handovers delays and reduction in waiting times (A)
- Backlog (B) – reducing elective waiting times
- Care (C) - £500 million adult social care discharge fund for this winter
- Doctors and Dentists (D) – greater access to GP appointments and changes to the dental contract.

This has raised expectations in terms of NHS performance and focus on these immediate priorities. These reflect the priorities of the public and are all areas very familiar to Lincolnshire and the ICB and system wish to get right for the population.

In terms of the assessment of current performance, Lincolnshire has been and remained really quite challenged around ambulance handover delays. Whilst the Lincolnshire system is far from being the most challenged in terms of performance across the country, the current position is unsatisfactory. The care being provided to patients is not at the level it should be. There is a considerable amount of work being undertaken with with system partners needs to continue to do to address performance, specifically around ambulance handovers. Updates would be provided to the Board on a regular basis.

In terms of recovery and addressing the elective backlog catch-up, Lincolnshire is one of the best performing systems, not just in the Midlands region but in the whole of the country.

Lincolnshire was one of the first systems to address the 104 week wait target and has made really good progress with achievement of the 78 week target. There are a considerable amount of challenges associated with this, but the current position is positive, although it was acknowledged there is a long way to go.

Cancer is also another challenging area, particular colorectal which remains a specific area of concern. A considerable amount of work has been undertaken to address this, and Mrs Raybould would provide further information as part of her performance update. In the round performance is fairly good but this area adds up to about 50% of all backlog challenges currently in the system.

In terms of care the ICB has been working very closely with colleagues in adult and social care to resolve issues with discharge and flow for some time now. As referred to by Terese Coffey £500m has been made available for the adult social care discharge fund, although no details had currently been provided as to how this will be deployed across the country and the associated expectations. It was hoped further details would be provided in short order. The ICB will be working with colleagues in adult and social care on how best to deploy that.

In broad terms the Lincolnshire population is approximately 1.5% of the total population in the country, which would amount to £7.5m out of the £500m which represents a fairly considerable investment being made which it was understood was on a non-recurrent basis.

In respect of GP appointments and looking at the 82 general practices in Lincolnshire, the overall performance is reasonably good with approximately 50% of patients being seen on a face to face basis and able to access same day appointments. Performance was also better than pre-pandemic levels and compared variably to other parts of the county. However, it was acknowledged that some practices had issues with performance and were struggling, compared to others who were some of the best performers in the country. Consideration needs to be given on how best to work with those practices who are struggling to provide appropriate support.

Lincolnshire has a massive challenge currently in terms of access to dental services and those difficulties increase in the east of the county.

Mr Turner referred the Board to the pack of papers circulated for the meeting and advised that he had included a letter received from NHS England summarising the discussion and outcome of the latest Quarterly System Review Meeting (QRSM) which took place a few weeks previously. The letter contained a considerable amount of positive noise and encouragement and acknowledgement and appreciation for the continued hard work demonstrated by the team.

Mrs Raybould was leading the process across the whole of the system to develop the Winter plan and excellent progress was being made. This would no doubt be referred to in further detail by Mrs Raybould under her update later in the meeting.

All of the above areas referred to would continue to have a sharp focus for the ICB and its system partners over the next six months.

There were a few other points to share:

- The provider collaborative stocktake review is now complete, and actions were now being progressed. It was now evident that the ICB Board will need to accommodate People and Digital within its frame and the logistics of how that will work is being considered. It was anticipated that piece of work will be completed by the time the Board has its planned Development Session on the 1st November 2022.
- A review of the structure of NHS provision in the county had commenced and the narrative and the Terms of Reference had been shared with the Board. This was at a very early stage in the process, but the Board would continue to be kept informed of developments.

- NHS England were continuing to work through the details of how they are going to reduce their headcount by 30-40% and their new operating model. ICBs will potentially be requested to take on more responsibilities alongside Pharmacy, Ophthalmology and Dentistry (PODs) and specialised commissioning which the Board was already aware of and Mrs Williamson was leading that process.
- The COVID and flu vaccination programme was now in full flow and had started off really well, primarily due to a huge team effort by everyone involved. Caroline Johnson, MP for Sleaford and North Hykeham and now the junior health minister had expressed an interest in visiting one of the sites in the next few weeks.
- The ICB Executive Team had met the previous week and had considered a paper in relation to the work being carried out with the Armed Forces. The Executive Team had agreed to sign up to the Armed Forces Covenant, which the predecessor Lincolnshire CCG had also supported. In addition it had been agreed to sign up to the Defence Employers Recognition Scheme which the three Trusts in Lincolnshire are signed up to and a range of actions in relation to that was also discussed. There is already a considerable number of support mechanisms in place for military families and veterans in the county. Mrs Connery is the Midlands region lead for veterans mental health. well.
- Touching on the letter referred to by Sir Andrew Cash in relation to the development of the clinical leadership arrangements, Mr Turner advised that he had regular meetings with the Chairs/Medical Directors of the four Professional Care Committees (referred to as the Four Pillars meeting) and this involves Dr McSorley, Mrs Mills and Mrs Williamson. The letter was touched upon at the recent meeting. Dr McSorley and Mr Turner would be meeting with senior primary care colleagues in the coming weeks to set out progress in response to that letter.
- The next Board Development Session is scheduled to take place on the 1st November and all of the actions previously agreed in relation to the IMPOWER work continued to be progressed.
- The first meeting of the Integrated Care Partnership (ICP) would be taking place later that day (immediately after the Health and Wellbeing Board meeting). Part of the focus of the meeting will be on the development of the Interim Integrated Care Strategy which has to be finalised by the end of December 2022.
- The ICP would be holding their Development Session on the 2nd November 2022.

Sir Andrew Cash thanked Mr Turner for his comprehensive update acknowledging the key operational delivery aspects for the ICB both now and going forward. It was essential to improve performance and outcomes for patients which would require a continued focus on areas such as cancer backlog (specifically colorectal), ambulance handover delays and the financial position.

Dr Baker referred to access to primary care and advised that overall Lincolnshire performs very well compared to some areas in the country, although it was acknowledged there are some pockets where there are challenges. The large majority of practices will not have an issue in meeting the targets set out by Terese Coffey, but some may struggle.

In respect of the COVID and vaccination programme, as referred to by Mr Turner this had started off well although there were some early indications the take-up was lower than expected in some cohorts such as healthcare support workers which was disappointing. The take-up by care home residents and older people was however reasonably good with some now having their fifth booster, which was very positive.

Mrs Pomeroy asked whether work was being carried out to tie both the flu and COVID vaccines in together, particularly in light of the indications from the southern hemisphere that they have had a particularly bad flu season, and this is normally reflected across the rest of the world. Dr Baker advised that provision of both vaccines at the same time is logistically quite difficult to carry out. 90% of flu vaccinations are provided in practices and for example on a typical Saturday around 800 flu vaccines would be provided in his practice.

If this was tied in with the COVID vaccine the numbers would be significantly reduced as some of the systems and questions associated with the provision of the COVID vaccine take several minutes to get through; it is much simpler with the flu vaccine. In short it is just not practical.

Ms Fosh advised that the position for NHS staff was slightly different as they were being offered the opportunity to have both together to encourage the workforce to take up both as much as possible.

Mr Fahy advised that in terms of flu the previous year performance was extremely good with about 86% of staff having the vaccine. There around 30,000 slots available at ULHT across all partners, so there is very good provision. The aim is to achieve around the same figures this year. Mr Fahy added that he supported Dr Baker's point in respect of the logistics in the provision of both vaccines – the delivery mechanisms are very different between flu and COVID.

The Board Members commended the 86% achieved last year, which compared very positively to other areas they were familiar with.

Mrs Kenson referred to the letter received by NHS England following the latest QSRM, the tone of which was really quite positive, and asked whether these were likely to continue. Mr Turner advised that the QRSM's form part of the new assurance and oversight framework and they have been in place for a number of years. Some of the early meetings which took place a few years ago were very different and definitely not so positive. There now appeared to be a growing confidence in how Lincolnshire was working and performing, but there should not be any doubt the ICB, and the Lincolnshire system has some very difficult performance challenges to address. The ABCD measures will form part of the assessment by NHSE going forward and will form a key focus for the performance report going forward.

Mrs Pomeroy suggested that the performance report and key papers going forward should be structured around the ABCD measures and delivery of those. Mr Turner advised that it will be essential to keep a sharp attention on those measures but alongside other performance measures as a whole, such as mental health, learning disabilities and autism. The position to date will be highlighted by Mrs Raybould as part of the presentation of the Performance Report.

On a final note Mr Turner referred to the question which had been received from a member of the public prior to the meeting – namely Mrs Mary Read. The question was submitted in writing in relation to neurology services and the priority the ICB is giving to this. The Board was asked to note the letter which raised some really important points. Mr Turner would respond to Mrs Read on behalf of the Board and suggest a conversation takes place with her about the concerns raised.

Mrs Mills added that there is an on-going conversation with Mrs Read and also colleagues at the Neurological Alliance which is a support group for people living with neurological conditions. The issues raised by Mrs Read were a prompt to the absence of reference to neurology services within the Joint Strategic Needs Assessment (JSNA). There are considerable variances in this service offer across the county which is partly due to legacy reasons in relation to how the previous four CCGs commissioned and developed this service. The development of an integrated community service provision would be key going forward for this particular client group.

In respect to the point Mrs Read raised about people affected by traumatic head injury, there is currently no clear strategy for this, and patients do have to travel a long way to get rehabilitated back into the county. This will need to be reviewed by working closely with mental health colleagues.

The Board agreed to:

- **Note the Chair and Chief Executive updates including supporting enclosures.**

22/30 KEY UPDATES

Public Health

Mr Andy Fox provided a verbal update from the public health perspective and highlighted the following points:

- The number of cases of COVID-19 peaked in July. In Lincolnshire the peak happened towards the end of July. Since then the numbers of cases had dropped significantly and there had been a declining picture in terms of the number of cases detected which was reassuring. It should be noted though that the number of people testing was not at the same levels as it was in previous peaks.
- There was now an increasing pattern of COVID-19 which is expected moving towards the Autumn and Winter and it is anticipated there will be a growth phase with this spreading again. The latest figures appeared to be trending upwards again, although they were still relatively low.
- Local data measures were also indicating a slight increase as well in the number of cases of influenza.
- In recent winters there had not really been a significant flu wave and that had been the same position in the Southern hemisphere. However, they had recently seen a lot of flu activity. A similar picture may happen in the Northern Hemisphere although there were no indications of that to date. In terms of the respiratory data which tests samples there had been prevalence of flu A detected so there were some early signs this could translate into a significant flu season, but the numbers were still low and had not crossed any of the thresholds.

In respect of specific areas of work taking place in Public Health, the following areas were highlighted:

- The team is working with Dr Hindocha, Interim Medical Director and the Clinical Care directorate to look at risk in the urgent and emergency care pathway, specifically related to the flu and the COVID-19 waves and the associated pressures that would bring. Some research is being carried out looking at the literature around this. Early indications suggest this is normally population behaviours which result in the specific timing of peaks through the winter period. These aspects are relatively predictable and are likely to demonstrate when peak days of activity will appear purely based on population behaviour.
- There has been further significant investment from the government for substance misuse services and work to implement that is underway in Lincolnshire and has been for some time. The Public Health team is currently looking towards a contract end date in June 2024 for the integrated lifestyle service. Early conversations are due to commence around the re-commissioning process for that key preventative service for Lincolnshire and as part of that work is taking place to look at a two year pilot for child and family weight management service which forms part of health inequalities duties.
- Professor Ward is continuing to work across the three Lincolnshire authorities and looking for further decisions in the next few months around the direction of that programme.

The Board considered the verbal update. Mrs Raybould provided some context in terms of the number of COVID cases and advised that the previous month there had been 40 patients in Lincolnshire hospitals beds. As of today that number was 82 which demonstrated an increasing trend upwards. A similar position was being seen at LPFT and it was really important to get this message across in communications out to members of the public in respect of having their boosters. COVID is still very much around.

Mr Fahy referred to the southern hemisphere and asked what the intelligence was currently indicating. Mr Fox advised that South Africa as an example have seen a wave of flu through their winter although this was not on the same scale seen in previous years. However, globally flu may be on the rise which is likely to impact on the North.

Dr Baker referred to the recommissioning of the integrated lifestyle service and asked whether consideration is being given to look at Tier 3 and Tier 4 weight management services which is lacking in Lincolnshire. Mr Fox advised that Tier 3 and Tier 4 were not at present part of the review of the service as these were generally clinically based. However, in terms of the lifestyle service conversations will be held as the ICB is the lead commissioner and it is a key preventative service for Lincolnshire. A process will be undertaken to establish what is the ambition for this service and potentially consideration of an alternative way to provide this as it may sit better elsewhere.

Sir Andrew Cash asked whether Public Health have to bid nationally for the substance misuse funding. Mr Fox advised that this is a national allocation per capita. Lincolnshire has a ring-fenced Public Health grant and there are certain requirements regarding delivery of specific services and substance misuse support is one of those. There has been an increase in investment for rolling out substance misuse support services in recent years which has translated into significant expansion of service delivery over the next 3-4 years. This does provide the opportunity to have a conversation about other elements that sit elsewhere, and Public Health and the local authority are looking at inflationary pressures and what that might mean for service provision going forward.

Sir Andrew Cash thanked Mr Fox for his update. As there were no questions received the Board moved on to the Healthwatch update.

Healthwatch

Mr O'Dell provided a verbal briefing and highlighted the key themes received by Healthwatch in the last month as follows:

Dental Services - NHS Dental Countywide:- Very prominent patient experiences with dental access and being able to be placed on a list. Many are now not accepting patients on waiting lists. Many patients are unable to fund private dental care. One dental practice is no longer seeing NHS patients and those who were on the NHS List are now having to look for alternative options, where there are none available. Healthwatch is supporting a piece of work on the development of the Lincolnshire Dental Strategy which Mrs Williamson is involved in to get a better understanding of what is available in Lincolnshire and to identify any gaps.

Healthwatch is about to launch a campaign on Improving Dental Services across Lincolnshire in response to the number of poor experiences shared by residents of Lincolnshire of Dental Service.

Communication – getting through to surgeries in the first instance, keeping patients informed about progress (including sharing of information), lack of sharing of information between professional especially if the patient receives treatment out of county.

Wheelchair assessments – Healthwatch had been made aware through patient feedback that they have to travel for their assessment; this used to be carried out in their homes. This in turned raised issues around inequalities and the reason given was the change had been made in response to the increase in petrol prices.

Mr Turner provided a short summary of the work taking place in respect of dental services to both understand the position in terms of dental access in the county and how these can be addressed, adding that NHS England still technically remain responsible for dentistry.

However, a group has been established to look at this and Mr Turner is in regular dialogue with the NHSE dental lead and has had number conversations about dental access. The intention is to bring a detailed update to the Board within the next few months.

Mr Turner added that the NHSE regional dental lead during the last discussion referred to a golden hello scheme which is being promoted across the Midlands and had received a really positive response with approximately 30 expressions of interest from people wanting to come and work in Lincolnshire. Further details on the extent to which those expressions of interest have materialised could be included in the update for the Board.

Mr Turner referred to GP access and advised that he is regularly made aware of issues by patients with telephone access for Lincolnshire practices but added that many patients choose to access services digitally. That aside Mrs Mills had been asked to carry out a piece of work to look into and get a granular understanding of the performance of each of the ICB's 82 practices such as assessing how long they take to answer the telephone. The outcome of that piece of work will be presented to the Board in due course.

As referred to by Dr Baker earlier in the meeting, overall performance with GP access in the county is relatively good but Mr Turner acknowledged there are some areas where some focused attention is required.

In respect of the concerns raised about the lack of sharing of information, particularly for patients receiving out of country treatment, it would be helpful to receive the specific details so these could be looked into, which was noted by Mr O'Dell.

Mrs Raybould referred to Wheelchair assessments and advised that the current provider has are two types of assessment which are carried out; some are home based but others have to be actioned in the centre due to the specialist nature of their assessment. Mrs Raybould asked if Healthwatch could share the specific detailed then this would be looked into, which again was noted by Mr O'Dell.

In response to the aspect about patients not getting feedback from their consultants about where they are on the waiting list, a considerable amount of work had been carried out on this area with Healthwatch including providing information on the ICB website including on the 'Waiting Well' initiative, but it was acknowledged there may need to be some awareness raising carried out in relation to this.

Dr Baker referred to GP telephone access and acknowledged that there are solutions coming out in primary care which will make huge difference whereby patients who can use digital systems they will be able to book directly into the system and not have to ring the practice. These types of systems are coming on stream very rapidly and could implemented across the Lincolnshire practices very quickly. His practice for example would be trialling this over the next few weeks. Mrs Mills supported Dr Baker's comments and added that it is key to assess what is going through the telephone lines and what alternatives are available to release some of that capacity.

Councillor Bowkett advised that the wheelchair service will be coming into the Lincolnshire Community Equipment Service in the future.

Sir Andrew Cash asked that the four points raised (two under communication) were recorded on the action log, which was noted by Mrs Ellis-Fenwick.

Action: Mrs Ellis-Fenwick

Following some further comments Sir Andrew drew the discussion to a close and thanked for Mr O'Dell for his update.

The Board agreed to:

- **Note the verbal updates.**

CORE PURPOSE 1: HEALTH INEQUALITIES

22/31 COVID VACCINATION UPDATE – HEALTH INCLUSION APPROACH

Mrs Williamson introduced the next item and advised that the purpose of the report shared with the Board was to highlight all the partnership work and the approach that has been taken to the COVID-19 vaccination programme with the sole purpose of achieving as higher an uptake as possible across all communities in Lincolnshire. The focus of the report is with a lens on health inequalities. As referred to by Mr Turner under his briefing, really good progress has already been made since the programme was launched.

Mrs Williamson handed over to Mr Clapton at this point, who introduced himself for the benefit of the Board members and those listening into the meeting.

Mr Clapton provided a presentation entitled Vaccination Health Inclusion Strategy for areas of low uptake. The following points were highlighted for the Board's information:

- Strategy
- Objectives and Tasks
- Data
- Key Primary Findings
- Success Criteria
- Next Steps

Sir Andrew Cash thanked Mr Clapton for his thorough presentation and asked whether there were any comments. Mr Fox commended the work undertaken to date and advised that some of this needs to be used and disseminated across the system in terms of that learning around how to engage with specific population groups.

Councillor Bowkett advised that it would be helpful to receive more information on when local facilities are available, such as the vaccination bus which moves around the county. Whilst it was acknowledged this information is available on line not all people access things digitally – this is about raising awareness through all available routes. This was noted by Mr Clapton to take forward.

Mrs Kenson advised that the work to date was extremely impressive and asked whether there is a system in place which captured information on how people received their communication and what prompted them to attend for their vaccination. Mr Clapton advised this had been carried out over the Summer with quite mixed results; there were no clear themes.

Mr Fosh reiterated the comments about the presentation, which was very interesting. It was good to see where this started and what information is now known. The next stage is how that is disseminated and captured in a way that can be taken forward in the provider organisations in terms of public and patient engagement and lifelong learning.

Mr Fahy outlined the level of communication and various routes applied to raise awareness of the vaccine programme, which was extremely vast and widespread. Digital does not work for everyone and as such other options were considered, such as the provision of handmade signs, which some staff did themselves to raise awareness. Live radio briefings also took place two to three times a week. In short outreach is why it worked - the NHS going out into communities. However, there is considerable resource associated with that. As referred to by Mrs Fosh there are wider opportunities to capitalise on wider conversations to synergise as much as possible.

The national model this year does not lend itself particularly well and the same level of resource is not available to run the bus in the same way as previously. However, we have now crossed the 50,000 threshold and therefore off to a good start.

Mrs Blyth added that the Communications and Engagement Team do look to measure communications and that it clearly much easier to assess where it is direct through social media but there is an acknowledgement that this is a mixed bag, and everyone will come forward through a broad range. In terms of getting that feedback out across the county as a whole, there are a number of mechanisms and provided some examples. The mechanisms are there but can be improved.

Mr Fox advised that he had held several discussions with Mrs Williamson in terms of getting the learning out across the system. This is being looked at in terms of the wider determinants of health and the reasons these produce inequalities in health. That piece of work is on-going.

The ICB Board agreed to:

- **Note the report and the actions being undertaken.**

Sir Andrew advised that there would be a 10 minute break at this stage. The meeting was therefore suspended at 11.30 am and recommenced at 11.41 am.

22/32 KINGS FUND EXPRESSION OF INTEREST – INCLUSION HEALTH FROM DAY ONE

Mr Fox advised that the Lincolnshire Integrated Care System has been chosen by The King's Fund as one of seven systems nationally to participate in a series of learning events (Action Learning Sets) focused on 'Inclusion Health' Groups. Lincolnshire ICS is the only one from the Midlands region to be asked to participate.

There will be a programme of six Action Learning Sets running through the winter into Spring 2023, which will be facilitated by the King's Fund and by leading national third sector organisations Pathway and Groundswell, who both have significant experience in working with excluded populations and homeless populations respectively. All six will focus on a specific theme.

The first event was held on Friday the previous week and was well attended. The King's Fund will issue a final report privately to participants; reflecting the intentions of participants, identified enablers and inhibitors to success, and lessons from the programme which might have wider application. This will be framed in such a way as to be of use in developing local documents & strategies.

It is proposed that a Lincolnshire System working group be created to oversee the engagement with the King's Fund work and to provide oversight of implementation of any recommended and agreed actions for the system, which was supported.

The Board agreed to:

- **Note the report.**

CORE PURPOSE 2: HEALTH OUTCOMES

22/33 INTEGRATED QUALITY AND PERFORMANCE REPORT

Performance Section

Mrs Raybould presented the latest version of the Integrated Quality and Performance Report and advised that she would highlight the key points from the performance section; Mr Fahy would cover the quality section. Some of the key areas had already been covered earlier in the meeting so those would not be referred to in great detail.

As advised at the last meeting the format and content of the report would continue to be further refined as System and Delivery Performance Committee becomes more established.

The data in the pack is for July/August but Mrs Raybould would refer to live data where that is available to supplement the content. The areas of significant concern do all fall into the same categories as the new Secretary of State for Health and Social Care had announced (ABCD) and those would be covered in the update under that context.

A – ambulance handovers: These are often a barometer of Urgent and Emergency Care (UEC) pressures across the whole pathway - from primary care right the way through to secondary care. The Board will be able see from the performance data is that ambulance response times locally are not meeting the standard and are not where we would expect them to be. This is mostly a direct outcome of delays handling over at acute hospitals, both in Lincolnshire and out of Lincolnshire (as in the North of the county). This is largely due to Emergency Departments (EDs) being overcrowded and an outcome of poor discharges for medically fit patients and poor flow in the hospital. On top of that that are far too many patients being conveyed to hospital or patients attending Emergency Departments (ED) that do not need acute level care which also places pressure on the hospital. There needs to be a reset in respect of all the non-conveyance pathways before the winter period commences.

The report set out a number of actions to address these issues. There is an Immediate Handover Policy for Category One calls. This relates to where calls should be responded to within seven minutes which overall is not generally an issue within Lincolnshire but there had been a few days recently where this had not been achieved and the escalation process has not worked. A review and learning process was being undertaken to understand that.

There is also an Ambulance Handover Trajectory Plan to eradicate 60-minute handover delays by the end of November 2022. The current position is off trajectory, and an Ambulance Task and Finish Group has been established to help understand the issues.

Linked to that is the work being undertaken on winter planning which will need to take into account making best of the non-conveyance pathways and making sure discharge is being optimised.

B - Backlogs (largely as a result of the COVID-19 pandemic): There is a mixed picture in terms of performance with both some good and poor areas. In terms of the 104 week waits that trajectory continues to be met and as referred to by Sir Andrew Cash at the previous Board meeting this is an area the ICB must not go back on, and that trajectory continued to be met. There were four patients who breached that at the end of September due to patient choice or complex pathway issues. There were not any breaches for capacity reasons in Lincolnshire in line with the target set in June.

There are 24 104 week patients in other providers outside of Lincolnshire, although that data was unvalidated as of the previous day. Again these are primarily due to patient choice or complex pathway issues but also included some in relation capacity issues. The ICB is working closely with those systems to get those reduced in terms of Lincolnshire patients.

In terms of 78 week waits, as previously referred to the pledge is to achieve zero by the end of March 2023 and delivery of that target is on trajectory and indeed slightly ahead.

Out-patient activity is the biggest challenge in respect of backlogs with 90% of the waiting list being people who require an appointment. This is generally one of the first areas which is affected when the shift in focus moves to urgent and emergency care. In respect of the improvement programmes this is one area that has been affected the most and has also been adversely affected by the infection prevention and control guidance which hospitals have to comply with, such as social distancing.

Cancer – this had already been referred to earlier in the meeting. There is significant focus on 62 day performance of which colorectal makes up to 60% of the backlog. The numbers have increased from those detailed in the pack mainly due to the August holiday period and were over the 600 mark. As a result daily colorectal recovery meetings have been put in place which are led by the Director of Operations for ULHT. Those numbers have now reduced to around the 500 mark, but high levels of referrals are being seen with sometimes over 100 being received each week. There is not sufficient capacity to deal with those numbers and deal with the backlog. A whole range of actions were outlined in the pack which detailed the work being undertaken to address this such as the FIT pathways which is used in primary care and helps stratify patients.

There was also a focus being maintained on other tumour sites as well as there is 40% backlog in other areas. The Cancer Board was meeting that day and would be carrying out a further deep dive on that.

This is a real challenge, and it will take time to get through the backlog, but good support is being provided by Dr Hindocha, the clinical directorate and clinical leads. The ICB does remain in Tier Two which is the oversight nationally. Mr Turner joins the team on the regional calls each week.

In terms of diagnostics, the Community Diagnostic Centre in Grantham opened in April 2022 and has now seen 21,000 appointments, which is really positive news. There are still some challenges with diagnostics, but the ICB is in a much better position than other areas.

The primary care backlog had been referred to earlier in the meeting so would not be covered in great detail but was now back to pre-pandemic levels in terms of access.

Mental Health – this was now starting to show signs of recovery in terms of two week Early Intervention Psychosis (EIP). Mrs Connery added that LPFT had achieved the target in August and performance was now back on track.

Out of Area placements – the system was performing very well in this area and Lincolnshire is now being held up nationally as an example of best practice, which was really good news.

Children and Young People (CYP) – there is a continued focus on this area and a real increase in demand for those services coming out of the pandemic is being seen and is a challenge.

C Care: Having robust social care provision is absolutely key to improving discharge. The ICB is aware that providers are really struggling to recruit in Lincolnshire. There is a significant amount of on-going joint work taking place between Lincolnshire County Council, health providers and the provider collaborative to improve discharge capacity and that is bearing green shoots. The announcement of the Winter Discharge Fund is very much welcomed.

D – Doctors/Dentists: Access to GP data is in the pack and practices benchmark very well in Lincolnshire with face to face appointments being above pandemic levels which benchmarks well nationally with almost 50% of patients being seen on the same day. Extended Access also has good availability but is only 74% filled; the appointments are there but are not always being used. The standard is 80%.

The Board considered the report. Mrs Kenson referred to the backlog and asked for clarification on how confident Mrs Raybould was that the numbers are correct. Mrs Raybould advised that they are as accurate as can be and a considerable amount of work has been taking place with the Elective Activity Coordination Hub (EACH) team in Lincolnshire who have been taking some of the most challenged specialties and ringing patients on the waiting list to see if their circumstances have changed. There has been a large reduction in numbers for various reasons. It was noted that more details will be shared at the next meeting of the Service Delivery and Performance Committee.

Mrs Kenson advised that it would be helpful to include some trajectories in the report which had been mentioned at the recent meeting of the Service Delivery and Performance Committee. Mrs Raybould advised that various leads for specific areas had been booked in to attend the next meetings of the Committee and that will be covered as part of the deep dive into those specialities.

Mrs Fosh advised that from the community perspective with waiting lists, some can be managed really well but as is being seen across health and social care at the moment, demand has increased, and this is proving more of a challenge to manage such as through Speech and Language Therapy. However, LCHS have got risk assessments in place and are ensuring patients are fit to wait and on the appropriate waiting list.

In respect of the discharge and flow work - this is two-fold. There is an element of challenge in recruiting workforce due to a number of factors, but there is also cultural change required, particularly around flow. There are green shoots being seen as referred to by Mrs Raybould and the four Lincolnshire NHS Chief Executives have oversight and scrutiny of that area and meet every Wednesday afternoon to discuss discharge and flow and ambulance handovers as examples and those meetings include Mrs Raybould and other senior system colleagues.

Sir Andrew Cash sought clarification that all cancer screening programmes were back up and running. Mrs Raybould advised that screening services were running but there was currently an issue with breast screening which is commissioned by NHS England, but the ICB is working closely with them and Public Health colleagues to resolve this.

Quality Section

Mr Fahy presented the Quality section of the report and advised that his update would focus on the patient safety and quality elements by exception. The following points were highlighted for the Board's information.

Areas of improvement

- Learning Disability Health Checks – there has been continued progress and this area remains on target, and the position is actually better than it was at the same point last year.
- Ambulance community response times (CAT1 & 2) have slightly improved since Mr Fahy last reported in July and are tracking in line with the national average.

Area of deterioration

- The A&E 12 hours waits, and ambulance handover two hour response times have deteriorated especially at the Pilgrim Hospital, Boston. This area had already been discussed on several occasions in the meeting so would not be touched on any further.

Mental Health

- There had been a slight dip in performance in Serious Mental Health (SMI) health checks. The target is 60% and currently performance is at 44.7% which is above both the national and Midlands average but is below target. The intention is to apply a similar methodology around the system to that used with the learning disability health checks with a view to improving performance.

Mrs Connery supported Mr Fahy's comments but added that there are issues with under reporting and completion of health checks not being captured. It was really important to ensure the data is correct and a piece of software is being considered to ensure more robust information can be obtained.

- Performance of early intervention in psychosis (EIP) performance has improved to 19% from 6% the last month.
- Learning Disabilities, Autism and Transforming Care - Delivery from April to July is 551 Health Checks which is 148 ahead of 2021/22 which is around three patients off track for 2022/23 It is too early for a robust performance projection, but current data indicates delivery of the 85% target by year end.

Serious Incidents and Never Events

There had been one Never Event reported in relation to Lincolnshire patients in July 2022 by ULHT which related to wrong site surgery and was reported on 21 July 2022. Never events were in short something which should never happen.

There has been a total of 39 serious incidents reported, this represents a reduction when compared to the last report, which was 50. However, this position was in keeping with average trends and run rates from previous years. There were no significant themes to identify from a patient safety perspective.

Mortality metrics:

All Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remain on trend for all the ICB's main providers which was very positive, and this has remained consistent in recent months. There is still some focused work taking place with colleagues at North West Anglia NHS Foundation Trust (NWAFT) to understand their position and bring their position back on track, which is being carried out in partnership with Cambridge and Peterborough ICB and NHS England.

COVID Vaccination Autumn Programme

The Autumn booster programme went live on the 5th September 2022 and take-up was really positive with almost 30,000 people vaccinated to date.

The Board will be kept regularly updated on progress.

Elective recovery and diagnostics

All key performance areas were rated as green in the report, which was really positive. All colleagues involved in those area should be congratulated on this achievement, which was really positive.

Care Home Quality

There had been a reduction in the number of care home suspensions from five to two. However, there had been an increase in default notices from 10 to 14 (areas of specific concern in respect of a Care Home). There had been some deterioration/ movements in Care Quality Commission (CQC) ratings with five rated as less than Good and three rated as Requires Improvement. Whilst these are small numbers they are closely tracked from a quality oversight perspective.

Primary Care Quality

Within primary care the recent data suggests a further increase in the percentage of patients seen face to face, and utilisation of extended access appointments remaining stable at between 70% and 80% (as referred to earlier in the meeting by Mrs Raybould).

In terms of CQC ratings, the following four practices remain rated as 'Requires Improvement':

- Lakeside Healthcare
- Marisco Medical Centre
- Spalding GP Surgery
- Branston Surgery

The Hereward Medical Centre had been rated as Good following its recent CQC inspection.

CCG senior representatives continue to meet regularly with the Practice Teams to receive assurance on continued actions to address concerns and to support the four practices who remain rated as Requires Improvement. The Local Medical Committee (LMC) were also supporting them, and some improvements were starting to be demonstrated.

The Board considered the report. Dr McSorley stated that his first comment related to Never Events and advised that as the title indicated these should never happen. The previous Lincolnshire CCG Quality Committee did note a trend in respect of wrong side surgery. The ICB Board would need to be very concerned if this trend continued.

His second comment was in relation to mortality SHMI at NWAFT, specifically at Peterborough City Hospital, which had remained consistently high for over two years and the reasons for this had never been fully understood. Mr Fahy and the Quality Team have been carrying out some very good work and reviews with NWAFT to understand this and clearly the ICB was partly dependent on the work of Cambridgeshire and Peterborough ICB in this regard.

Mr Turner advised that the position should be zero for Never Events and this had not actually ever been the case at ULHT. It was suggested this was an area for Dr Hindocha to have a look at to gain a greater level of understanding and assurance in respect of this as wrong site surgery has been a feature at ULHT as highlighted by Dr McSorley.

In respect of the SHMI at Peterborough City Hospital, Mr Turner is aware that Dr Hindocha has been looking to open up a relationship with the Medical Director at Cambridge and Peterborough ICB and also the new Medical Director at NWAFT and suggested this is an area of focus for discussions going forward. Mr Fahy advised that there is a meeting planned to take place with the new NWAFT Medical Director and that includes Dr Hindocha. NWAFT are in formal escalation with NHSE.

Mr Burnett referred to Serious Incidents and the number of slips, trips and falls at ULHT and pressure ulcers at Peterborough Hospital and asked whether there was anything the Board should be specifically concerned about or any action which would be taken. Mr Fahy advised that currently there was nothing to indicate the numbers were above trend, but there is a specific piece of work being carried out jointly with LCHS to lead a focus on pressure ulcers. It was noted that how the numbers are reported has to be in line with national requirements but equally most of those issues will have occurred in the community and are picked up post-admission by LCHS staff.

Councillor Bowkett referred to residential homes and nursing homes and advised that some of those had not been subject to a CQC inspection for some time. There had been information coming through in recent weeks which appeared to identify concerns about some of the homes and not being fit for purpose.

Sir Andrew Cash summarised the discussion and identified three areas of concern as flagged: SHMI, Never Events and Residential/Nursing Homes. It was proposed and agreed that further information was obtained in relation to those, and updates brought back to a future meeting.

The ICB Board agreed to:

- **Note the Integrated Quality and Performance Report.**

CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY

22/34 FINANCE REPORT

Mrs Rhodes presented the Month Five Finance Report which set out the financial position of the Lincolnshire Healthcare NHS System and the Lincolnshire ICB as at the 31st August 2022 and the forecast to the end of the current financial year (2022/23).

The report identified that the system is predicting to a deliver a breakeven position by the end of the year. This is however predicated on £68.3m efficiency schemes of which £19.9m is either identified or has high risk of non-delivery.

On the 31st August the system reported £57.3m of identified risks which included the £19.9m. Only £30.0m is mitigated, leaving £27.3m unidentified.

In terms of the revenue position the Lincolnshire system reported a £10.3m deficit against allocations and income for month five. Against a planned £1.5m year to date deficit this represented £8.8m adverse variance. There were four principal reasons for the overspend which were detailed in the report as follows:

- Under-delivery of efficiency and waste reduction
- Unplanned costs associated with COVID-19
- A higher than planned level of open beds
- Higher than planned staff costs driven by bank and agency volume and price

It was essential to reduce staff costs and also the number of open beds, both of which would help the system to get back on track. Currently both of these areas continued to incur a higher than planned spend to date with the number of open beds attributable to an increased number of COVID patients in the acute Trust, which had been referred to earlier in the meeting.

On a positive note the Lincolnshire system reported year to date efficiencies of £13.5m against a plan of £15.8m, acknowledging this was slightly behind plan. The full year forecast is subject to system risks, the main risk being £19.9m of unidentified system efficiencies. The most likely means to close the shortfall is through the System Improvement Plan. Three programmes are in phase one; the details of which were set out in the paper. The sprint phase for these three programmes was completed in October 2021.

Work continued to take place to identify opportunities to bridge the £19.9m gap.

The Phase 2 initiatives were due to commence shortly which is around Frailty and Same Day Emergency Care, although these have not yet been through the sprint phase evaluation so benefits are yet to be agreed but it is hoped they will bridge some of the financial risk highlighted in the report.

There are a number of actions underway to mitigate against the risk such as continuation of the Investment Panel, a double lock on organisational spend to control system expenditure and greater focus on controls to reduce bank and agency spend. Work is also underway to recover and accelerate delivery through the mechanisms of the risk and gain share arrangements and a commitment to take a longer-term view of the financial and efficiency position by creating an 18 to 24 month forecast. There is a strive towards ensuring an in-month position by the end of March 2023 and ensure accelerated processes for implementation and transformation are in place; this is where schemes are identified across the system and ensuring there are ways to ensure these are progressed in a timely manner and transformation takes place. Finally, an internal audit review of system financial governance across the system is planned to take place which is being run by the HFMA; this involves the ICB and all three Lincolnshire provider organisations.

The Board considered the report. Mr Turner thanked Mrs Rhodes for presentation of the report and referenced the discussion that had taken place at the recent Quarterly System Review meeting (QRSM) about finances. From the Chief Executive perspective it is evident there is a considerable amount of really good work taking place from the financial perspective but alongside that the ICB and the Lincolnshire system is clearly facing a huge financial challenge in year. This was expected to remain a key focus of challenge from NHSE for the quarterly review meetings going forward.

As highlighted by Mrs Rhodes work was underway to look at efficiencies and expenditure on agency staff and locum staff. However, the financial position at month five is clearly not where the system would want it to be and with the large gap in system efficiencies the seriousness of the position should not be under estimated. No doubt the ICB Finance and Resource Committee will continue to be very active and diligent over the financial position.

Mrs Pomeroy advised that she is the Chair of the Finance and Resource Committee and at the recent meeting those present expressed a real concern about the significant financial risk to the Lincolnshire healthcare system in the current year. On top of which is the added pressure of having to deliver financial balance over a two year period, otherwise there is a further £22.7m risk that will come into effect. There is clearly a lot of work to do, and the required focus is there, but there are big numbers to deliver and to achieve the significant savings required means looking at the longer term solutions on an 18-24 month basis as referred to by Mrs Rhodes.

Mrs Kenson advised that a considerable amount of the numbers identified in the report were non-recurrent and sought clarification that the appropriate resource is in place to look at this.

Mrs Pomeroy advised that that this had been discussed at the recent Finance and Resource Committee meeting and it had been confirmed that the resource was being looked at. Mrs Rhodes added that this emphasised the need to look at the in-month position and to be really clear on the underlying run rate in the system.

Sir Andrew Cash thanked Mrs Rhodes for presentation of the report and the contributions received. It was proposed and agreed that a briefing session on the financial position would take place at the next Board Development Session on the 1st November 2022. Mrs Ellis-Fenwick to note for the agenda.

Action: Mrs Ellis-Fenwick

The Board agreed to:

- **Note the reported financial position of the Lincolnshire Healthcare System and endorse the actions that are in progress with the ICB and Partner executive team.**

CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE

22/35 COST OF LIVING

Mrs Mills advised that the rising costs of fuel, food and other essentials are combining with existing disadvantages and vulnerability in our communities to put many households at greater risk of both immediate hardship and with that reduced opportunity and wellbeing. It is also placing the most vulnerable within our health and care system at significant risk and this is further exacerbated with additional illnesses facing the population through winter such as COVID and flu.

The Integrated Care System has commissioned a task force via the Better Lives Lincolnshire Leadership Team to develop strategic priorities and a communication strategy to enable a coordinated response to the challenge and make the best use of the opportunities available to support individuals including through grants. This would be available to not only members of the public but also the ICB staff who may be affected by the issues highlighted but also may be in contact with individuals who are the most vulnerable.

There had been two meetings of the taskforce which are led by District Council colleagues in partnership with the third sector. It was already evident from those meetings the breadth of interventions taking place across the county and the work underway to bring all of that together. There is link on the Lincolnshire County Council website to some key information and from a health perspective the intention is to make sure the detail is communicated as widely as possible including reaching front line staff so they can have discussions with patients directly.

In summary this a very vibrant space in terms of the cohesion and shared objectives to really put the mechanisms in place to support local people.

The report presented had been produced to provide an overview of the opportunities available and proposed actions for consideration by members of the ICB and Mrs Mills advised that she was happy to respond to any questions.

The Board considered the report. Mrs Kenson advised that she noted the number of organisations involved but asked whether work was being undertaken with the local housing associations. Mrs Mills confirmed that the stakeholders and partners involved in the task force have connections into the housing association who had a richness of information available to help understand the population and particular areas of challenge.

The ICB Board considered the contents of the paper and agreed to:

- **Note the report.**

GOVERNANCE

22/36 **MEMORANDUM OF UNDERSTANDING: LINCOLNSHIRE INTEGRATED CARE BOARD AND NHS ENGLAND**

Mr Burnett advised that by way of some background information, when Integrated Care Boards (ICBs) became statutory bodies from July 2022, NHS England regions and ICBs were required to refresh the arrangements supporting their relationships, developing how they will underpin their working arrangements in the first year. To support this, every ICB has been required to work with NHSE through their regional team to agree an MOU which sets out the future ways of working taking account of the system architecture in Lincolnshire and outlines the approach to governance and oversight and roles and responsibilities regarding performance improvement.

The report included in the pack of papers had been produced to outline to the ICB Board the key features outlined in the Memorandum of Understanding (MOU) between NHS England (NHSE) and NHS Lincolnshire ICB. It was presented to the Lincolnshire Leaders Group (LLG) in August and submitted to the Regional Team for approval. NHSE had now approved the MOU and it had been signed by Mr John Turner, ICB Chief Executive.

Mr Burnett provided a brief outline of the key points and advised that MOUs with NHSE have been in place for a number of years. However, the key change from the previous arrangements that were in place with NHS Systems pre-July 2022, is the ICB will be the first port of call in most circumstances from NHSE. Therefore, if NHSE have concerns with individual providers or service delivery the regional team will contact the ICB and request them to ensure they are resolved. NHSE will also delegate duties for provider oversight and performance improvement to ICBs.

The Board was reassured that the governance structure and arrangements the ICB put in place when it was established will ensure this duty will be delivered.

On a final note, the MOU takes account of the system National Oversight Framework (NOF) rating which determines the oversight arrangements with the regional team. As the system has a NOF 4 rating this will mean that NHSE will have Quarterly Review Meetings with the System and join the monthly LLG meeting and attend the ICB Executive meeting once a month.

The Board considered the document presented. Mrs Connery advised that a representative from NHSE sits on the Mental Health, Learning Disabilities and Autism alliance so there is a level of cross-utilisation in place.

The Board agreed to:

- **Note the agreed Memorandum of Understanding between NHS Lincolnshire Integrated Care Board and NHS England.**

22/37 ICB CONSTITUTION

Mrs Ellis-Fenwick advised that following commencement of the Health and Care Act (2022) NHS England's legal team conducted a review of the model constitution that was published by NHSE in May 2022 and identified several small amendments that need to be made. The ICB received a communication from the NHS England Midlands Strategy & Planning Team on the 15th September 2022 advising that they had been asked to make the ICB aware of the details of those amendments which need to be made to all ICB Constitutions.

The paper presented summarised the details of those amendments which the Board was requested to approve along with a change to section 1.6.2 (a) as below.

From:

- The Chief Executive may periodically propose minor amendments to the Constitution which shall be considered and approved by the ICB prior to submission to NHS England.

To:

- The Chief Executive may periodically propose minor amendments to the Constitution which shall be actioned and submitted to NHS England.

The Board considered the paper and the proposed amendments and agreed to:

- **Approve the proposed amendments for submission to NHS England.**

22/38 FINANCE AND RESOURCE COMMITTEE

Mrs Pomeroy presented the report from the Finance and Resource Committee first meeting which was held on the 16th September 2022. The Committee focused on a number of areas which were highlighted in the paper. This included ways of working and all those present were committed to making the Committee work. Further discussion will take place at the next meeting.

There was also a discussion on the key risks facing the system, specifically in terms of delivery of the system plan which was noted in the report as an item of escalation to the Board.

Sir Andrew Cash sought clarification that the Finance and Resource Committee had now approved its Terms of Reference. Mrs Pomeroy advised that it was agreed that the Terms of Reference required further review alongside discussions on ways of working. This would take place at the next meeting in October. It was agreed that meetings would be held on a monthly basis rather than bi-monthly for the time being in light of the current financial position.

Mr Turner referred to the ICB's System Committees and sought clarification on whether they were envisaging meeting face to face on occasion rather than continually on a virtual basis. Mrs Pomeroy advised that the meetings were likely to take place on a virtual basis due to the agreement to meet monthly and also in light of the diverse nature of those involved. Whilst it was acknowledged you can gain a greater richness from meeting on a face to face basis, it is more challenging to organise and takes up more time with people having to travel to venues. That said, periodically it would make sense to either get everyone together in one room or adopt a hybrid arrangement with some available virtually and others in the room.

The Board agreed to:

- **Note the report.**

22/39 SERVICE DELIVERY AND PERFORMANCE COMMITTEE

Mrs Kenson presented the report from the inaugural meeting of the Service Delivery and Performance Committee meeting held in October 2022. The meeting was predominantly held face to face with one or two members joining virtually.

The first meeting of the Committee was aimed at ensuring members were clear on the purpose, the role within the wider governance arrangements and to approve the Terms of Reference. The TOR were supported but with a note to have 75% minimum attendance required and consideration may also be given in the future to potentially having a Lay Member attend on occasion. Further discussion would take place at the December meeting to review implementation and discuss some additional points in relation to patient voice.

The Committee also discussed the Functions and Decisions Map, Forward Work Plan, the System Plan and the System Performance Report.

The Board considered the report and agreed to:

- **Note the report.**

22/40 AUDIT AND RISK COMMITTEE

Mrs Pomeroy presented the report from the Audit and Risk Committee meeting held on the 13th September 2022 and outlined the contents.

The following were specifically referred to:

- Internal Audit Plan
- Risk Management and Board Assurance Framework
- Terms of Reference – some minor amendments were identified, and the revised version was attached to the report for approval by the Board.

There were no specific areas to escalate to the Board.

The Board considered the report and agreed to:

- **Note the report**.
- **Approve the revised Audit and Risk Committee Terms of Reference.**

22/41 DATE AND TIME OF THE NEXT MEETING

Sir Andrew Cash thanked everyone for their attendance and advised that the next formal ICB public Board meeting will take place on Tuesday, 22nd November 2022 at 9.30 am at Bridge House, Sleaford, not the 1st as indicated on the agenda. The 1st November will be an informal session for the Board.

The meeting on the 22nd November will be held as a Live Event to enable a wider audience to access the meeting.

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Chair Signature **Date**

Not Delivered
In Progress
On Track to Deliver
Delivered

NHS
Lincolnshire
Integrated Care Board

ACTION LOG - PUBLIC

Date of Meeting:	Tuesday, 22nd November 2022
Agenda Item:	1 (iv)
Reporting Officer:	Sir Andrew Cash, Interim ICB Chair

Date of Meeting	Minute Number	Item	Action	Lead	Due Date	Progress
27th September 2022	22/30	Healthwatch update	Four actions – dentistry, communication (two items) and wheelchair access. Updates to be provided at the next meeting.	Mr O'Dell and the ICB Executives.	November 2022	Update to be provided at the next meeting.
27th September 2022	22/34	Finance	Finance to be included on the agenda for the Board Development Session on the 1st November 2022.	Mrs Ellis-Fenwick	November 2022	Delivered.

NHS
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Integrated Care Board

MINUTES OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP ANNUAL PUBLIC MEETING HELD ON MONDAY, 26TH SEPTEMBER 2022 AT 4.30 PM AT BRIDGE HOUSE, THE POINT, SLEAFORD

PRESENT:	Sir Andrew Cash	Interim ICB Chair
	Mrs Maz Fosh	Partner Member, NHS & Foundation Trusts
	Mrs Dawn Kenson	Non-Executive Member, Chair of Service Delivery and Performance Committee
	Mr Martin Fahy	Director of Nursing
	Dr Gerry McSorley	Non-Executive Member, Chair of Primary Care and Delegated Functions Committee and Remuneration Committee
	Mrs Julie Pomeroy	Non-Executive Member, Chair of Finance Committee
	Mrs Emma Rhodes	Associate Director of Finance (Deputising for Mr Gaunt)
	Mr John Turner	Chief Executive
IN ATTENDANCE:	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mr Andy Fox	Public Health Representative
	Mrs Clair Raybould	Director for System Delivery
APOLOGIES:	Dr Dave Baker	Interim Partner Member, Primary Medical Services
	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mrs Sarah Connery	Executive Board Mental Health Member
	Mrs Sarah Fletcher	Healthwatch Representative
	Mr Matt Gaunt	Director of Finance
	Dr Sunil Hindocha	Interim Medical Director
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mr Pete Moore	Non-Executive Member, Chair of Audit and Risk Committee
	Professor Derek Ward	Public Health Representative
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board
	Professor Sir Jonathan Van-Tam	Non-Executive Member, Chair of Quality Committee

APM/01 WELCOME AND INTRODUCTIONS

Sir Andrew Cash introduced himself and expressed a warm welcome to the final Annual Public Meeting of the former NHS Lincolnshire CCG. The Annual Public Meeting was being held as part of the CCGs statutory commitments prior to the establishment of NHS Lincolnshire Integrated Care Board (ICB) on 1st July 2022.

The meeting was being held virtually as a Live Event on Microsoft Teams. A recording of the meeting will be posted on the ICB website after the meeting for those who were unable to attend.

APM/02 MINUTES OF THE PREVIOUS NHS LINCOLNSHIRE CCG ANNUAL PUBLIC MEETING

Sir Andrew Cash invited Dr Gerry McSorley to present the minutes of the former NHS Lincolnshire CCG's Annual Public Meeting held in September 2021. Dr McSorley was previously the Acting CCG Chair.

It was noted that these minutes were being presented for information only having been approved by the NHS Lincolnshire CCG Board.

Dr McSorley presented the minutes and outlined the contents. No questions were received.

APM/03 CHIEF EXECUTIVE PRESENTATION

Mr Turner, ICB Chief Executive and the previous CCG Chief Executive advised that he would provide a presentation which was split into three parts:

- Reflections of the last 18 months
- Current position and forward look
- Presentation of the NHS Lincolnshire CCG Annual Report and Accounts 2021/22

Mr Turner highlighted the following points:

- On-going good progress
- On-going challenges
- NHS Awarded the George Cross Medal
- Current Context and Forward Look - Better Lives Lincolnshire and the Lincolnshire Integrated Care System (ICS)

Mr Turner expressed his utmost appreciation to the continued dedication and commitment of staff and its partners.

Mr Turner also expressed his appreciation to the previous CCG Board Members – namely Mr Sean Lyons, Mr Jim Connolly, Mr Murray Macdonald, Ms Sue Liburd, Mrs Fenella Chambers, Mr Graham Felston and Mrs Janet Inman

It was noted that the presentation slides would be made available on the ICB website for information.

APM/04 QUESTIONS FROM THE PUBLIC

It was noted no questions had been submitted prior to the meeting using the proforma which was made available, and nothing had come through the on-line Question and Answer facility during the meeting.

On that basis Sir Andrew Cash thanked everyone for their attendance and closed the meeting.

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22nd November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	4 (i)
Title of Report:	Equity and Equality Lincolnshire Maternity and Neonatal System
Purpose:	To highlight the partnership work and approach to Equity and Equality across the LMNS
Appendices:	Presentation – Lincolnshire Maternity and Neonatal System (LMNS)

1.	**Key Points for Discussion:**

- Background
- Key Findings
- Focus on areas of deprivation
- What next

2.	**Recommendations**

The ICB Board is asked to note and consider all the information in this report and the actions being undertaken.

3.	**Executive Summary**

Background

Maternity and neonatal services contribute to the health, wellbeing, and socioeconomic development of the nation. Good health in pregnancy significantly influences a baby's development in the womb which, in turn, influences long-term health and educational outcomes. By giving every child the best start in life, we will help them fulfil their health, wellbeing and socioeconomic potential

Socioeconomic inequalities account for pregnancy outcomes, including stillbirths, preterm births, and fetal growth restriction. Birth outcomes are not just the end product of pregnancy, but of the entire life of the mother.

The MBRRACE-UK (appendix 1) reports about maternal and perinatal mortality show worse outcomes for those from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas.

The Marmot review called for action to be universal, but with a scale and intensity proportionate to the level of disadvantage; this is known as 'proportionate universalism'. To do this maternity and neonatal services need to respond to each person's unique health and social situation – with increasing support as health inequalities increase – so that care is safe and personal for all.

The review underlined how important maternal health is to fetal development. Low birth weight is associated with poorer long-term health and educational outcomes.

The government's national maternity safety strategy sets out an ambition, by 2025, to halve rates of stillbirths, neonatal and maternal deaths, and brain injuries during or soon after birth and to reduce the rate of preterm births from 8% to 6%. To achieve the 'halve it' ambition, it is important to improve outcomes for those groups most at risk.

Core20PLUS5 – An approach to reducing health inequalities

20 support for most deprived 20% of the national population,
Plus, groups such as ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others.

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5 For Maternity: ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups.

In 2021 the NHS made 4 pledges to women, babies', families, and staff

1. The NHS will take action to improve equity for mothers and babies and race equality for NHS staff
2. Local maternity systems will set out plans to improve equity and equality
3. LMSs will receive support to improve equity and equality
4. The NHS will measure progress towards the equity aims

Key Findings

The vision for the Lincolnshire LMNS is that all mothers and babies will achieve outcomes that are as good as the areas that achieve the best outcomes. We are making efforts to improve pregnancy outcomes and to lessen inequalities.

- 48% of people in Lincolnshire live in rural areas compared to the national average of 18%.
- Skegness and Mablethorpe are in the top 10% most deprived areas in the country and consequently, a notable proportion of women in these areas are reliant on public transport. This presents specific issues for some women accessing maternity care in rural Lincolnshire.
- Poor road systems, especially to the most deprived areas, making access to care an issue.
- Poor connectivity to mobile systems especially in the more remote areas of the county.
- High levels of women continuing to smoke during pregnancy.
- Increasing levels of Obesity and Diabetes.
- Increasing number of women experiencing Mental Health issues.

Focus on an area of deprivation (Coastal Communities)

Skegness is a coastal town that sits in the top 10% most deprived areas in the country; a known risk factor to poor pregnancy outcomes.

- A notable proportion of women in these areas are reliant on public transport. This presents specific issues for some accessing maternity care.

- A group of young mothers in Skegness got in touch with the Local Maternity and Neonatal System (LMNS) to say that travel was difficult and that they wanted maternity services closer to home.

Lincolnshire's LMNS responded by:

- Holding listening events to gather feedback. These were carried out at schools,
- children centres and at the beach.
- Undertaking surveys with families and staff to understand the need.
- Engaging with local communities through all stakeholders involved in care of families

Working in collaboration across the LMNS the concept of community hubs evolved

- Four sites were selected as community hubs sites; these were situated in some of the county's most deprived communities and included Skegness.
- Utilising existing Children Centres meaning that community hubs were more likely to be sustainable.
- Working parties were set up to develop each site and ensure the hubs reflected local communities need and acknowledging 'one size does not fit all'.
- As well as providing maternity and health visiting services the hubs were seen to address the social determinants of health, providing training and employment advice, childcare and early education.

To date we now have 8 Community Hubs and are working with LCC in the development of the Family Hub models for Lincolnshire.

Next Steps for Skegness development of Continuity of Carer team

Focus on Seldom heard

Military Families

Through a variety of other mechanisms including social media, we have heard from families about their stories of isolation, struggles with support for Mental Health, separation from their partners at times of distress, moving to a new location during a pregnancy with no support from family and friends, unpredictability and unable to plan family life, planning pregnancies, IVF treatment being delayed due to deployments, adoption processes being put on hold and interrupted continuity of care during the pregnancy journey.

Since July 2022 we now support these families with a bespoke Care Navigator who guides families around the complex and sometimes challenging systems in the NHS and partner services and established a parent voice a Military Maternity Voice made up of serving members, dependents, reservists, and veterans.

Focus on Intervention

Tobacco Prevention

Deprivation

- Women from the most deprived communities are 12x more likely to smoke during pregnancy than women from more affluent areas.
- Rates of smoking among white women (aged 18-34) in routine and manual occupations are currently more than double that of women on average (26.7% compared to 12%)

Age

- 30% of women aged under-20 were current smokers at their booking appointment compared to just 6% of women over the age of 40

Race

- Smoking at booking rates are highest among the 'white' (15.2%) and 'mixed' (12.7%) ethnic groups, which account for 86% and 2.2% of the population

Migrant communities

- The 'Other white' group includes communities from Eastern European countries with high rates of smoking, particularly Poland and Romania which have smoking rates of 25.3% and 23.5% respectively

By 2023/24 all people admitted to hospital who smoke (acute and mental health) will be offered NHS funded tobacco treatment services, including pregnant women and their partners.

The model for pregnant women is more intensive and is intended to be delivered within maternity services, building on the Saving Babies' Lives Care Bundle version 2 (SBLCBv2), where all women are assessed for CO exposure at booking and will support pregnant women to beat their tobacco dependence through weekly face-to-face behavioural support and licensed pharmacotherapy –specifically combination NRT.

Lincolnshire LMNS are working with worked with ULHT Maternity team to implement a dedicated team 'STARR' now working in the pilot areas of Skegness, Boston and Spalding where we see the highest rates of smoking at delivery.

The ambition is to work with women and families to have smoke free homes to continue the tobacco prevention work and ultimately smoke free communities.

Next Steps

- 'What matters to you' roadshows continue across the county
- LMNS Equity and Equality Strategy March 2023
- Project with PAB translation service to recruit champions in hard-to-reach communities and produce films and literature relevant to the pregnancy pathway

4.	Management of Conflicts of Interest

No conflicts of interest

5.	Risk and Assurance

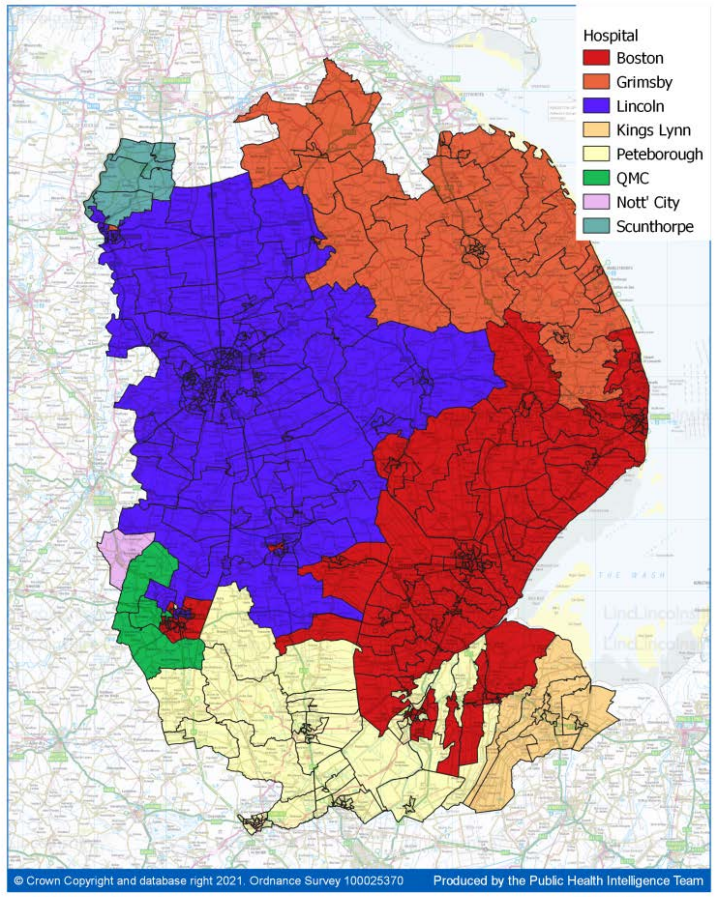
Improving Health Inequalities and Health Outcomes are key aims for the ICB and will feature as part of the risk themes in the ICB Board Assurance Framework.

6.	Financial/Resource Implications
As noted in the report	
7.	**Legal, Policy and Regulatory Requirements**
None to be noted.	
8.	**Health Inequalities implications**
As noted in the report	
9.	**Equality and Diversity implications**
As noted in the report	
10.	**Patient and Public Involvement (including Communications and Engagement)**
Maternity Voice Partnership represents the voice of families within the LMNS programme	
11.	**Report previously presented at**
N/A	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Sue Jarvis Maternity and Neonatal Programme Manager LMNS Sandra Williamson Director for Health Inequalities, Prevention and Regional Collaboration	

Lincolnshire Maternity & Neonatal Programme
Better Births

The Lincolnshire Maternity Picture

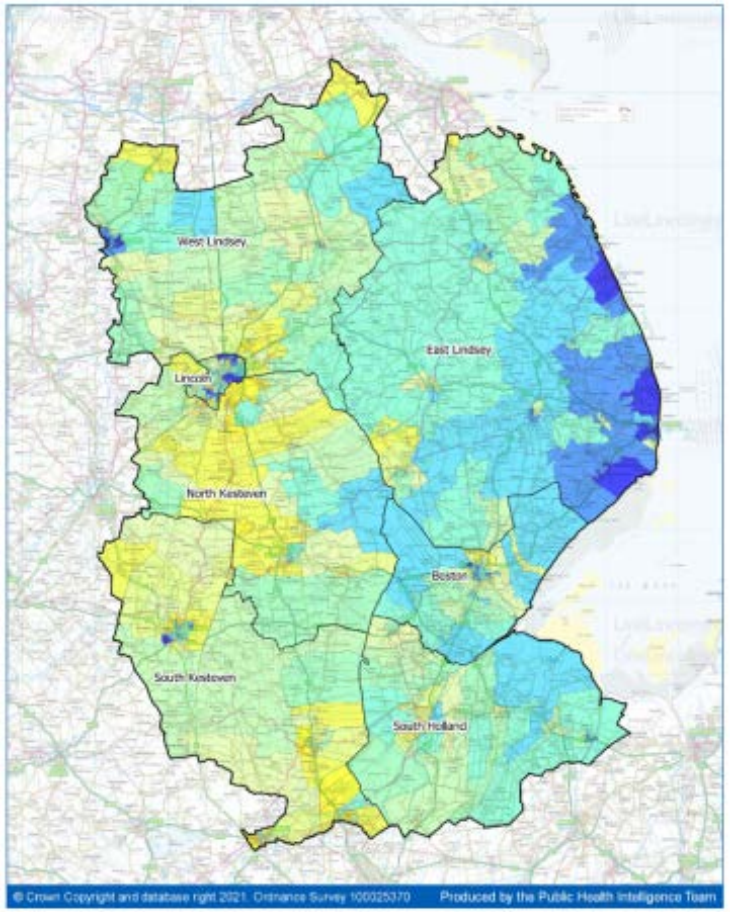
- There were 6,384 births in 2021/22:
  - 4,276 (67%) were at ULHT
  - 964 (15%) at NWAFT
  - 515 (8%) at NLAG
- High risk women and babies are predominantly cared for out of Lincolnshire; mainly at the Nottingham sites.
- Babies born under 28 weeks go out of county for their care.
- Whilst women may birth outside of the county some women will receive antenatal and postnatal care from ULHT.
- All women will receive care from our Lincolnshire Children's Health 0-19 (SEND 25) service, Early Years Providers and Mental Health Trust.



Most dominant hospital of birth by LSOA

Public Health Intelligence

Lincolnshire



Overall deprivation by LSOA IMD 2019

Most deprived

Least deprived

Public Health Intelligence

Lincolnshire

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) – poorer health outcomes for BAME & those living in areas of deprivation

Lincolnshire Maternity & Neonatal Programme
Better Births

National Reports

Missing Voices
Key messages from the report 2022

MBRRACE-UK

229 women died during or up to six weeks after the end of pregnancy in 2018-20

10.9 women per 100,000 giving birth 24% higher than 2017-19

27 of their babies died

366 motherless children remain

A further 289 women died between six weeks and a year after the end of pregnancy in 2018-20

13.8 women per 100,000 giving birth

9 women died from covid-19

Excluding their deaths, 10.5 women died per 100,000 giving birth

19% higher than 2017-19

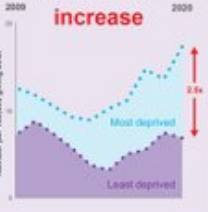
1 in 9 women who died had severe and multiple disadvantage

Most women died in the postnatal period 86%

Black women were 3.7x more likely to die than white women (34 women per 100,000 giving birth)

Asian women were 1.8x more likely to die than white women (16 women per 100,000 giving birth)

More women from deprived areas are dying and this continues to increase



In 2020, women were 3x more likely to die by suicide during or up to six weeks after the end of pregnancy compared to 2017-19

1.5 women per 100,000 giving birth

1,001 Critical Days Manifesto

"A pregnant mother suffering from stress can sometimes pass on the message to the unborn baby that the world will be dangerous, so that as a child he or she will struggle with many social and emotional problems"

– The 1001 Critical Days – The Importance of the Conception to Age Two Period, cross-party 'manifesto', 2013, revised 2015 and 2019.[20]

Department of Health & Social Care

Independent report

Ockenden review: summary of findings, conclusions and essential actions

Published 30 March 2022

Department of Health & Social Care

Policy paper

Women's Health Strategy for England

Updated 30 August 2022

REDUCING HEALTHCARE INEQUALITIES

NHS

CORE20 The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

PLUS ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Target population

20%

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **MATERNITY** ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups
2. **SEVERE MENTAL ILLNESS (SMI)** ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)
3. **CHRONIC RESPIRATORY DISEASE** a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
4. **EARLY CANCER DIAGNOSIS** **75%** of cases diagnosed at stage 1 or 2 by 2028
5. **HYPERTENSION CASE-FINDING** and optimal management and lipid optimal management

SMOKING CESSATION positively impacts all 5 key clinical areas

Classification: Official

Publication approval reference: C0734

NHS

Equity and equality
Guidance for local maternity systems

September 2021

Independent report

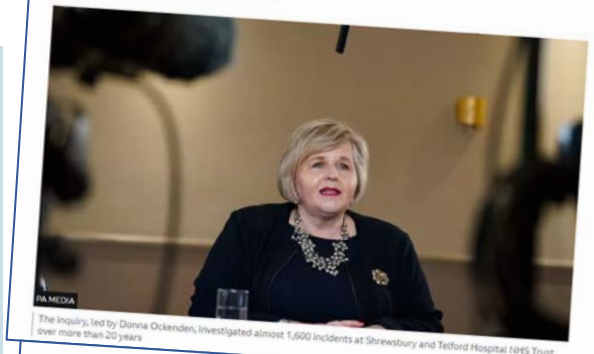
Maternity and neonatal services in East Kent: 'Reading the signals' report

The report of the independent investigation led by Dr Bill Kirkup on maternity and neonatal services in East Kent.

Donna Ockenden to visit victims of Shrewsbury maternity scandal

30 May

Shropshire baby deaths investigation



The inquiry, led by Donna Ockenden, investigated almost 1,600 incidents at Shrewsbury and Telford Hospital NHS Trust over more than 20 years

Marmot Review report – 'Fair Society, Healthy Lives

The Marmot Review into health inequalities in England was published on 11 February 2010. It proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities.

Key Statistics

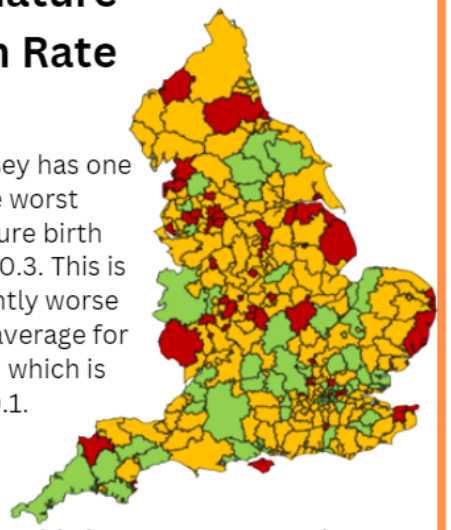
Stillbirths

United Lincolnshire Hospitals Trust stillbirth rate of 3 per 1,000 births is in line with the average for England.

In 2020, nearly 3 of every 4 stillbirths within the Trust were to mothers from the lowest 5 deciles of deprivation (IMD)

Premature Birth Rate

East Lindsey has one of the worst premature birth rates at 90.3. This is significantly worse than the average for England which is 79.1.



Premature births 2018-2020 crude rate, per 1,000

Infant Admissions

Admission of babies under 14 days of age are worse than the average for England. 106.2 per 1000 babies are admitted under 14 days old.

Lincolnshire Child Deaths Overview Panel (CDOP)

The top three themes identified in child deaths in Lincolnshire are

- congenital abnormalities
- consequence of prematurity
- maternal smoking in pregnancy

These all link to the maternity pathway.

Teenage Pregnancy

Teenage pregnancy rate is similar to England, with 162 girls becoming pregnant in a year (2020)

42.6% of these conceptions lead to abortions, which is lower than the average for England

Lincolnshire has a higher proportion of teenage mothers than the average for England

Teenage mothers are 3 times more likely to be within the most deprived decile than the least deprived decile.

Breastfeeding

2021/2022 - 67.8% of babies born in ULHT received breastmilk as their first feed. This equates to 70.4% at the Lincoln site and 63.4% at Boston.

In 2020, 31% of women booking with ULHT were categorised as being obese

In 2021/22, 15.7% of women cared for by ULHT smoked while pregnant. This is higher than the average for England.

ABORTIONS

Lincolnshire has a significantly lower rate of abortions than the average for England.

- Lincolnshire sees a high rate of abortions in under 25's after previous birth.
- Lincolnshire has a higher proportion of abortions taking place 10 weeks after conception.

This may suggest there is an issue in accessing sexual health services. It may also suggest an issue with access to or delivery of termination services.

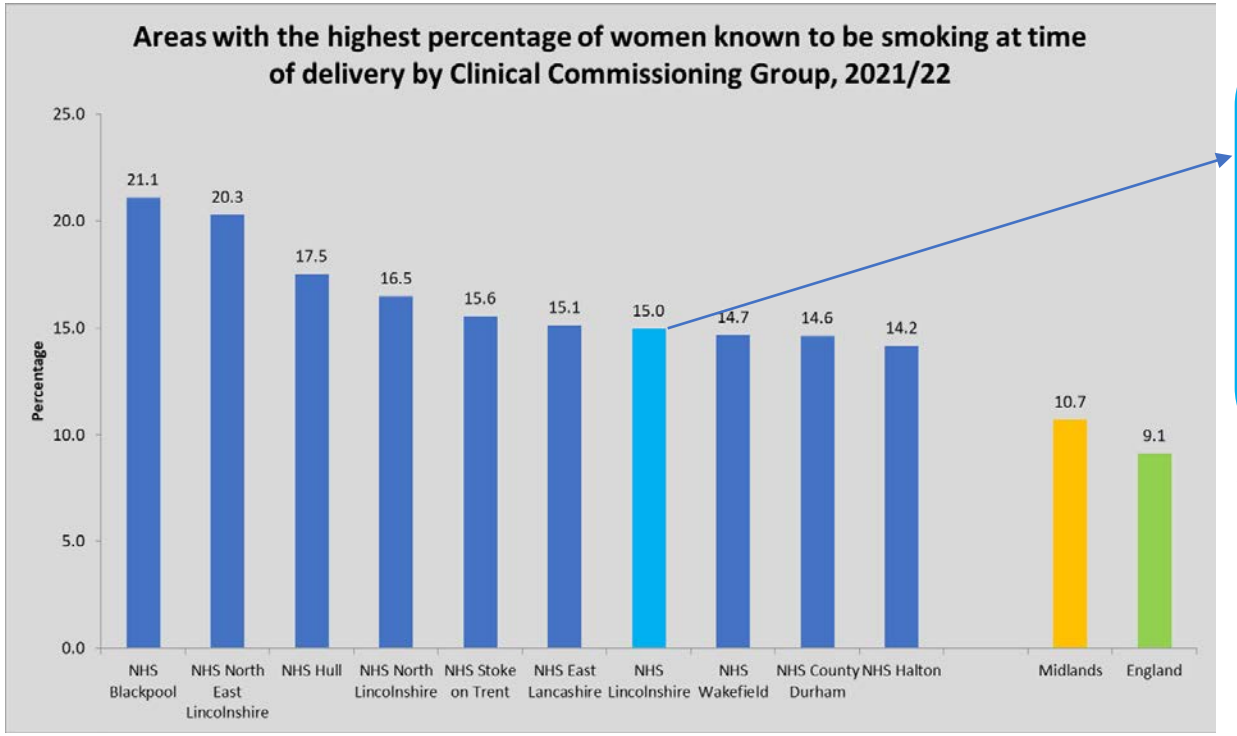
Smoking in pregnancy

Smoking in pregnancy remains a key public health concern and is the single most modifiable risk factor for adverse outcomes in pregnancy.

In 2021/22 Lincolnshire's smoking at time of delivery (SATOD) rate was 15.0%, this compares to a Midlands rate of 10.7% and national rate of 9.1%. At CCG level Lincolnshire had the 7th highest rate.

	Maternal smoking	Second-hand smoke exposure
Low birth weight	Average 250g lighter	Average 30-40g lighter
Stillbirth	Double the likelihood	Increased risk
Miscarriage	24%-32% more likely	Possible increase
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden Infants Deaths	3 times more likely	45% more likely

Source: Action on Smoking and Health. Smoking in challenge group. Review of the Challenge 2018. July 2018.



Source: NHS Digital Smoking at Time of Delivery

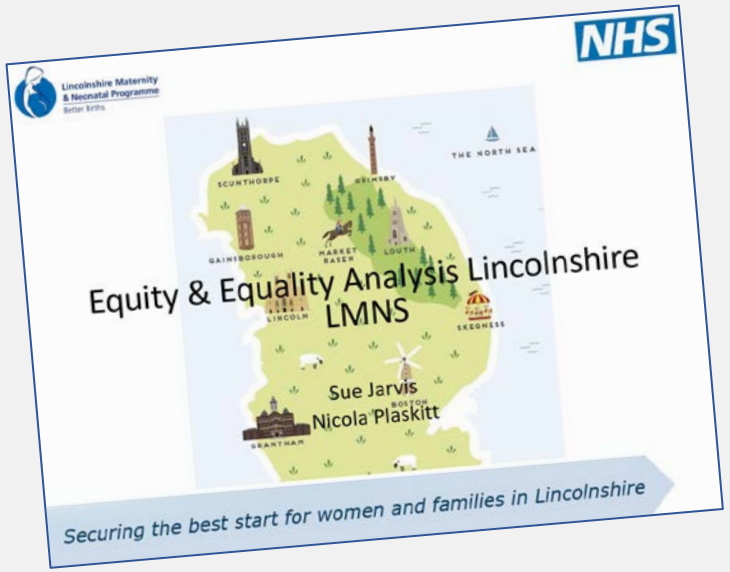
In 2021/22, the SATOD rates for Lincolnshire residents by trust were:

- ULHT - 15.7%
  - LCH - 13.6%
  - PHB – 19.0%
- NWAFT – 11.6%
- NLAG – 14.8%

Source: ULHT Maternity Dashboard & NHS Digital Quarterly Returns

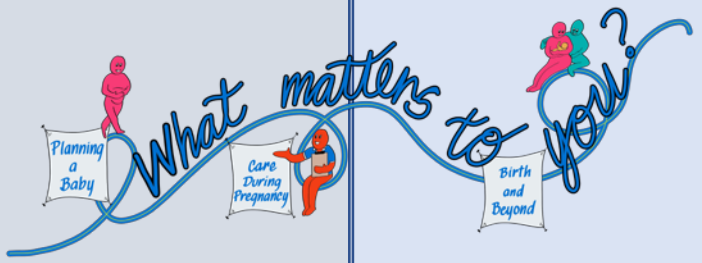
Data

Population analysis submitted to NHS Regional as part of the ongoing Equity & Equality work.



System Wide Staff Engagement

Patient Engagement



- Events taking place across the county
- First event held in Skegness, October 22.

Watch the What Matters To You event video here

Intelligence Informed Approach

Gathering intelligence from the public, staff and data to inform what will make a difference to the families across Lincolnshire

Lincolnshire Maternity & Neonatal Programme
Better Births

What we have done so far…

LINCOLNSHIRE MILITARY Maternity Voices
Working in partnership to improve maternity services

- ✓ Implementation of a bespoke Care Navigator
- ✓ Establish a Military Maternity Voice

2 year pilot commenced July 2022.
Funded by NHS Armed Forces

Aim:

- Military personnel and families access the relevant Lincolnshire services in a timely manner and feel less isolated.
- The voices of military families are heard and used to shape future services.

PAB

Working with PAB translation services to establish;

- Community Engagement and feedback.
- Co-production of educational maternity specific communication aids.
- Cultural Awareness Training

6 – 12 month initial project

Aim:

- All women, and families, receive relevant information in their own language in order to access care and make informed choices.
- The voices of non English speakers/English additional language are heard and used to shape future services.

STAAR TEAM
Stop Smoking Team
Act, Advise, Refer

Working with ULHT maternity team to

- Implement a dedicated in-house Tobacco Dependency Treatment team
- Support pregnant women to beat their tobacco addition.

Phase 1: Boston, Skegness and Spalding - 100% delivery by end of 23/24

Aim:

- All pregnant women are supported to beat their tobacco dependency and have a smoke free pregnancy.
- The voices of maternal smokers are heard and used to shape future services.

Development of Equity & Equality Strategy

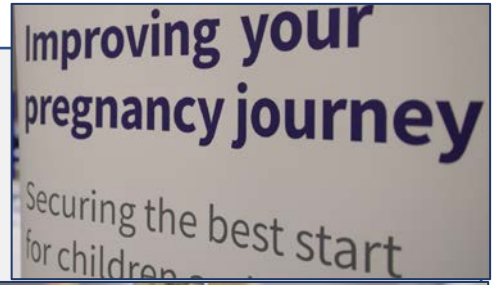
Lincolnshire Maternity & Neonatal Programme
Better Births

Thank You

What you can do to help

System support

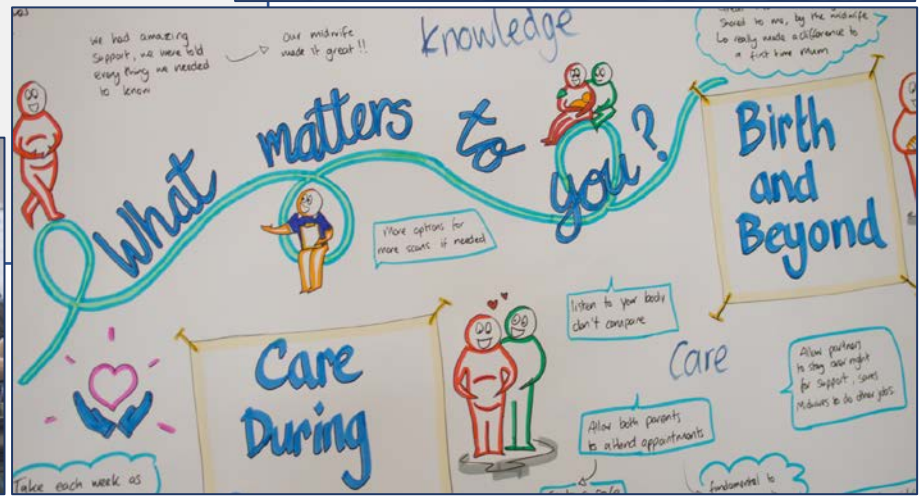
- Co-dependencies with other programmes – Health Inequalities, Primary Care Networks, Children & Young People, Family Hubs and Diabetes.
- Digital and Data support & digital maturity strategy.
- Maternity Champions. Raising the profile of the pregnancy journey and it's role in prevention.
- Involvement in 'What Matters To You' roadshows



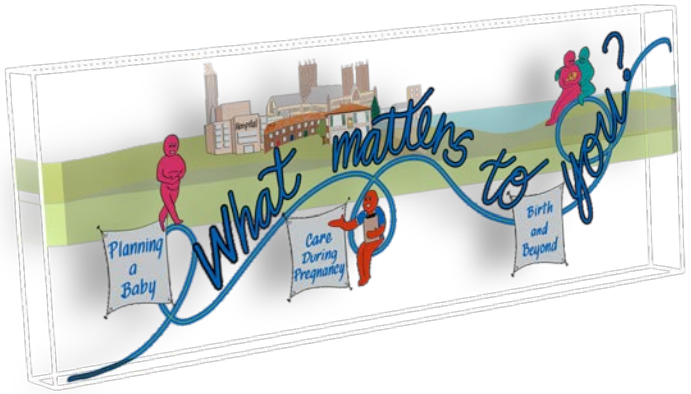
To hear more

Contact details

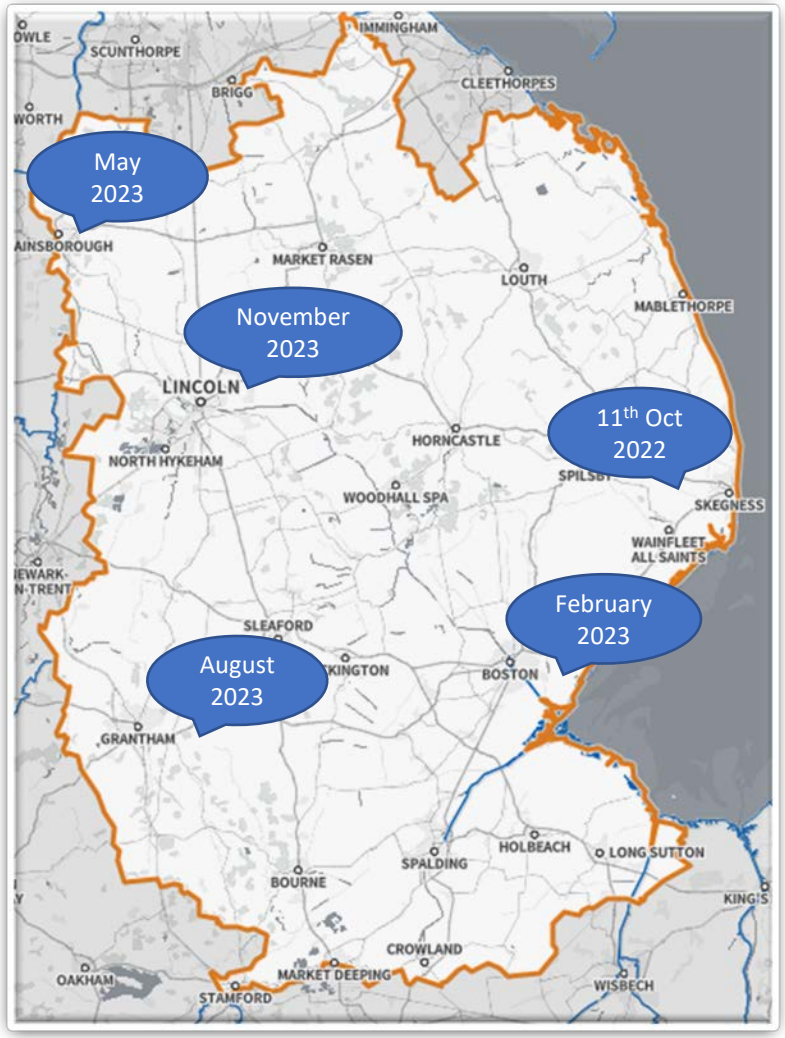
- Sue.jarvis1@nhs.net



'What Matters To You' Public Roadshow Events



- Skegness – 11th October 2022
- Boston – 23rd February 2023
- Gainsborough – Est. May 2023
- Sleaford/Grantham – Est. August 2023
- Lincoln – Est. November 2023



October 2022 sees the launch of the 'What Matters To You' roadshow events. These events, which are planned to take place across the county, will invite families and professionals to share their thoughts and views about all aspects of care before, during and after pregnancy.

We want to hear what matters to Lincolnshire communities and the professionals working with them while also giving them the opportunity to tour the pregnancy journey and meet with the services who might support them along the way.

In addition to these roadshow events, the LMNS and the Maternity Voice Partnership attend other events; for example, Primary Care Network (PCN) led events.

5a (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22nd November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	5a (i)
Title of Report:	Integrated Quality & Performance Report – November 2022
Purpose:	This report provides the Board with information on achievement against the ICB's key performance targets and quality standards
Appendices:	Performance Report

1.	**Key Points for Discussion:**

- To discuss the update to any quality and performance concerns for provider services and across the Lincolnshire Health and Care system as detailed in the executive summary
- The approach was made in 2021 to incorporate targets presented in the Quality Performance report into a single Integrated Performance Report for use at system QPEC and ICB board and is therefore presented for discussion and feedback. As the new system moves forward there is an opportunity to discuss the current format and make improvements to the report, and so the format is presented in a new more concise draft.
- This report shows information of normal variation, trends and shifts in performance over time for key metrics and measures across a number of areas of ICB delivery. It also highlights those areas where there is an immediate cause for concern. The report is designed to provide assurance to the Board that there full understanding of the drivers for performance and that actions are in place to address off track performance and quality in areas that are likely to have the most significant impact for patients.

2.	**Recommendations**

1. To ensure the ICB board are aware of any significant performance & quality concerns for any provider. The board to receive assurance via report and verbally on the mitigations in place.
2. To discuss the format of the report going forward.

3.	**Executive Summary**

Overview

The November integrated performance report incorporating constitutional standards, quality and safety measures and elective recovery activity, presents CCG and system performance updated to October where available. The focus areas are urgent care pathways, cancer, elective treatment backlog, long waiters, mental health and primary care.

Never Event

- There has been a never event reported in relation to Lincolnshire patients in October. The never event was reported by ULHT and related to a retained foreign object post procedure.

Urgent & Emergency Care

- The number of people waiting more than 12 hours in A&E increased to 1,114, from 869 in September
- Ambulance response times increased to 1 hour 13 minutes for Category Two incidents (18 minute standard) and two hour ambulance handover delays remain high at both Lincoln (307) and Pilgrim (312)

Cancer

- In October, 540 patients were waiting over 62 days, reducing from 608 in September
- The number of patients waiting 104 days or more increased in October to 171, from 169 in September

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals has increased by 396 to 112,105 in September
- The number of patients waiting more than 78 weeks increased to 954 from 677 in August

Mental Health

- Performance of early intervention in psychosis (EIP) waiting times is now at 41% seen within 2 weeks, improving from 31% in August but still lower than the 60% standard.

Primary Care

- Trent Valley Practice has been rated as Requires Improvement by the CQC. The inspection report is now available on the CQC website.

4.	**Management of Conflicts of Interest**

No conflicts of interest have been declared by individuals involved in the development of this report.

5.	**Risk and Assurance**

Risks to the achievement of performance standards are outlined in the body of this report.

6.	**Financial/Resource Implications**

Finance and resource implications directly associated with the issues outlined in this report are set out in the body of the report.

7.	**Legal, Policy and Regulatory Requirements**

Not applicable.

8.	**Health Inequalities implications**

Health inequalities implications directly associated with the issues outlined in this report are set out in the body of the report.

9.	Equality and Diversity implications
Not applicable.	
10.	**Patient and Public Involvement (including Communications and Engagement)**
Not applicable.	
11.	**Report previously presented at**
Not applicable.	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Tim Fowler Associate Director of Contracting and Performance e-mail: t.fowler1@nhs.net telephone: 07810 770476	

Integrated Performance & Quality Report

NHS
Lincolnshire
Integrated Care Board

November 2022

21/11/2022

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Executive Summary

NHS Lincolnshire Integrated Care Board

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Lincolnshire ICB Performance Dashboard

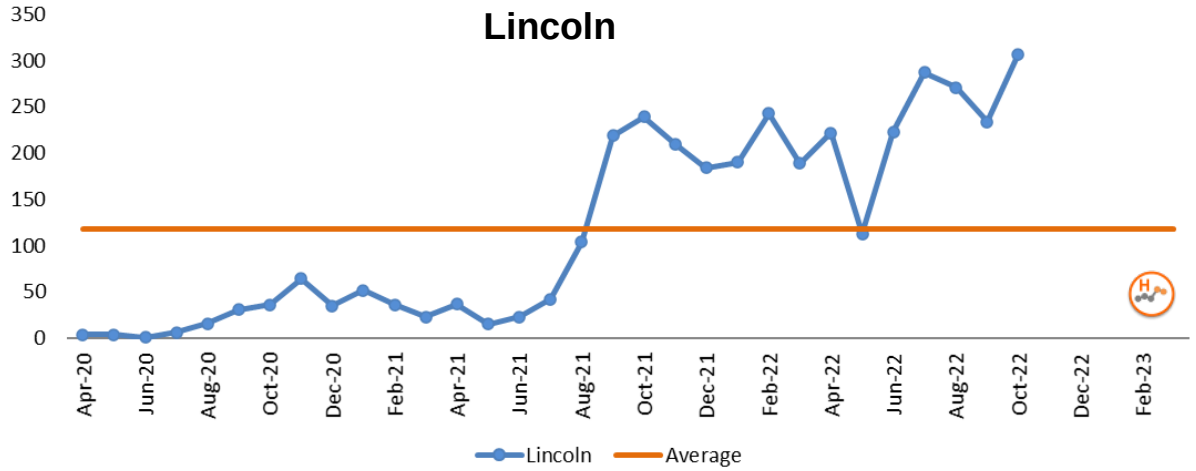
Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Direction	Variation
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	●	95%	Oct-22	71.5%	65.1%	69.3%		↑	
	A&E attendances- patients waiting over 12 hours (ICB)		0	Oct-22	1114	N/A	N/A		↑	
	A&E attendances- time to first clinical assessment within 60 minutes (ULHT)		-	Oct-22	47.9%	36.7%	34.8%		↓	
	Ambulance response times - Mean response time- Category 1 (ICB patients)	●	00:07:00	Oct-22	00:09:38	00:09:09	00:09:56		↓	
	Ambulance response times - Mean response time- Category 2 (ICB patients)	●	00:18:00	Oct-22	01:13:52	01:10:49	01:01:19		↑	
	Ambulance handover times - number of handover delays of > 2 hours (Lincoln)		0	Oct-22	307	N/A	N/A		↑	
	Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)		0	Oct-22	312	N/A	N/A		↑	
Cancer	% Suspected Cancer Referrals First Seen Within 14 Days	●	93%	Sep-22	62.0%	73.0%	72.6%		↑	
	Patients receiving treatment for cancer within 62 days of an urgent GP referral	●	85%	Sep-22	48.1%	51.6%	60.5%		↓	
	Total 62 Day Backlog (ULHT)		-	Oct-22	540	N/A	N/A		↓	
	Total 104 Day Backlog (ULHT)		-	Oct-22	171	N/A	N/A		↑	
	% of patients told cancer diagnosis outcome within 28 days (ICB)	●	75%	Sep-22	57.7%	65.4%	67.2%		↑	
Planned Care	RTT: % of incomplete pathways within 18 weeks	●	92%	Sep-22	51.8%	55.7%	59.4%		↓	
	Percentage waiting six weeks or less for a diagnostic test	●	99%	Sep-22	57.0%	60.9%	70.2%		↑	
	Patients waiting over 52 weeks for treatment (% of total ICB waiting list size)		0%	Sep-22	8.2%	7.8%	5.7%		→	
	Patients waiting over 104 weeks for treatment (% of total ICB waiting list size)		0%	Sep-22	0.02%	0.05%	0.03%		→	
	Patients waiting over 78 weeks for treatment (ICB)		0	Sep-22	954	-	-		↑	
	Total waiting list size (ICB)		-	Sep-22	112,105	N/A	N/A		↑	
	Total elective spells (ICB)		10,509	Sep-22	10,036	N/A	N/A		↑	
Mental Health	IAPT access - people that enter treatment (ICB)	●	2.75%	Jun-22	1.84%	N/A	1.62%		↓	
	IAPT recovery rate (ICB)		50%	Jun-22	52%	N/A	0%		↑	
	Inappropriate Out of Area Placements for adults per 100,000		-	Jul-22	9	128	111		↓	
	People experiencing first episode psychosis waiting to start a package of care (ICB)	●	60%	Sep-22	41%	N/A	N/A		↑	
	Estimated diagnosis rate for people with dementia (ICB)		66.7%	Sep-22	61.6%	61.3%	62.2%		→	
	People with SMI who have received six physical health checks in the preceding 12 months (ICB)		60%	22/23 Q2	44.9%	41%	43%		↑	
	CYP with MH disorder receiving treatment (one contact) in the reporting period last 12 months		7,000	Sep-22	6,995	N/A	N/A		↓	
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)		95%	22/23 Q2	55.9%	N/A	N/A		↑	
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)		95%	22/23 Q2	76%	N/A	N/A		↓	

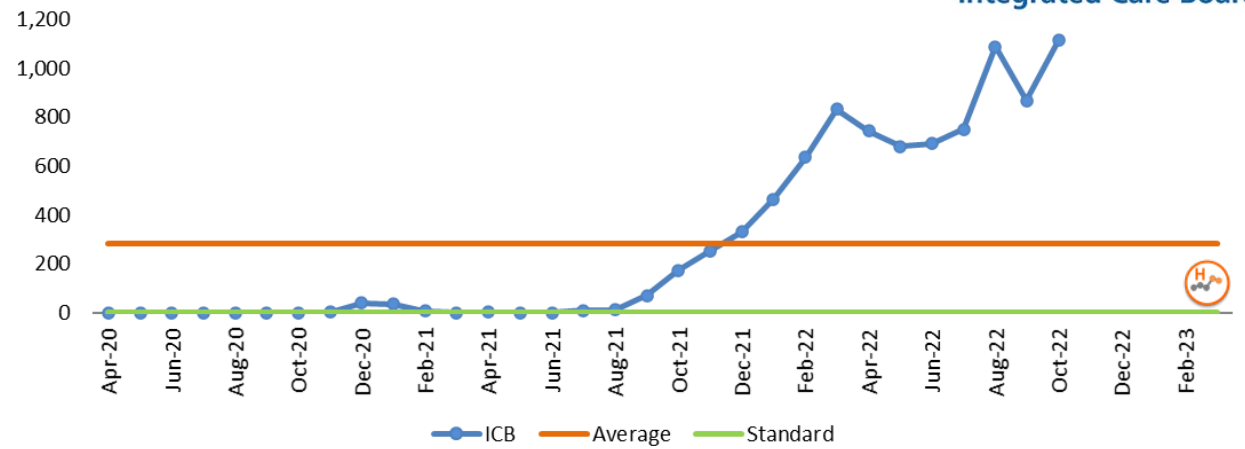
Key Performance Updates November 2022

Programme	Indicator	Cause Identified	Actions Being Taken
Urgent Care	High rate of ambulance handover delays	The main challenges faced by the system have been around demand (time profile and acuity), system wide workforce, capacity for supported discharge and flow through all bedded services.	On 7th November 2022, ULHT implemented 'Breaking the Cycle' this is an approach consistently being implemented across England to move patients waiting beds to wards even if a bed space is not available. A safe and transparent algo-rhythm is in place to ensure patient safety and by ensuring that patients are cared for upon their specialist wards rather than often overcrowded Emergency Departments will ensure swifter specialist oversight, reduce length of hospital stay and help minimise ambulance handover delays. The approach has already had a positive impact with a dramatic reduction in the number of ambulance handover delays during the past 10 days and an associated reduced in system OPEL reporting score.
Cancer	Cancer 62 day backlog	The backlog position has reduced significantly however is still off trajectory at 506 patients over 62 days. Colorectal continues to account for the largest part of the backlog at 58%, the colorectal backlog is now at 294 patients. Almost 100 less patients than last month.	New Rapid Access Colorectal Pathway has gone live this week leading to a significant reduction in referral numbers, referrals this week have totalled 76 compared to 139 the previous week.
Planned Care	Patients waiting over 78 weeks for treatment	Echo continues to be the main challenge and a deep dive was completed by NHSE on 12th October 2022 which has resulted in actions and recommendations to clear the backlog and reduce waiting times. In addition MRI and DEXA are also experiencing challenges.	Outpatient recovery continues to be the biggest area of challenge and is where the majority of patients are currently waiting. The outpatient recovery and improvement programme within ULHT has had a delayed mobilisation. However, a focussed 8 week period will begin in November to drive pace through the programme including increasing clinic efficiency and the roll out of patient initiated follow ups.
Mental Health	Early intervention in psychosis	EIP has 290 patients to 18 staff. Of the 18 staff, x2 are on maternity leave, x2 are on long term absence, x2 staff have resigned with a 3rd resignation has been submitted within the last few weeks. With 7 staff out of a small service, this had a detrimental impact on the service.	Early Intervention in Psychosis remains on the LPFT Divisional risk register, recruitment and retention and increase in demand due to extending the age range remain the significant issues. Ongoing management discussions on how to support the team.

Urgent Care

Ambulance handover times - number of handover delays of > 2 hours A&E attendances- patients waiting over 12 hours (ICB)

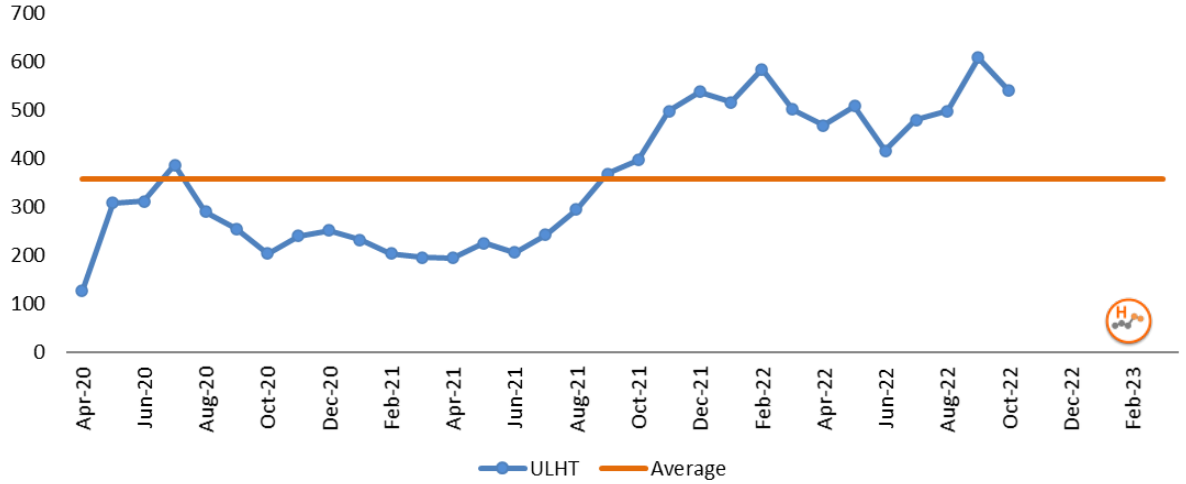




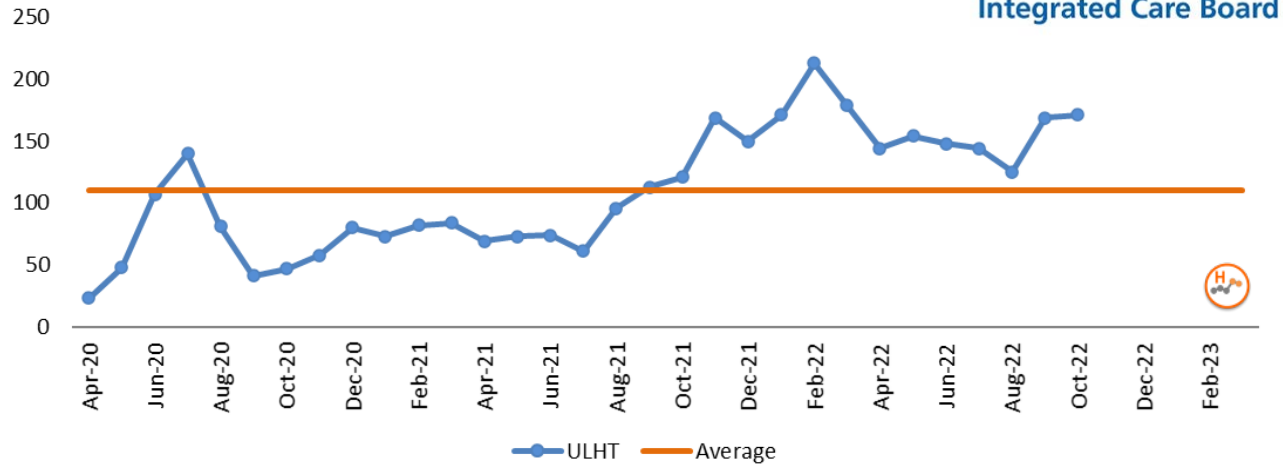
Current system pressures	Actions to recover
• The Lincolnshire system has remained under significant levels of pressure throughout October and into November. • The main challenges faced by the system have been around demand (time profile and acuity), system wide workforce, capacity for supported discharge and flow through all bedded services. 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 resulting in further increasing ambulance handover delays. • Bed occupancy has remained high, but has remained stable. The number of patients in beds over 21 days also remains high. • The number of UTC attendances has reduced slightly, but overall Type 3 activity remains relatively consistent. 4 hour breach numbers within UTCs has increased and in August achieved the 95% target.	• On 7th November 2022, ULHT implemented 'Breaking the Cycle'; this is an approach consistently being implemented across England to move patients waiting beds to wards even if a bed space is not available. A safe and transparent algo-rhythm is in place to ensure patient safety and by ensuring that patients are cared for upon their specialist wards rather than often overcrowded Emergency Departments will ensure swifter specialist oversight, reduce length of hospital stay and help minimise ambulance handover delays. The approach has already had a positive impact with a dramatic reduction in the number of ambulance handover delays during the past 10 days and an associated reduced in system OPEL reporting score. • Internal ULHT work on improving ward processes to maximise efficiency for discharges. This will support de-escalation at the front door, reducing the clinical risk in community as a result of ambulance handover delays. UCRIG commenced – senior clinical and operational leadership driving improvements • ULHT started full capacity protocol pilot – demonstrating early improvements to flow. • LCHS bolstering community nursing workforce to improve resilience and capacity. • LCHS progressing with VW development to ensure services are enhanced to provide capacity to support pressures this winter where possible. • Strategic oversight of the current pressures and development winter mitigations.

Cancer

Total 62 Day Backlog (ULHT)



Total 104 Day Backlog (ULHT)

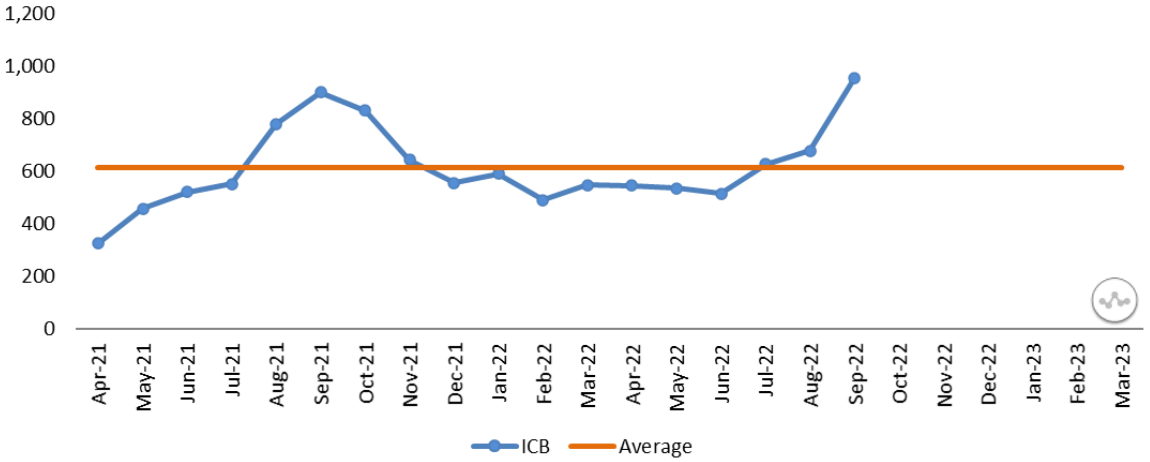


NHS Lincolnshire Integrated Care Board

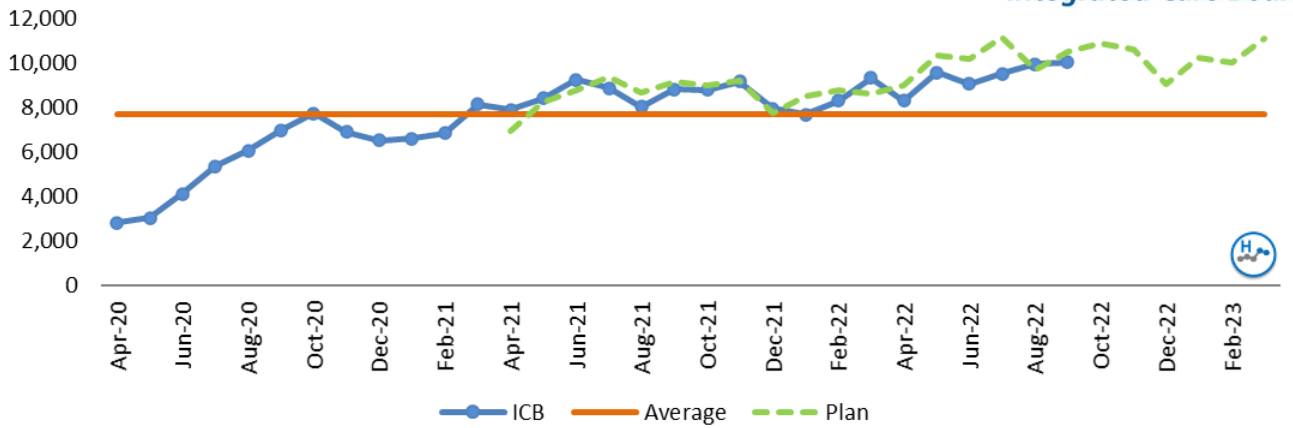
Current system pressures	Actions to recover
• The backlog position has reduced significantly however is still off trajectory at 506 patients over 62 days. Colorectal continues to account for the largest part of the backlog at 58%, the colorectal backlog is now at 294 patients. Almost 100 less patients than last month. • Referral rates remain higher than previous years, however they do appear to be reducing. • Colorectal referrals continue in high numbers at 176% above baseline until the first week of November. • Lung have also seen a significant increase in referrals, referral numbers have increased by 25% to 534 in October compared to July of this year. Capacity for 1st outpatient appointment is severely impacted with a wait time of 7 weeks.	• Daily colorectal recovery meetings with Executive lead – Simon Evans. Focus is on reducing number of patients over 62 days. • New Rapid Access Colorectal Pathway has gone live this week leading to a significant reduction in referral numbers, referrals this week have totalled 76 compared to 139 the previous week. • New process agreed between Radiology and Respiratory teams to discharge normal CTs at radiology to reduce workload has gone live but has not improved workload as referral numbers have increased. Meeting to be convened in next week between ICB & ULHT to discuss an action plan.

Planned Care

Patients waiting over 78 weeks for treatment (ICB)



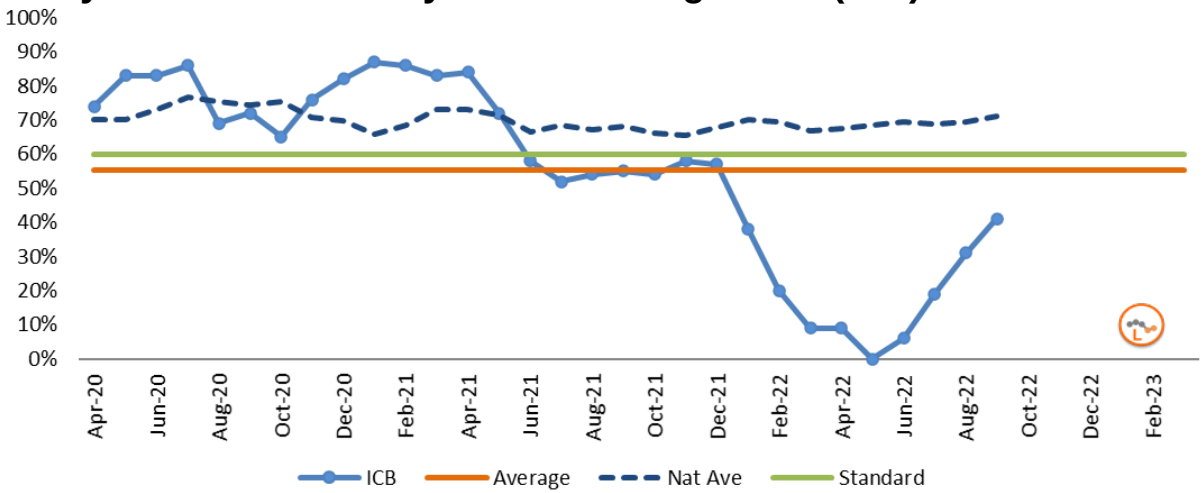
Total Elective Spells (ICB)



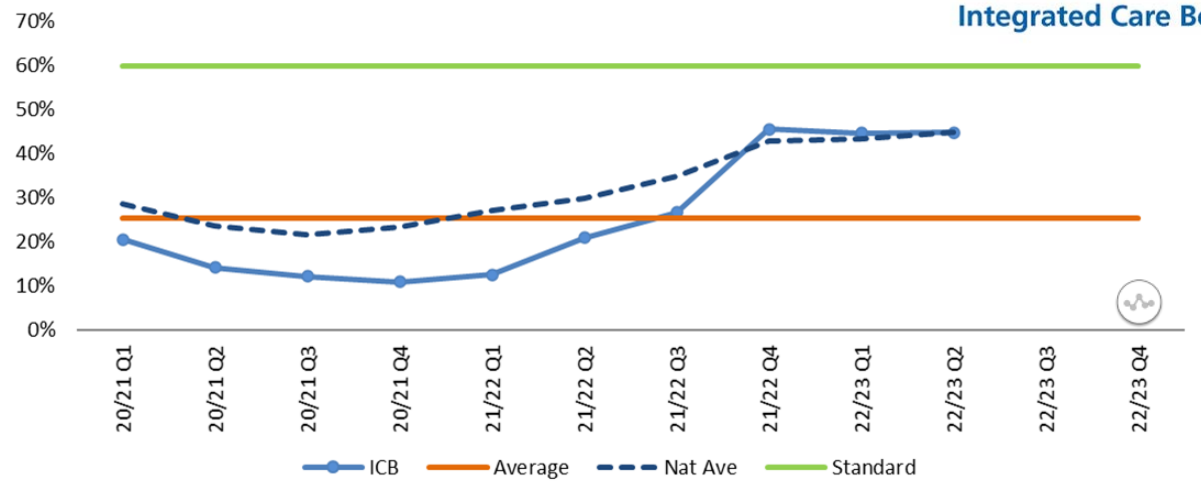
Current system pressures	Actions to recover
• It is important to view and read this in the context of the current National Covid Restore Agenda and the move away from a focus on constitutional standards to the expectation of focus upon cancer and clinical urgency. • This means there is a clinical risk based patient selection process as opposed to selection based upon the longest waits. Within this context it is unlikely that there will be material improvement to statutory RTT performance for some time. • Hospitals continue to experience patients who are reluctant to travel to alternative sites where wait times may be quicker. • Workforce levels continue to be a challenge for Providers • Lincolnshire are performing better than any other system across the Midlands region in respect of their achievement against 120% activity based on 2019/20 activity levels for diagnostic performance, with 5 out of the 9 modalities already achieving in excess of 120% activity. Echo continues to be the main challenge and a deep dive was completed by NHSE on 12th October 2022 which has resulted in actions and recommendations to clear the backlog and reduce waiting times. In addition MRI and DEXA are also experiencing challenges. Additional capacity for these 3 modalities is planned within the current Grantham Community Diagnostic Centre and the future second CDC.	• Majority of Providers have eliminated waits of over 104 weeks except where patients have chosen to wait longer. Some Providers outside of Lincolnshire are challenged in meeting the national waiting list targets. The University Hospitals of Leicester had over 200 patients waiting 104 weeks in mid-October (as at 23rd October, this included 6 Lincolnshire patients) • ULHT are on track to eliminate waits of over 78 weeks by the end of March 2023 although there are some challenges expected within a few specialties. • The system continues to use and liaise with the independent sector providers to ensure maximum capacity for Lincolnshire patients. A national 'Super September' initiative delivered by the Elective Activity Coordination Hub resulted in over 2000 patients being contacted over a 2 week period to check whether their appointment was still required and offer them an alternative provider. • Outpatient recovery continues to be the biggest area of challenge and is where the majority of patients are currently waiting. The outpatient recovery and improvement programme within ULHT has had a delayed mobilisation. However, a focussed 8 week period will begin in November to drive pace through the programme including increasing clinic efficiency and the roll out of patient initiated follow ups. ICB specialist advice usage which is also part of the OP recovery programme is above the national target of 16% of first outpatient appointments

Mental Health

Early Intervention in Psychosis Waiting Times (ICB)



Physical Health Checks for people with SMI (ICB)



NHS Lincolnshire Integrated Care Board

Current system pressures	Actions to recover
• The derivations necessary to support reporting under the new commissioning structures are underway but are yet to be completed. As a result, it has not been possible to include ICB breakdowns in the IAPT publication data since July 2022. • Although the 60% standard for early intervention in psychosis (EIP) waiting times is not being met, there are improvements in the delays. • EIP has 290 patients to 18 staff. Of the 18 staff, x2 are on maternity leave, x2 are on long term absence, x2 staff have resigned with a 3rd resignation has been submitted within the last few weeks. With 7 staff out of a small service, this had a detrimental impact on the service which accounted for the 6% for EIP service. • Latest performance data for physical health checks for patients with severe mental illness shows performance is stable, with improvement anticipated in Q4.	• Early Intervention in Psychosis, remains on the LPFT Divisional risk register, recruitment and retention and increase in demand due to extending the age range remain the significant issues. Ongoing management discussions on how to support the team. • To address the vulnerable situation, Service managers have offered out bank staff (from within LPFT), overtime which has had a good uptake from staff and also offered weekend appointments which has brought the service back to the 60% national marker. • LPFT have put in place systems to enable sharing of SMI health check data and outcomes with GP practices. Health checks carried out in secondary care can be coded in clinical systems giving a more complete picture of local delivery. • Funding is available to develop a community outreach model for SMI healthcheck delivery – recruitment to project management capacity has been delayed slightly but expected to be underway in Nov. Funding also available for personalisation in SMI health checks has been received from NHSE and will be factored into the programme in Q4.

Lincolnshire ICB Quality Dashboard

Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Direction	Variation
Incidents	Never events (ULHT)		0	Oct-22	1	N/A	N/A		↑	
	Never events (NLAG)		0	Oct-22	0	N/A	N/A		→	
	Never events (NWAFT)		0	Oct-22	0	N/A	N/A		↓	
	Serious Incidents (ICB)		-	Oct-22	29	N/A	N/A		↑	
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)		1.0000	Jun-22	1.0672	1.0387	1.0001		↑	
	Hospital Standardised Mortality Ratio (HSMR) (ULHT)		100	Sep-22	95.34	N/A	N/A		↑	
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)		1.0000	Jun-22	1.0317	1.0387	1.0001		↑	
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)		1.0000	Jun-22	1.0888	1.0387	1.0001		↓	
Infection, Prevention, Control	MRSA Cases (ICB)		0	Sep-22	1	0.4	0.6		→	
	C. Difficile Cases (ICB)		0	Sep-22	18	15.4	13.3		↓	
	E-Coli Cases (ICB)		0	Sep-22	51	36.5	32.9		↓	
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICS)		13	Oct-22	17	N/A	N/A		↓	
	Rate per 1000 of people with a learning disability receiving inpatient care (ICB)		-	Oct-22	51	44	41		↑	
	Cumulative Learning Disability Healthchecks (ICB)		929	Sep-22	943	N/A	N/A		↑	
Patient Experience	Patient experience of GP services (ICB)		-	2022	72.2%	70.5%	72.4%		↓	
	Friends & Family Test: A&E Recommended (ULHT)		-	Jul-22	75.2%	74.5%	74.5%		↑	
	Friends & Family Test: Inpatient Recommended (ULHT)		-	Jul-22	87.6%	92.7%	93.6%		↓	
	Friends & Family Test: Maternity Recommended (ULHT)		-	Jul-22	95.5%	91.8%	95.2%		↑	
	Friends & Family Test: Community Recommended (LCHS)		-	Jul-22	85.8%	91.8%	95.2%		↑	
	Friends & Family Test: Mental Health Recommended (LPFT)		-	Jul-22	91.2%	86.4%	86.1%		↑	
Primary Care	Primary Care CQC- number of practices rated as 'Inadequate' by CQC		0	Oct-22	1	N/A	N/A		→	
	Primary Care CQC- number of practices rated as 'Requires Improvement' by CQC		-	Oct-22	5	N/A	N/A		↑	
	GP Appointments- percentage seen by a GP		38.2%	Aug-22	33.0%	N/A	N/A		↑	
	GP Appointments Mode- percentage seen face to face		63.0%	Aug-22	73.4%	N/A	N/A		↑	
	GP Appointments- time from booking to appointment same day		48.6%	Aug-22	41.0%	N/A	N/A		↑	
	GP Appointments- time from booking to appointment 1-6 days		21.7%	Aug-22	22.6%	N/A	N/A		↓	
	The number of extended access appointments booked excluding did not attends (ICB)		5723	Aug-22	4987	N/A	N/A		↓	
	The percentage of available GP extended access appointments utilised (ICB)		80%	Aug-22	76.5%	N/A	N/A		↑	

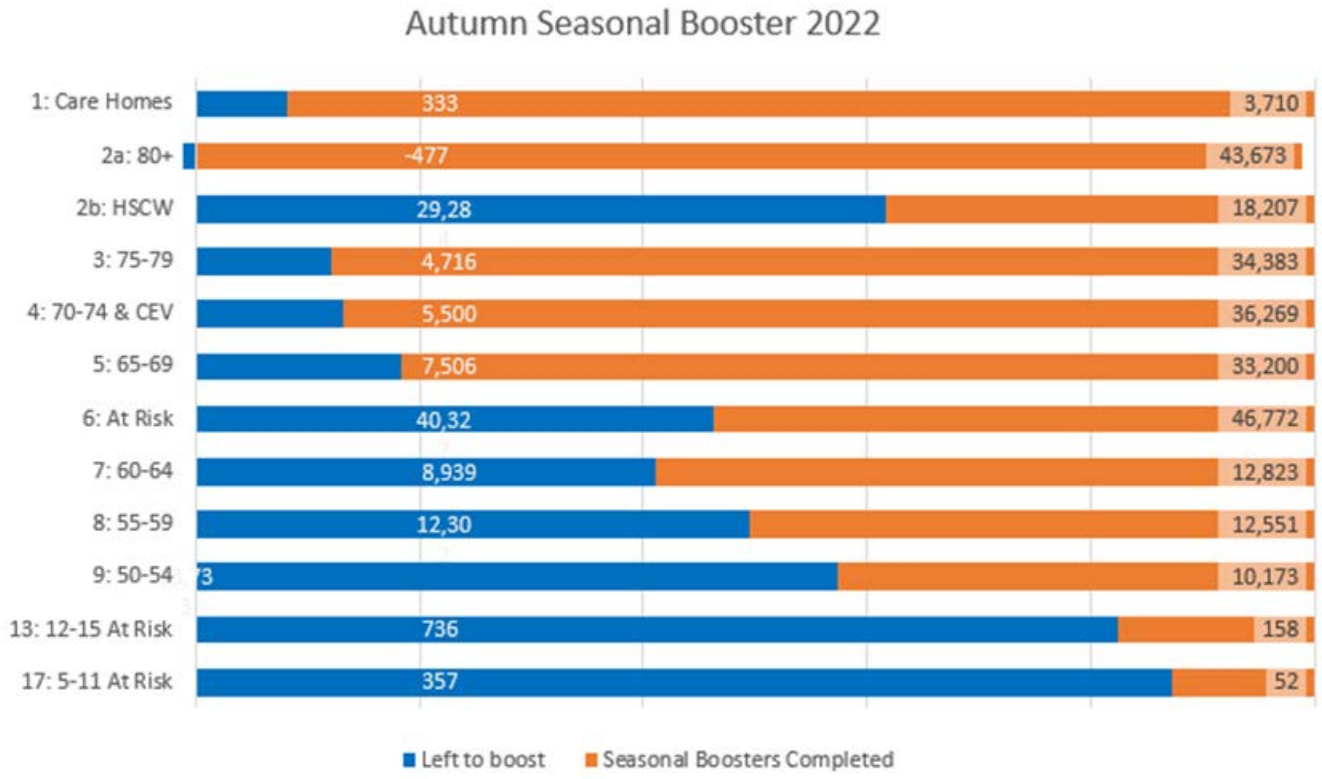
Key Quality Updates November 2022

Programme	Indicator	Cause Identified	Actions Being Taken
Serious Incidents	Never Events	There has been a single never event reported in relation to Lincolnshire patients in October 2022. The never event was reported by ULHT and related to a retained foreign object post procedure.	• Full investigation reports are received by the ICB quality services team which include actions that have been taken as a result of the incident being reported and subsequently investigated. • The completed Never Event Report is taken through the ICB Serious Incident Review Group Meeting. The investigation is reviewed, assurance secured where necessary and closure of the incident agreed – or further action identified (where required).
Infection, Prevention & Control	Communicable disease outbreaks	The ICB Health Protection Team continue to monitor both Monkeypox and Covid trends and guidance. The team have been supporting the Local Authority with a high number of scabies outbreaks in care homes.	• The ICB Health Protection team put in place an immediate response to communicable disease outbreaks internally and usually without disruption to any other health service provision and has been noted by UKHSA as a successful model.
Learning Disabilities	LD Inpatients	There are currently 17 LDA ICB Inpatients. This current figure is above the October target of 13) There are currently 11 LDA IMPACT inpatients below target of 14	• Recruitment to community forensic and crisis and home treatment teams with posts readvertised and a number of appointments made. • DSR process working well with significant impact on admission rates • ICB working with LCC to support market development of community based options for current long stay inpatients
Primary Care	CQC Inspection	Trent Valley Practice has been rated as Requires Improvement by the CQC. The inspection report is now available on the CQC website.	• ICB representatives continue to meet regularly with all practices with CQC concerns to receive assurance on continued actions to address the concerns and to support. LMC are also supporting.

Covid-19 Vaccinations

NHS Lincolnshire Integrated Care Board

All Cohorts	Evergreen 1st Doses	Evergreen 2nd Doses	Evergreen 3rd Doses	Seasonal Booster
Total Completed	626,363	601,442	15,525	254,884
Activity Last 7 Days	123	250	8	24,352
Difference from previous week	**12**	**-34**	**-5**	**-4,980**

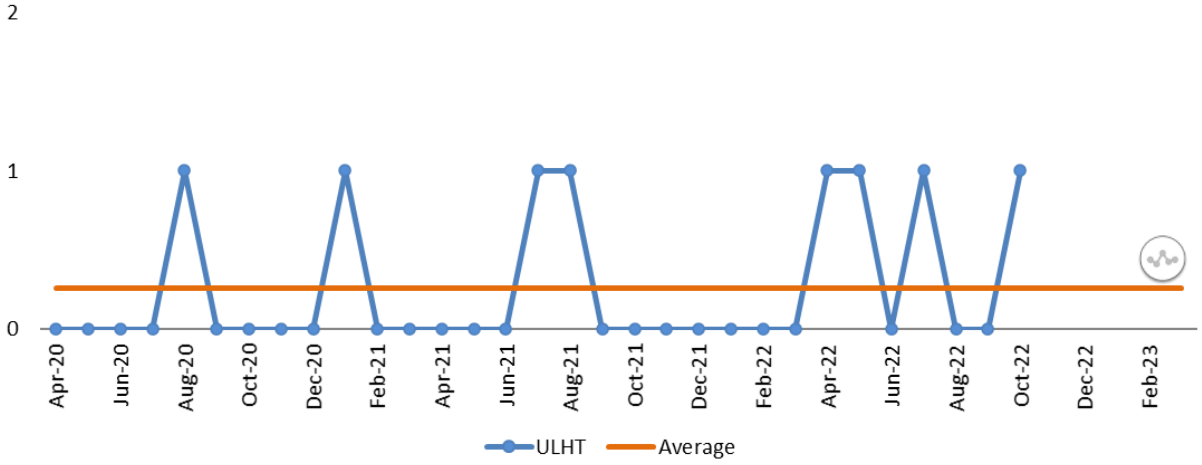


Update

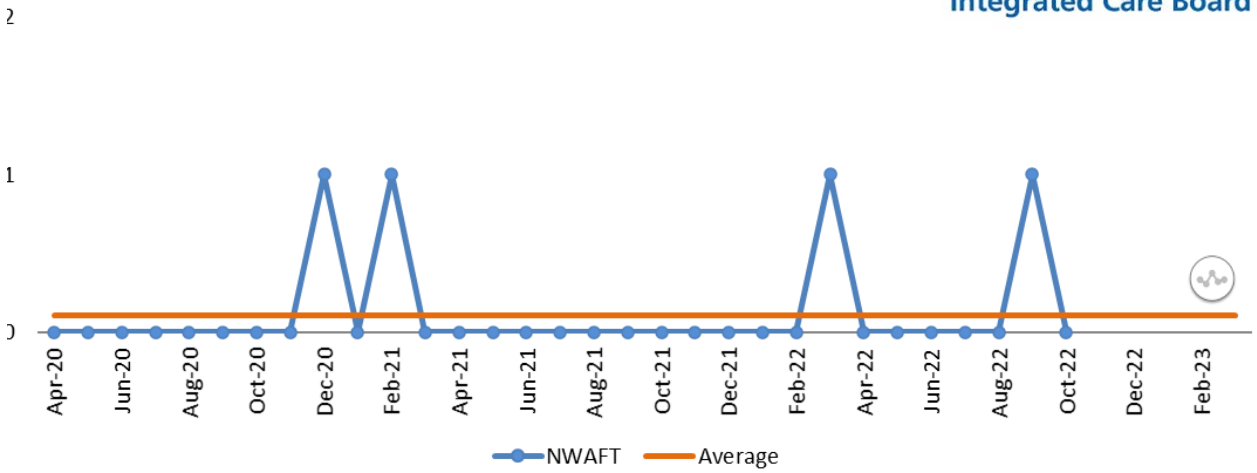
- The Autumn booster programme went live 5th September 2022 with Care Home visits
- All eligible patients are now able to book appointments at vaccination centres
- This will be delivered in partnership by PCNs, the Mass vaccination centres, the Hospital Hub and Community pharmacies, as has been the case in previous phases of the vaccination programme.
- The following groups are eligible for an Autumn booster covid vaccination
  - aged 50 or over
  - pregnant
  - aged 5 to 49 years and at high risk due to a health condition
  - aged 5 to 49 years and at high risk due because of clinical vulnerabilities
  - aged 5 to 49 years and live with someone who has clinical vulnerabilities
  - aged 16 to 49 years and are a carer
  - living or working in a care home for older people
  - frontline health and social care workers

Never Events

Never Events (ULHT)



Never Events (NWAFT)



Lincolnshire Integrated Care Board

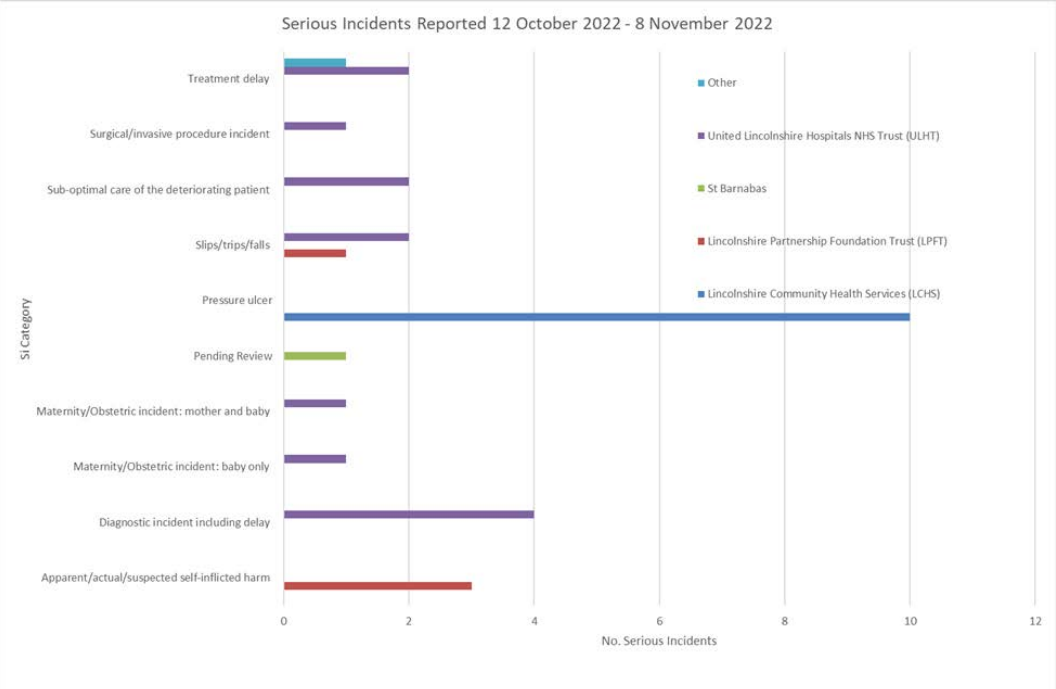
Current system pressures

- There has been a single never event reported in relation to Lincolnshire patients between 12 October – 8 November 2022. The never event was reported by ULHT and related to a retained foreign object post procedure.

- The table below indicates the never events reported between 1 April 2022 – 31 August 2022 by Trusts providing care to Lincolnshire patients. The table has been updated using information from NHS England/Improvement publication illustrating Never Events Reported between 1 April 2022 – 31 August 2022 (published 13 October 2022).

	Apr-22	May-22	Jun-22	Jul-22	Aug-22
United Lincolnshire	1	0	1	1	0
Lincolnshire Partnership	0	0	0	0	0
Doncaster & Bassetlaw	1	0	0	0	0
North West Anglia	0	0	0	1	1
Northern Lincs & Goole	0	0	0	0	0
Nottingham University	1	0	0	0	1
Sherwood Forest	0	0	0	1	0
The Queen Elizabeth	0	0	0	0	0
University Leicester	0	3	0	0	0

Serious Incidents



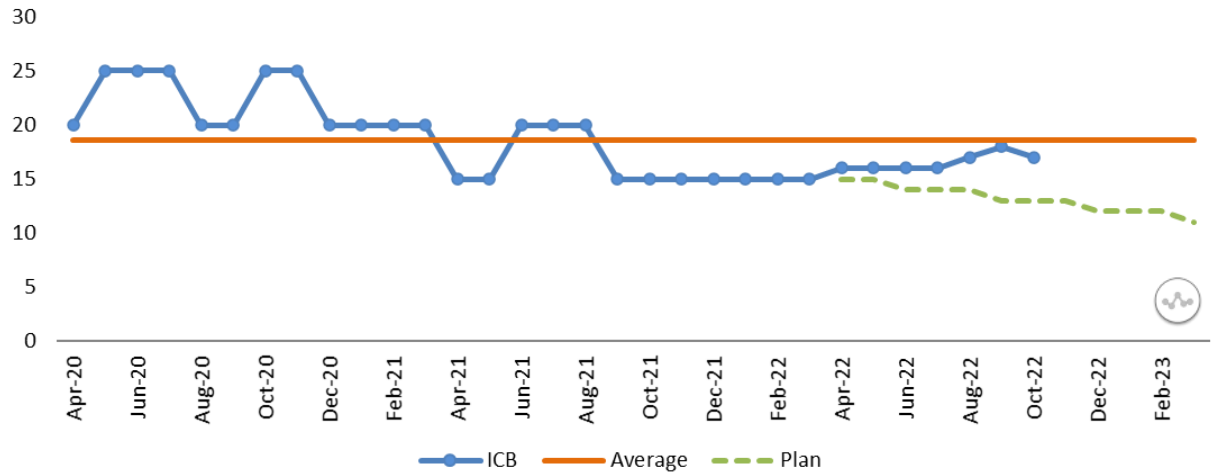
Update

• There has been a total of 29 serious incidents reported between 12 October 2022 – 8 November 2022, this is in keeping with previous reporting rates i.e., September (n=23). It is noted that there had been 59 serious incidents referenced in the last report (October), this was attributed to the data collection period extending over 34 days.
• During the timeframe referenced there have been (n=10) serious incidents reported by LCHS. The focus of serious incident reporting for the Trust continues to be category 3 and 4 pressure ulcers (n=10).
• ULHT reported a total of (n=13) serious incidents within the timeframe referenced. Reflective of previous reports, diagnostic incidents (n=4); slips/trips/falls (n=2); sub optimal care of deteriorating patient (n=2); maternity service incidents (n=2) and treatment delays (n=2) continue to be a focus of serious incident reporting for the Trust. In addition, there were also single serious incidents reported in relation to a surgical/invasive procedure, which was categorised as a never event. The never event related to a retained foreign object post procedure.
• LPFT reported a total of (n=4) serious incidents in the timeframe referenced, the focus of the Trusts serious incident reporting continues to be apparent/actual/suspected self-inflicted harm (n=3). In addition, the Trust reported a single slip/trip/fall serious incident.

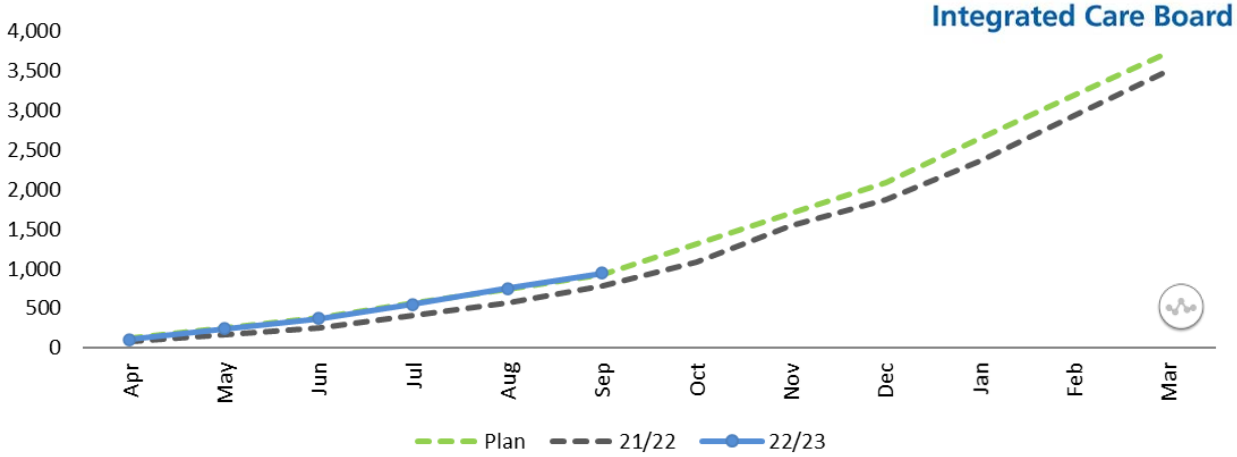
Learning Disability & Autism

NHS Lincolnshire Integrated Care Board

People with a learning disability/autism receiving inpatient care (ICB)



Learning Disability Annual Healthchecks (ICB)

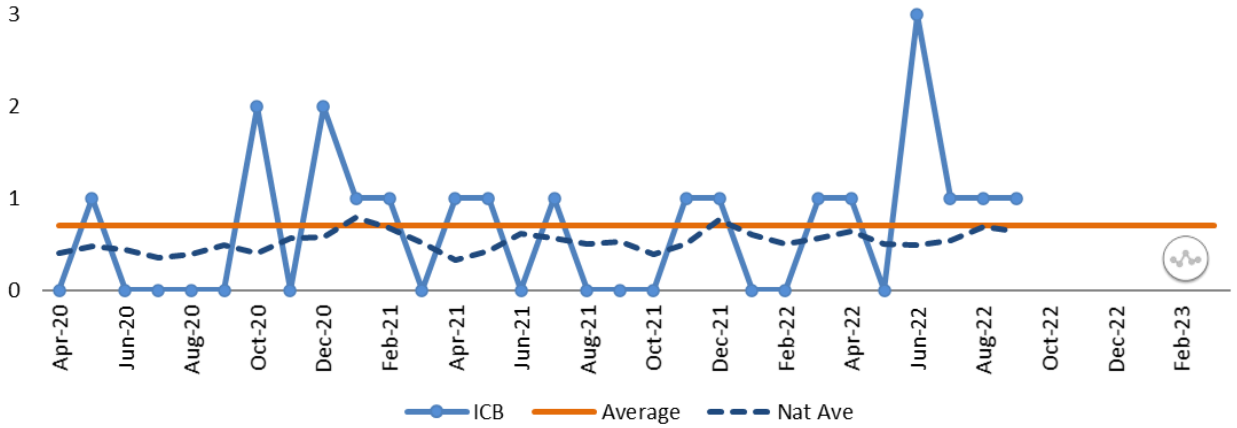


Current system pressures	Actions to recover
LD Inpatients • There are currently 17 LDA ICB Inpatients. This current figure is above the October target of 13) There are currently 11 LDA IMPACT inpatients below target of 14	**LD Inpatients** • Recruitment to community forensic and crisis and home treatment teams with posts readvertised and a number of appointments made. • DSR process working well with significant impact on admission rates • ICB working with LCC to support market development of community based options for current long stay inpatients
LD Health checks • Delivery YTD is 943 Health Checks, ahead of YTD delivery for 21/22 and ahead of the plan for 22/23. • It is too early for a robust performance projection but current data indicates delivery of the 85% target by year end.	**LD Health checks** • Planning for 22/23 required factoring in of missed checks from 21/22 over Q1 and Q2. Data indicates that this catch up is happening. • 9 PCNs signed up to the additional catch-up funding from NHSE with 1 PCN dropping out during the project due to competing demands. • Work with LPFT on promoting dementia screening as part of the health check is being undertaken.

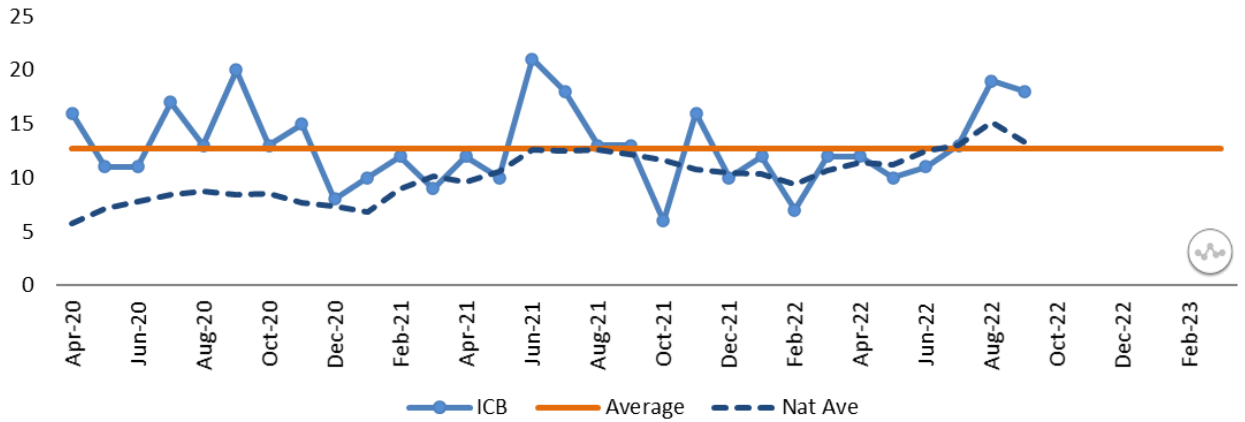
Infection, Prevention & Control

NHS Lincolnshire Integrated Care Board

Infection Prevention & Control- MRSA Cases (ICB)



Infection Prevention & Control- C-Diff Cases (ICB)



Current system pressures	Actions to recover
MRSA • To date 1 MRSA bloodstream infection case has been reported by ULHT. The total number of ICB cases is 5. **ULHT** • The ICB Health Protection (HP) Team will be conducting a routine assurance visit this month (October) and will focus on criteria 3, 5, and 7 of the of the Health and Social Care Act (Code of Practice). **Communicable disease outbreaks** • The ICB Health Protection Team continue to monitor both Monkeypox and Covid trends and guidance. The team have been supporting the Local Authority with a high number of scabies outbreaks in care homes. • The HP team have begun responding to Avian Influenza outbreaks which have begun unusually early in the season. We are expecting a long season with many outbreaks, as we had last year.	**MRSA** • Each case of hospital onset MRSA bloodstream infection is investigated and managed through the Trusts Infection, Prevention & Control (IPC) group meetings. From April 2022, each system case will be investigated and reported through the DIPC. **ULHT** • ULHT are reviewing their C.diff cases and implementing a reduction plan. Criteria 3 focusses on appropriate antimicrobial use. The HP team will be reviewing the Trust systems and processes in place to monitor antimicrobial use. **Communicable disease outbreaks** • The ICB Health Protection team put in place an immediate response to communicable disease outbreaks internally and usually without disruption to any other health service provision and has been noted by UKHSA as a successful model. • The team issue antivirals to any exposed or soon to be exposed workers at the infected sites and the local rendering plant.

Care Home Quality

CQC rating October 2022	Outstanding	Good	Requires Improvement	Inadequate
No. of Homes: 278 16 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	185 (3 hoes less than last month)	55 (remains the same as last month)	6 (2 more than last month)

CQC rating November 2022	Outstanding	Good	Requires Improvement	Inadequate
No. of Homes: 278 15 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	187 (2 homes more than last month)	54 (1 homes less than last month)	4 (2 less than last month)

Update

The CCG Safeguarding Leads (Head of Safeguarding Adults & Continuing Health Care Safeguarding Lead) have with Lincolnshire County Council (LCC) colleagues undertaken assurance visits to providers, where indicated by risk assessment. Homes identified as high risk according to the risk matrix are discussed at the monthly Service Quality Review meetings, led by LCC.

Care Homes with high risk issues – under enhanced level of surveillance via CCG/LCC officers: x15 providers (down two from last month)

There are 4 Suspensions in place by Health and Lincolnshire County Council:

- One in each locality
- Themes include LD placements, lack of leadership and governance, poor quality care plans and pressure management

There has been a total of 12 Default Notices by Lincolnshire County Council:

- Across all localities
- Themes include poor quality care homes, safeguarding and quality concerns, inadequate staffing and poor governance

A new Operational Quality Review Group (OQRG) has been set up by Wendy Martin following a business case review on how the ICB assures itself on the quality of care delivery in care homes commissioned by the ICB. This group has an ICS representation to identify themes and trends in care homes and provide strategies on how the system can support and improve quality.
November 2022

Safeguarding

Safeguarding Team

- Jenny Harper, Designate Nurse Safeguarding Adults, Children and Looked After Children retired on 31st October. Nicola Wilkinson has now commenced in this position. Following approval for the restructure of the ICB safeguarding team, there has been movement within the team and new post is currently out for recruitment. In addition to the change of Designate, Gail Colley-Bontoft has been appointed as Deputy Designate Nurse Safeguarding Adults, Children and Looked After Children, Rebecca Pinder to Head of Safeguarding Children, Looked After Children and Transition and Claire Tozer to Head of Safeguarding Adults and Primary Care

Partnership Working

- In total the boards have x9 ongoing DHR, x1 SAR: scoping continues for one potential SAR and x1 combined Child Safeguarding Practice Reviews (CSPR) and DHR. The Designate Doctor has been involved in the Child Sexual Abuse Strategy steering and working groups; the strategy will be launched on the 2nd of November 2022.

Safeguarding Issues/Risks

- Completion of Initial health Assessments within statutory timescales remains a challenge for Lincolnshire. LCHS continue to work proactively to increase medical practitioner sessions (GPs and contract through ULHT for paediatrician sessions). To mitigate the risk, all Children in Care (CiC) who will not receive their assessment within timescales has a health and wellbeing check (completed by the CiC nurses) to assess health needs and identify issues requiring further action and referral. Work ongoing with partners to update the LAC Service Specification. LCCG executives and the LSCP Strategic Management Board are aware of the risk which has been placed on the relevant risk registers.

SEND

The SEND team submitted the fourth Maturity Matrix to NHSE. The matrix is the Integrated Care Boards (ICB) governance and infrastructure self assessment tool is designed 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 ICBs maturity in relation to children and young people with SEND

Lincolnshire ICB rating is green which is very positive and the work congratulated by NHSE. However, issues identified were:

- Provider collaboratives are not established in Lincolnshire currently. Complex CAMHS provider collaborative in place at regional level and our CAMHS service lead at LPFT sits on our SEND Health Committee.
- ICB level data dashboard is work in progress and is a standing agenda item at the SEND Steering Group hosted by the LA.
- Quality framework- Developing a SEND Quality Assurance Group and have draft ToRs, this group will focus on the new cloud based EHCP system which is at the implementation stage.

Primary Care

NHS Lincolnshire Integrated Care Board

Practices Rated Inadequate: 1

Practice	Inspection Date	Locality
Hawthorn Medical Practice	30/09/2022	East

Practices Rated 'Requires Improvement: 5

Practice	Publication Date	Locality
Lakeside Healthcare	01/06/2022	South
Marisco Medical Centre	19/01/2022	East
The Spalding GP Surgery	30/11/2021	South
Branston Surgery	09/11/2021	West
Trent Valley Surgery	19/10/2022	West

New Reports

Practice	Publication Date	Locality	Overall Rating	Previous Rating
Trent Valley Surgery	19/10/2022	West	Req improvement	Good

Actions to recover

Lakeside

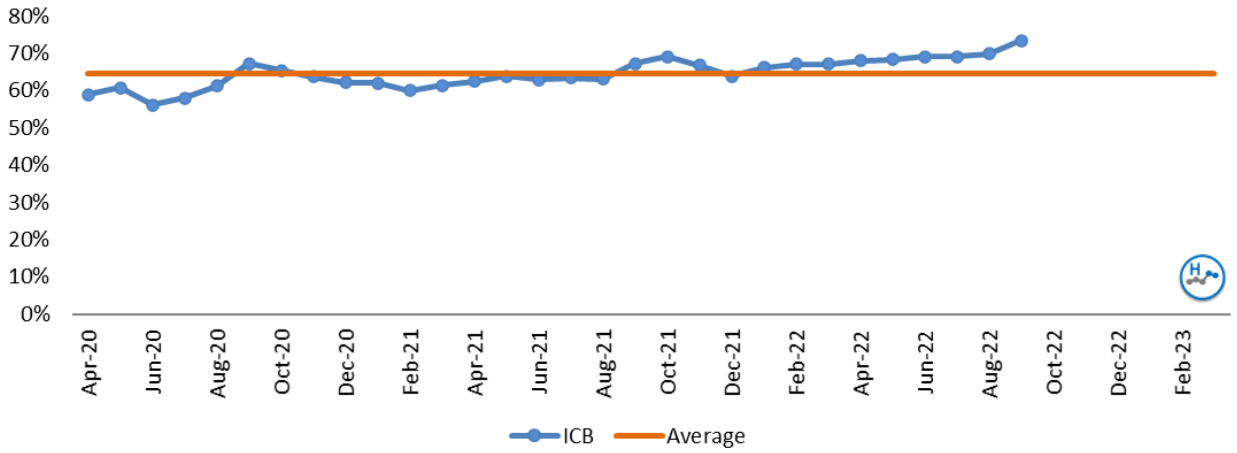
Lakeside received inadequate CQC rating in June 2021. At follow up inspection visit in September 2021 improvements noted, but still areas to address regarding staffing and governance.
Further CQC full inspection in early March 2022 – the CQC report for this inspection was published on the 1st June with an overall requires improvement rating

Hawthorn Practice in Skegness had a CQC inspection in August 2022 and has been rated as inadequate overall and placed in special measures, with a further CQC inspection planned within 6 months. The inspection report is now available on the CQC website. Concerns identified include access issues, dispensary oversight, infection prevention and control, staff training and supervision and also the adequacy of governance systems and processes. The ICB is now meeting with the Practice regularly and in conjunction with the LMC to ensure the Practice has a robust plan to address the improvements required, providing support with those improvement actions where necessary.

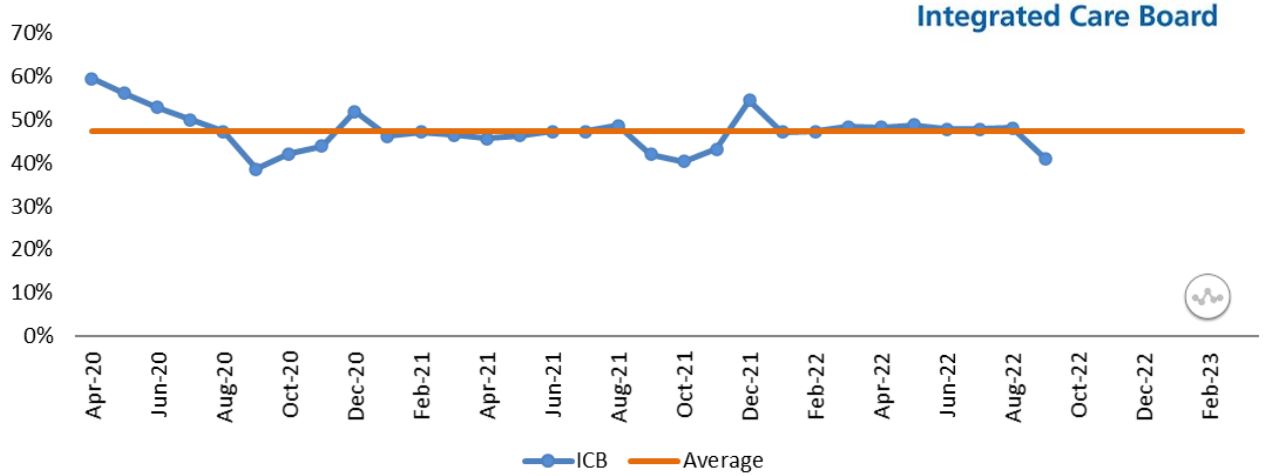
ICB representatives continue to meet regularly with all Practices with CQC concerns to receive assurance on continued actions to address the concerns and to support. LMC are also supporting.

Primary Care

GP Appointments Mode- percentage seen face to face



Time from booking to GP appointment (Same Day)



Current system pressures	Actions to recover
Quality • Trent Valley Practice, Saxilby has been rated as Requires Improvement by the CQC • Hawthorn Medical Practice remains rated Inadequate **Access** • The development of online triage, new ways of working over the covid pandemic alongside introduction of additional, non-medical roles into primary has changed how people access primary care • Access is generally improving although there is month-to-month variation. Data consistency is an issue and GP appt data sets are heavily caveated. Data does not include covid vaccination appts. • Enhanced access data completeness is an ongoing issue.	**Quality** • The ICB is now meeting with the Practice regularly and in conjunction with the LMC to ensure the Practice has a robust plan to address the improvements required, providing support with those improvement actions where necessary. • An improvement plan has been agreed between Trent Valley and the ICB Quality Team **Access** • Practice support available through Livi system and LMC • Lantum available to support practice capacity and actively promoted to practices and PCNs • GPAS monitoring practice pressures and reporting through to OPEL system: managed by the LMC. Discussing the options for more detailed information through GPAS with the LMC. • Primary Care and Performance teams are supporting Enhanced Access reporting and following up with PCN.

5a (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22ND November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	5a (i)
Title of Report:	Winter Plan 2022/23
Purpose:	To note the System Winter Plan 2022/23 Rebecca Neno, ICB Deputy Director for System Delivery
Appendices:	System Winter Plan 2022/23 for Lincolnshire

1.	**Key Points for Discussion:**
The purpose of this report is to present the System Winter Plan 2022/23 for Lincolnshire.	

2.	**Recommendations**
Receive and note the Winter Plan for 2022/23	

3.	**Executive Summary**

The Lincolnshire Integrated Care System (ICS) Winter Plan has been developed collaboratively and influenced by national best practice, guidance issued by NHS England and learning from previous winters within our system.

The health and social care system continues to experience significant levels of pressure and the continued impact of managing increased demand, COVID-19 and elective recovery has led to a challenging summer; particularly in the context of constrained capacity due to infection prevention and control (IPC), workforce issues and the rising cost of living.

We recognise that we need to ensure that services can respond to the increases in demand expected during this time. Resilience over winter can only be achieved through partnership working across the health and social care system. As partners of the ICS, we are committed to working together to manage these challenges.

The purpose of the Winter Plan is to highlight the predictions for winter demand and set out our planned response, with extra initiatives, capacity and information to manage the urgent care and patient flow pressures that the system will inevitably see. The plan is designed to supplement the ongoing improvements and developments in urgent care.

This year we have focussed on the avoidance of patient harm by adopting an approach that focuses on clinical risk, as recommended by our clinicians at our clinical summit.

The following actions have been completed during late Summer / Autumn 2022 as preparation for the winter plan 22/23:

- ✓ Late August Regional Demand & Capacity submissions for beds. The amount awarded to Lincolnshire has been confirmed as 6.08m. The Winter Oversight Group has oversight of delivery and spend and currently, as of 26th October 2022 the programme is overall on track.

- ✓ 31st August Regional winter event with early indications of national expectations

- ✓ 13th September Winter Resilience Oversight Group deep dive to consider current organisational plans, confirm challenge of winter money and opportunities to secure improvements across the urgent care system in readiness for Winter

- ✓ 7th October 2022 system UEC clinical summit which brought together key clinicians and senior officers from across the system to consider experiences, data, projected peaks, key areas of risks and identify areas for improvement (appendix one, agenda of clinical summit)

- ✓ On 18th October 2022, NHS E published a letter to systems 'Going Further on Winter Plans' (appendix 2) specifically systems are asked to:

- ✓ Expand our current falls response service to ensure full geographical coverage between the hours of 08.00 – 20.00, 7 days per week of community-based alternatives for double crewed ambulance response for level one and two falls.

- ✓ Launch a System Response Centre by 1st December to co-ordinate the system and help balance risk.

- ✓ Ensure support is available for High Frequency Users.

- ✓ Decrease inappropriate conveyance from care homes to acute care

- ✓ Realise potential of Virtual Wards and consider development of Acute Respiratory Hubs.

The Winter Plan 22/23 contains a clear ambition for Lincolnshire which will be utilized to orientate and guide decisions during the preparation for and delivery of Winter, this ambition states that our residents can expect:

1. Assessment for and access to admission avoidance services where they can be safely cared for without the need to be admitted to acute hospital care
2. Where required a 999-ambulance response time that is in line with national targets and if conveyance to an acute hospital is required, ambulance handovers will be minimised and in line with agreed trajectories.
3. When acute hospital admission is necessary, care will be optimised early by speciality and discharge will be within 24 hours of being declared medically fit. Where ongoing care needs have been identified, discharge may be to another suitable health or care facility or at home.

The Winter Plan 22/23 clearly sets out the actions and schemes that will be delivered during winter 22/23 and describes the governance mechanisms to help identify early issues and the need for course corrections.

4.	Management of Conflicts of Interest
None identified.	
5.	**Risk and Assurance**
Risks are clearly defined within the document and included or escalated on the ICB Risk Register where necessary. A system risk register has been introduced for UEC and is overseen by the UEC Partnership Board.	
6.	**Financial/Resource Implications**
Detailed within the plan, additional 6.08million secured for Lincolnshire Winter Plan 2022/23.	
7.	**Legal, Policy and Regulatory Requirements**
None identified.	
8.	**Health Inequalities implications**
None identified.	
9.	**Equality and Diversity implications**
None identified.	
10.	**Patient and Public Involvement (including Communications and Engagement)**
Communication plan in place to support the Winter Plan 2022/23.	
11.	**Report previously presented at**
System Service Delivery & Performance Committee – 16th November 2022.	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Rebecca Neno, Deputy Director System Delivery, rebecca.neno@nhs.net Clair Raybould, Director for System Delivery, clair.raybould@nhs.net	

NHS
Lincolnshire
Integrated Care Board

Lincolnshire Integrated Care System

Winter Preparedness

2022-2023



Executive summary

The Lincolnshire Integrated Care System (ICS) Winter Plan has been developed collaboratively and influenced by national best practice, guidance issued by NHS England and learning from previous winters within our system.

The health and social care system continues to experience significant levels of pressure and the continued impact of managing increased demand, COVID-19 and elective recovery has led to a challenging summer; particularly in the context of constrained capacity due to infection prevention and control (IPC), workforce issues and the rising cost of living.

We recognise that we need to ensure that services can respond to the increases in demand expected during this time. Resilience over winter can only be achieved through partnership working across the health and social care system. As partners of the ICS, we are committed to working together to manage these challenges.

The purpose of the Winter Plan is to highlight the predictions for winter demand and set out our planned response, with extra initiatives, capacity and information to manage the urgent care and patient flow pressures that the system will inevitably see. The plan is designed to supplement the ongoing improvements and developments in urgent care.

Urgent action is required to address the ambulance handover delays within the Lincolnshire system to ensure we meet agreed trajectories, and our residents receive the best possible care and experience.

This year we have focussed on the avoidance of patient harm by adopting an approach that focuses on clinical risk, as recommended by our clinicians at our clinical summit. Figure 1 shows the key risks associated with ambulance handover delays (aligned with NHSE clinical review of standards). These risks will be mapped throughout the document to illustrate the intended impacts. All risks are interlinked, therefore the addressment of one is likely to impact others.

Contents

1.Introduction

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

We recognise the importance of all local health and care providers and commissioners working together to provide the best services we can. This document outlines our collective response to urgent and emergency care during anticipated peak times of demand to ensure patients get the safest, most effective, and efficient services.

This winter, we recognise that we require additional capacity to manage the number of patients that will require health and care. Other improvements are required to improve the access and timeliness of services, including immediate action to address the ambulance handover delays within Lincolnshire. As ambulance handover delays is a system priority, we are working to share the risk more widely to avoid the delays in care for those using our ambulance service and emergency departments (EDs). Our winter plan outlines the additional capacity we will create during the winter period and does not include any core services already been delivered across Lincolnshire.

System partners across Lincolnshire have been focussed on winter preparations since late summer and the following page details the work undertaken to date to ensure we develop robust plans to keep patients as safe as possible. Through this collaborative approach, the Lincolnshire system has agreed a clear and concise ambition to help orientate and guide all work during the winter period.

Within Lincolnshire, health and care is always delivered with a 'Home First' focus, however if this is not possible, residents can expect:

- Assessment for and access to admission avoidance services where they can be safely cared for without the need to be admitted to acute hospital care
- Where required a 999-ambulance response time that is in line with national targets and if conveyance to an acute hospital is required, ambulance handovers will be minimised and in line with agreed trajectories.
- When acute hospital admission is necessary, care will be optimised early by speciality and discharge will be within 24 hours of being declared medically fit. Where ongoing care needs have been identified, discharge may be to another suitable health or care facility or at home.

2. Context

The purpose of the winter plan is to communicate the Lincolnshire system approach for winter, the specific pressures that winter presents for our system and how we intend to mitigate them. Urgent and Emergency Care is under significant pressure across the country. Staff have faced one of the busiest summers ever with record numbers of Emergency Department attendances, ambulance call outs and a further wave of Covid. Despite our best effort staff have not always been able to provide timely access for our patients in the way they would have wanted. Winter 2022/23 is expected to bring additional demands with higher-than-average influenza rates, the return of norovirus outbreaks and a further wave of COVID19 with the potential for new variants as the population regains normal social activity. Lincolnshire have the following measures in place to address this:

- ✓ **Arrangement with primary care out-of-hours provider to prescribe flu prophylaxis to those meeting the clinical requirements.**
- ✓ **COVID19 Medicines Delivery Unit (CMDU) 7 days a week.**
- ✓ **Care home Infection Prevention and Control support including local outbreak management support.**
- ✓ **ICS wide Infection and Prevention Control group to share best practice, standardise approaches to guidance implementation, learn from outbreaks and monitor infection rates.**
- ✓ **Pre-winter review of learning from outbreaks in NHS providers to inform outbreak management practice.**
- ✓ **ICB engagement in all outbreak meetings across the system.**
- ✓ **Provider local policies and processes to maintain safe respiratory pathways and prevent the spread of infection.**

This winter it will be more important than ever to work as one system, we will not only have the pressure from both covid and influenza; we will also have the additional pressures as a result of the cost-of-living crisis which could enhance the pressure on health and other services. To address this, a Lincolnshire Task Force focusing on the rising cost of living and its social impact locally has been launched. The forum provides an opportunity to bring together a range of stakeholders to share their knowledge of the impact and support available for our population and communities. The Task Force continues to meet monthly to look at gaps and further actions stakeholders can take jointly

within Lincolnshire to support our residents struggling with the cost-of-living increases, with a focus on ensuring that the most vulnerable in our community are supported.

As we transition from a period of pandemic emergency response to pandemic recovery, the focus is increasingly on protecting those in society who continue to be more at risk of severe COVID-19 infection. To achieve this, a planned and targeted vaccination programme is considered more appropriate than a reactive vaccination strategy. The Lincolnshire COVID-19 vaccination programme has been very successful in ensuring good uptake across the system and has regularly been one of the best performing systems both regionally and nationally. Our work amongst our underserved communities and those with health inequalities has been used as an exemplar in regional briefings. The programme has successfully worked with all system partners to achieve this success.

Delivering a sustainable COVID-19 vaccination programme, is an essential mainstay of health prevention and therefore we will make vaccination services accessible to all eligible groups, including those affected by health inequalities by:

- ✓ **Ensuring there is sufficient capacity across the system to safely deliver a sustainable COVID-19 vaccination programme to the eligible population.**
- ✓ **Ensuring we have a skilled and competent workforce to deliver the programmes safely**
- ✓ **Develop a vaccination offer that provides convenience and ease of access across the system. This will include outreach sessions and focused work that addresses inequalities and harder to reach communities.**
- ✓ **Ensuring that the vaccination offer is consistent utilising a combination of fixed centres and roving/pop-up sites**
- ✓ **Develop contingency plans for periods of surged activity (for example new COVID-19 variant response)**
- ✓ **Develop a coordinated vaccination programme that incorporates co-delivery of other vaccinations when possible and that Makes Every Contact Count (MECC) by incorporating appropriate health advice/screening in line with the NHS Core20PLUS5 approach.**

The flu vaccination programme started in September for adults aged over 65 and those identified as at risk. All 82 practices will be offering flu vaccines with some practices offering them alongside Covid vaccines. Most practices will be offering the flu vaccine at practice level

with a small number offering them across the PCN footprint. There is an aspirational target for over 65s of 75% and for those under 65 who are risk of 65%.

3. Preparation for Winter 2022/23

The following preparatory work and actions have been completed during late Summer / Autumn 22 as preparation for winter:

- ✓ Late August Regional Demand & Capacity submissions for beds. The amount awarded to Lincolnshire has been confirmed as 6.08m. The Winter Oversight Group has oversight of delivery and spend and currently, as of 9th November 2022 the programme is overall on track.
- ✓ 31st August Regional winter event with early indications of national expectations
- ✓ 13th September Winter Resilience Oversight Group deep dive to consider current organisational plans, confirm challenge of winter money and opportunities to secure improvements across the urgent care system in readiness for Winter
- ✓ 7th October 2022 system UEC clinical summit which brought together key clinicians and senior officers from across the system to consider experiences, data, projected peaks, key areas of risks and identify areas for improvement
- On 18th October 2022, NHS E published a letter to systems 'Going Further on Winter Plans' specifically systems are asked to:
    - Implement a falls response service with full geographical coverage between the hours of 08.00 – 20.00, 7 days per week of community-based alternatives for double crewed ambulance response for level one and two falls.
    - Launch a System Response Centre by 1st December to co-ordinate the system and help balance risk.
    - Ensure support is available for High Frequency Users.
    - Decrease inappropriate conveyance from care homes to acute care
    - Realise potential of Virtual Wards and consider development of Acute Respiratory Hubs.

Our Clinical Summit, led by our ICB Medical Director, brought senior clinicians and officers together from across the Lincolnshire system to consider the key risks and opportunities to improve clinical care across the UEC pathway. Following the patient pathway, delegates heard from key clinical leaders from across the health and care system in Lincolnshire and worked collaboratively to identify core actions that need to be taken to minimise risk to patients accessing health and care. These 4 actions form the basis of our overall plan for winter detailed later in the document, but due to the importance and prominence of the clinical summit these are also highlighted below.

- ✓ **Simplify admission avoidance options on Directory of Service with only 2 access points for onwards referral (one for acute and one for community). GPs to have direct access to ULHT consultants for advice and direct admission to SDEC**
- ✓ **Care Home staff to be trained to administer IVs and rehydration therapy as previously agreed and to have access to senor decision makers via the Clinical Assessment Service (CAS)**
- ✓ **Achieve agreed trajectory for Virtual Wards (to include respiratory hub) and maximise opportunity to exceed agreed capacity**
- ✓ **Creation of system UEC Risk Register**

4. Capacity & Demand Modelling

We have undertaken detailed modelling of capacity and demand to test whether services can manage the winter pressures effectively, minimise ambulance handover delays, and excessive delays in the Emergency Departments including waits for admissions. This year's challenge has been made more complex with the post-pandemic recovery, compounded by significant increase in walk-in demand.

The capacity and demand modelling suggests three key areas of focus for our system during winter which are critical in ensuring our urgent care system is able to manage the aforementioned pressures:

- Demand Management to reduce unnecessary use of the acute trusts (prehospital) 
- Best practice for in-hospital Flow (in hospital) 
- Continued delivery of the Discharge Requirements (post hospital) 

Our key actions for the winter (detailed in section 4) have been developed against these three key areas to ensure the interventions are the right ones, that will be delivered at the right time and have the right impact to protect patient care during the winter period. In addition, further modelling work has been completed to assess the likely impact of these interventions. The interventions which have received additional fuding this winter are forecast to provide a potential of 158 equivalent beds (further detail can be found in section 5.5) However, this plan includes a former ambition to close 122 beds, as part of system transformation, as we move care closer to home, which may need to be re-opened during surge and escalation. Should the 122 beds be required for escalation, and the worst-case scenario demand modelling is realised, the potential bed gap could be up to 240.

Given this risk, predicting peaks in demand during the winter period is essential to further mitigate risks and system pressures. Currently the UK Health Security Agency (UKSA) is unable to predict what might happen during Autumn and Winter 2022 as there are too many unpredictable variables for the modelling to be of value. Once the Influenza season commences some short-term prediction may be available but essentially it is difficult to say for certain what demand profiles may be post pandemic. However,

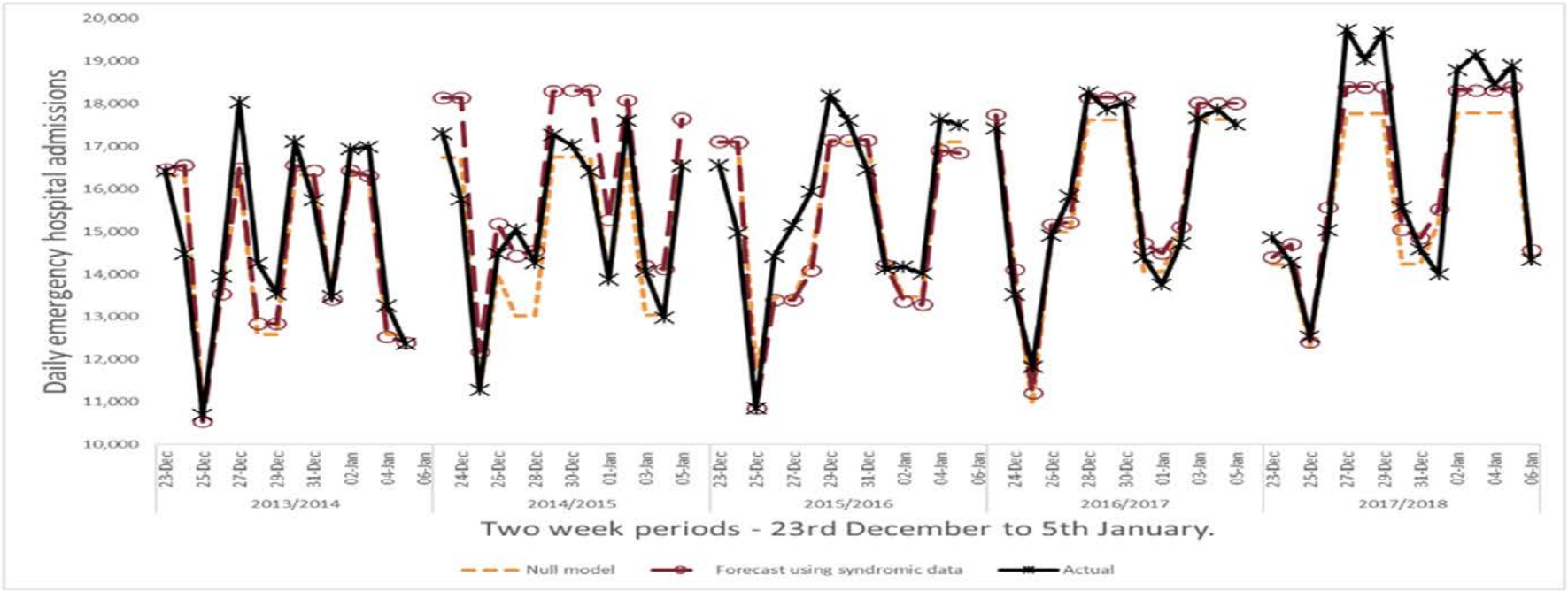
during the Lincolnshire Clinical Summit, colleagues from public health presented information in relation to syndromic surveillance. Syndromic surveillance presents a consistent annual pattern in relation to demand relating to respiratory illness and clearly shows

peaks in pressure from 23rd. December to 5th January each year. This indicates a need for additional primary and community care services to be available during the Christmas and New Year period to aid early identification and treatment of those with respiratory illnesses.

Can syndromic surveillance help forecast winter hospital bed pressures in England?

Fig 2

Example forecast using GP consultations for upper respiratory tract infection compared to null forecast model with no syndromic data.



doi: https://doi.org/10.1371/journal.pone.0228804.g002

This almost identical peak demand profile can also be clearly seen within EMAS modelling (appendix one) which predicts highest demand into both Lincoln County Hospital and Pilgrim Hospital, Boston occurring between 19th December and 1st January inclusive. Winter schemes detailed in section 4 will be fully operational during this peak time to minimise unnecessary conveyances and protect against handover delays where possible.

4.1 Bed modelling

As detailed, the system had previously agreed to close 122 beds across ULHT sites as part of system transformation. Modelling is therefore based upon this assumption for best case scenario with the full delivery of pathway improvements through our agreed winter schemes. In comparison, a worst-case scenario has been modelled which assumes continued use of the 122 beds as escalation beds with non-delivery of pathway improvements. The following metrics were used as a basis for the modelling which provides a prediction of what could happen during the winter period:

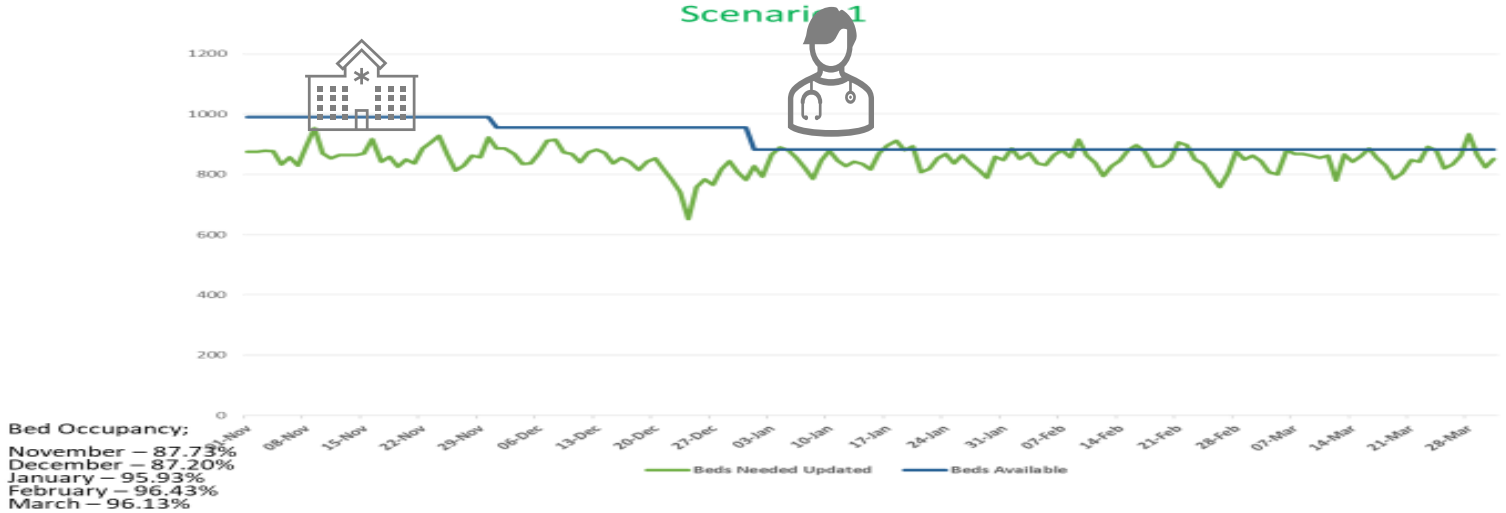
	Scenario 1	Scenario 2
Non-Elective Activity vs 20/21	100% + Additional variance currently being seen in past 3 months	100% + Additional variance currently being seen in past 3 months
Non-Elective Length of Stay	5.0 (recent average)	5.0 (recent average)
Elective Activity vs 20/21	100%	100%
Elective Length of Stay	2.8 Recent Average	2.8 Recent Average
Bed Occupancy	None-Elective: 92% Elective: 85%	None-Elective: 92% Elective: 85%
Winter Planning	Bed Reduction – 122 Beds (pathway improvements etc)	No Bed reduction (Pathway improvements not seen)

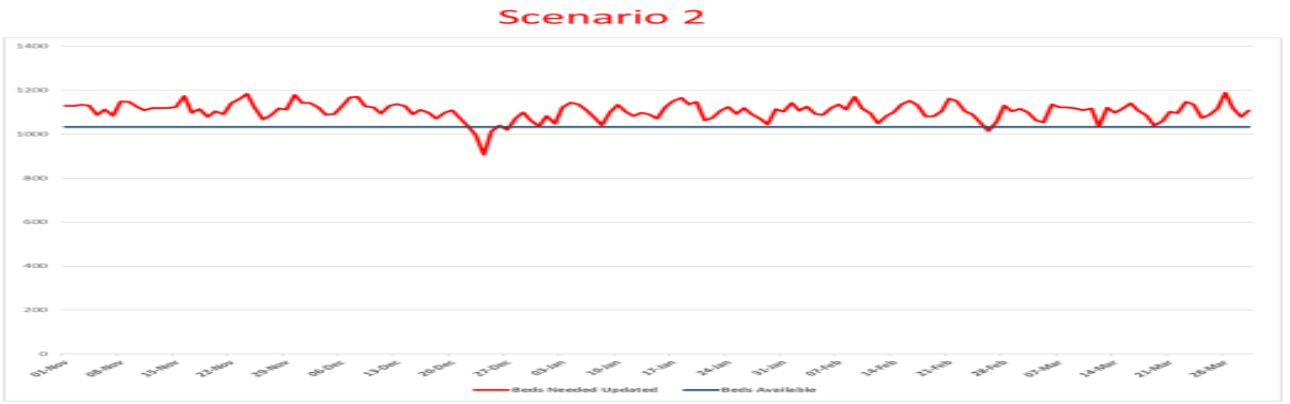
Both scenarios are detailed over the page. Scenario one demonstrates a favourable system position with only isolated peaks of demand above the number of beds available highlighting the absolute need to realise the benefits of all winter schemes. Scenario 2 highlights a position where demand is consistently above bed availability and reveals a potential bed gap of 240 beds across the winter period. This scenario is likely to lead to flow issues and result in significant numbers of 12-hour delays to admission within our Emergency Departments.

Month	Daily Average of 12 hour delays to admission
Nov 2022	115
Dec 2022	81

Jan 2023	56
Feb 2023	88
Mar 2023	59

To address this the system may need to consider some actions more focused on the short term than our longer-term transformation objectives. For example, within the bed modelling there is an assumption of a bed occupancy rate of 92%. The system may need to consider increasing the bed occupancy up to 100%. The impact of increasing bed occupancy rates is that flow would be significantly affected and waits within the Emergency Departments would be likely to increase further, this would be a fine balance of risk that would need careful managing at a system level.



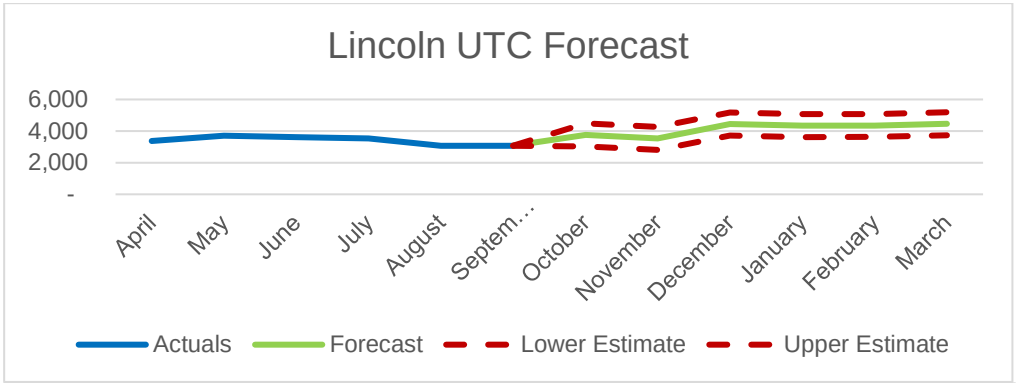


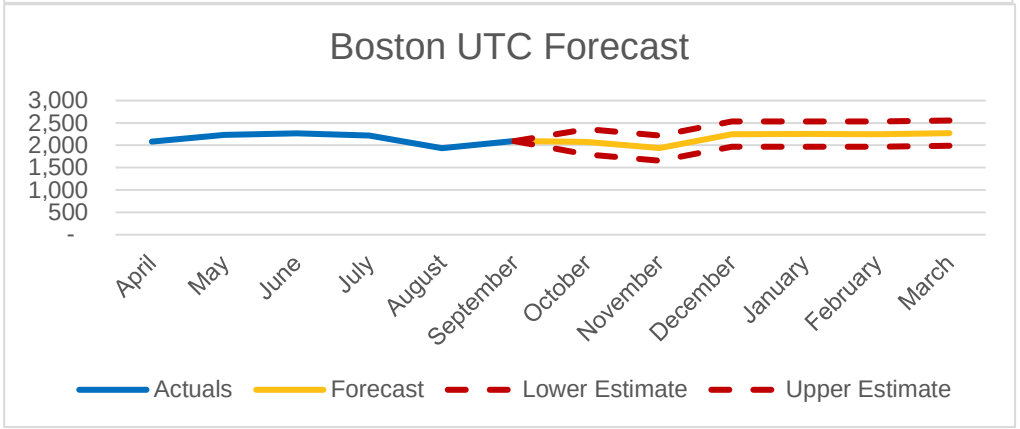
Bed Occupancy;
November - (108%)
December – (105%)
January – (106%)
February – (107%)
March – (107%)

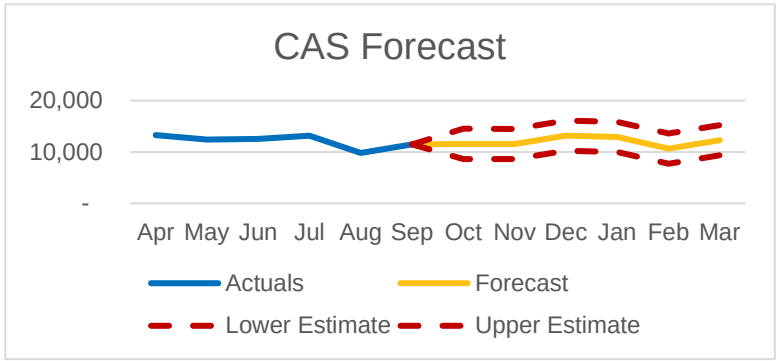
4.2 Community modelling

Modelling has been completed for both Urgent Treatment Centres (UTCs), the Clinical Assessment Service (CAS) and 2-hour Urgent Response Service as they are essential components of the urgent care pathway particularly focused upon keeping people away from Emergency Departments who do not need to be there.

Within our Urgent Treatments Centres activity for the first 6 months of the financial year across all sites was 80,517, this is a 4% increase compared to the same period in 21/22. Performance against 4-hour breaches was 93.14% for the period which is increased from 92.64% last year despite the increase in activity. The percentage of patients referred to A&E has remained at 9% and performance against the 15-minute clinical assessment rate has increased from 79% to 90% across UTCs







Clinical Assessment Service activity is forecast to increase over winter due to RSV, Covid and influenza predicted increases, with our Out of Hours sites at Grantham & Stamford to support increased booked appointment activity as well as Grantham providing an enhanced walk-in service to support the local ED to close overnight.

5.Improvement & Winter Schemes

During Autumn 2022, Lincolnshire secured an additional 6.08 million to support key schemes and improvements, this money is being utilised to fund some new schemes and support work that was previously underway to expedite its delivery. Through the work undertaken, as detailed in section 3, to prepare for Winter, a focused action plan has been developed which provides clarity of the work required to ensure our residents can access high quality and timely health and care during the winter period. This action plan has been structed across

key settings including, care homes, primary and community care, hospital care and discharge and key enablers, the action plan can be found in appendix 2.

5.1 Care Homes

- ✓ **Work with care homes to promote use of CAS, existing services & pathways & use of POC testing to reduce conveyances.**
- ✓ **Digital Tele Health to be fully deployed within care home settings to support conveyance avoidance**
- ✓ **Care Home staff to be trained to administer IVs and rehydration therapy as previously agreed**
- ✓ **Care Homes should have access to specialist nursing support to care for terminal patients in their preferred place of care**

Keeping people well at home is a key strategic component of the Lincolnshire 'Home First' strategy and that includes people where a care home setting is their own home. When those living in care homes become ill, staff should have swift access to health care support. In Lincolnshire we have a Clinical Assessment Service dedicated to care home staff where senior clinical advice can be accessed swiftly, this model has been in place for several years, but we will be taking the opportunity to ensure staff are reminded to use this rather than dialling 999 where appropriate. Similarly digital telehealth has also been available across Lincolnshire for several years but during this winter period we will ensure that this strategy is maximised to avoidance hospital attendance and admission where possible. Similarly, those living in a care home should have the same access to end of life specialist services to ensure they are able to die in their preferred place of care, again, this winter we will ensure everyone has this access as appropriate. In neighbouring counties Registered Nursing staff working in care homes can administer intravenous interventions including rehydration therapy, this ensures those living in care homes requiring this care do not need admission to hospital. This winter we will invest within a trial across 3 care homes within Lincolnshire to test this way of working, if successful this will be rapidly implemented across all eligible care homes.

5.2 Primary and Community Care

Keeping people well and out of hospital where clinically appropriate to do so is a key aim of our winter ambition during 2022/23. As such we have developed several actions to help realise this ambition.

- ✓ **Consistent Risk Stratification of patients to proactively identity and support those that are vulnerable and High Frequency Users**
- ✓ **Achieve agreed trajectory for Virtual Wards (to include respiratory hub) and maximise opportunity to exceed agreed capacity**
- ✓ **Simplify admission avoidance options on Directory of Service with only 2 access points for onwards referral (one for acute and one for community). GPs to have direct access to ULHT consultants for advice and direct admission to Same Day Emergency Care (SDEC)**
- ✓ **Expansion of Outpatient Anti-Microbial Therapy Service**
- ✓ **Additional Primary Care capacity to be available during Christmas & New Year demand**
- ✓ **Expansion of a falls response service with full geographical coverage between the hours of 08.00 – 20.00, 7 days per week of community based alternatives for double crewed ambulance response for level one and two falls**
- ✓ **Additional clinical staff to support triage and safety netting of those awaiting an ambulance**

Our Primary Care practices and Primary Care Networks (PCNs) have been asked to ensure that those that are vulnerable or are high frequency users have been risk stratified and an appropriate plan of care is in place to ensure hospital attendances and admissions are clinically appropriate and care is received in the community where possible. We will deliver on our commitment to further develop virtual wards, where patients can receive specialist led care within their homes. So far, we have launched virtual wards for cardiology, frailty, respiratory and complex neurology equating to 99 acute beds with a further ambition to achieve 116 by December 22. We will also explore how we can expand the trajectories further so more people can benefit from this model of care.

We heard clearly from our clinicians at our clinical summit that admission avoidance pathways need to be simplified and we will ensure that only 2 access points (one for community and one for hospital) are available for our primary and community care clinicians so that timely advice and interventions can be secured. Similarly, we will ensure that our GPs can have direct access to secondary care consultants and can admit into the same day emergency care unit as an alternative to sending people to the Emergency Department.

We will expand our outpatient anti-microbial service so more people can benefit from the service; this means that anyone requiring IV antibiotics that can safely be discharged from hospital will be able to return on an outpatient basis rather than staying in hospital.

As the capacity and demand modelling clearly indicates, we can expect to see increased demand across services during the Christmas and New Year period, our Primary Care Networks and GP Practices will work together to additional primary care support to ensure effective use of resources for minor illness.

We already have in place a commissioned service across Lincolnshire that responds when a person has fallen in their home as an alternative to an ambulance attendance. We will expand this service to cover 8am – 8pm daily and will further integrate this with East Midlands Ambulance Service and our Clinical Assessment Service to ensure the most clinically appropriate service attends to a person that has fallen.

When the ambulance service is busy, those waiting for an ambulance may find themselves within a queue system, to ensure safety and ongoing review of people awaiting an ambulance we will invest in additional clinical staff who support triage and help identify if a quicker response is required.

5.3 Hospital Care & Discharge

- ✓ **Implementation of 'Breaking the Cycle' for Non-Elective Flow at ULHT on 7th November 2022**
- ✓ **Additional Hospital Ambulance Liaison Officer (HALO) support to assist with ambulance off loads at acute sites**
- ✓ **Discharge to Assess, minimise all delays across Pathway 0 and achieve agreed trajectories**
- ✓ **Discharge to Assess, minimise all delays across Pathway one and achieve agreed trajectories**
- ✓ **Procurement of 60 additional recovery beds by November 2022 including funding for GP Support**

On 7th November 2022, ULHT implemented 'Breaking the Cycle' this is an approach consistently being implemented across England to move patients waiting beds to wards even if a bed space is not available. A safe and transparent algo-rhythm is in place to ensure patient safety and by ensuring that patients are cared for upon their specialist wards rather than often overcrowded Emergency Departments will ensure swifter specialist oversight, reduce length of hospital stay and enhance the patient experience.

To protect impact of ambulance handover delays we have also invested in additional Hospital Ambulance Liaison Officer roles (HALO) this winter, this means that individual crews do not need to always remain with patients awaiting emergency department care and if safe to do so patients can be cared for in a cohort by HALOs, HALOs also have an essential role in communication between the hospital and ambulance service.

Earlier in 2022 we launched our Integrated Discharge hubs across Lincolnshire. These hubs bring together key partners to help people with additional care needs to leave hospital earlier and operate 7 days per week on site at Lincoln County Hospital and Pilgrim Boston Hospital. A weekly system flow programme meeting (previously known as the flow cell) oversees all improvement work across the system for discharge & flow and provides the framework for the 100-day challenge which includes11 key initiatives used by the system to continue to drive improvement. To increase capacity for pathway one discharges (those requiring a short-term package of care) this winter we will specifically:

- ✓ Increase capacity in pathway 1 reablement, rehabilitation and recovery through the additional commissioning of 60 care homes beds
- ✓ Increase capacity within the health element of the pathway enabling increase in patient caseload to 70
- ✓ Additional home care reablement capacity commissioned via Lincolnshire Reablement Service increasing from mid-October to December 2022
- ✓ Our Local Authority will support prime providers with additional substantive workforce aimed at reducing delays in reablement transfers into long term packages of care and protecting Lincolnshire Reablement Service as reablement provider
- ✓ Adult Social Care will have brokerage support at weekends to support with request for home care packages
- ✓ Adult Social Care are increasing the use of interim beds to ensure people that are medically optimised can be discharge safely and timely from the acute and wait for their home care package to be available. Use of interim beds is monitored daily and patients transferred have their pathways overseen to ensure clear plans in place.
- ✓ Care Home Trusted Assessors (CHTA) are on-site 7 days a week to complete assessments on behalf of care homes to facilitate discharges to care homes.
- ✓ Three AGE UK schemes are being extended:
    - Age UK telephone support post discharge from ULHT
    - Discharge and home support buddies scheme
    - Hospital discharge recovery scheme providing one off payment for patients and carers enabling them to provide care and support not currently provided through existing NHS and Local Authority commissioned services to facilitate timely discharge home.

There is also more work to do to make sure those people requiring no ongoing support can leave hospital as quickly as possible (pathway 0). This work is overseen by the ULHT Urgent and Emergency Care Improvement Programme which consists of a 1-year rapid

implementation approach to improving current position, followed by a transformational programme of work aligned to the Integrated Improvement plan until 2025. Specifically, this will:

- ✓ Increase capacity, flow and discharge through the Emergency Departments, Urgent Treatment Centres and Same Day Emergency Care by March 2023
- ✓ Maximise the Same Day Emergency Care Pathways across the Trust by March 2023
- ✓ Treat all patients in the correct setting, receiving the right care. Reducing hospital length of stays and reducing time to discharge to the right setting by March 2023.

5.4 Enablers

- ✓ **Deployment of SHREWD and launch of System Control Centre on 1st Dec 2022 to direct balance of risk across the system**
- ✓ **Creation of system Urgent & Emergency Care Risk Register**

System Control Centres (SCCs) are being introduced across England to ensure the safest highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all acute, community, mental health, primary care, and social care services. Led by senior clinicians and operational leaders, the Lincolnshire SCC will ensure a consistent and collective approach to managing system demand and capacity as well as mitigation of risks. It will facilitate collaboration through senior system level operational leadership and will deliver:

- Visibility of operational pressures and risk across providers and system partners
- Concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges
- Dynamic responses to emerging challenges and mutual aid
- Efficient flows of information.

Funded through the additional winter monies secured by the system, we collectively agreed to purchase the SHREWD resilience data management platform which will allow real time visibility of whole system data. This will deploy in early December 2022 and will provide the 'flight deck' visibility for the system and allow the SCC to appropriately act in relation to increased risk and demand.

Following our clinical summit, we have developed a system Urgent and Emergency Care risk register and whilst acknowledging this will be evolutionally the UEC Partnership Board agreed the first version in November 2022.

5.5 Extra Bed Capacity

As detailed in section 4, funding received for winter 2022/23 equates to 158 equivalent acute beds across Lincolnshire, how this is derived from each applicable scheme can be seen below. It is worthy of note that schemes already delivering transformational change across Lincolnshire, such as Virtual Wards, are also measured by equivalent acute beds but are not included in the table below.

Scheme	Capacity Equivalent to Acute Beds (FYE)
Discharge to Assess Pathway 0 Discharge to Assess Pathway 1	Recurrent capacity equivalent to 122 acute beds
Hospital Acute Liaison Officers (HALO)	Potential equivalent of 1 acute bed
HART – increased community care capacity	Potential equivalent of 16 acute beds
Outpatient Antimicrobial Therapy service expansion	Potential equivalent of 13 acute beds
Additional IFT capacity and triage	Potential equivalent of 1 acute bed
Integrated discharge hub increased capacity	Potential equivalent of 3 acute beds
EMAS additional clinical input for those awaiting an ambulance	Potential equivalent of 2 acute beds
<u>Additional schemes to contribute to additional capacity:</u> •Implementation of SHREWD •Additional primary care during peak periods •Active recovery beds including primary care, therapy, and social work support	

6. Workforce

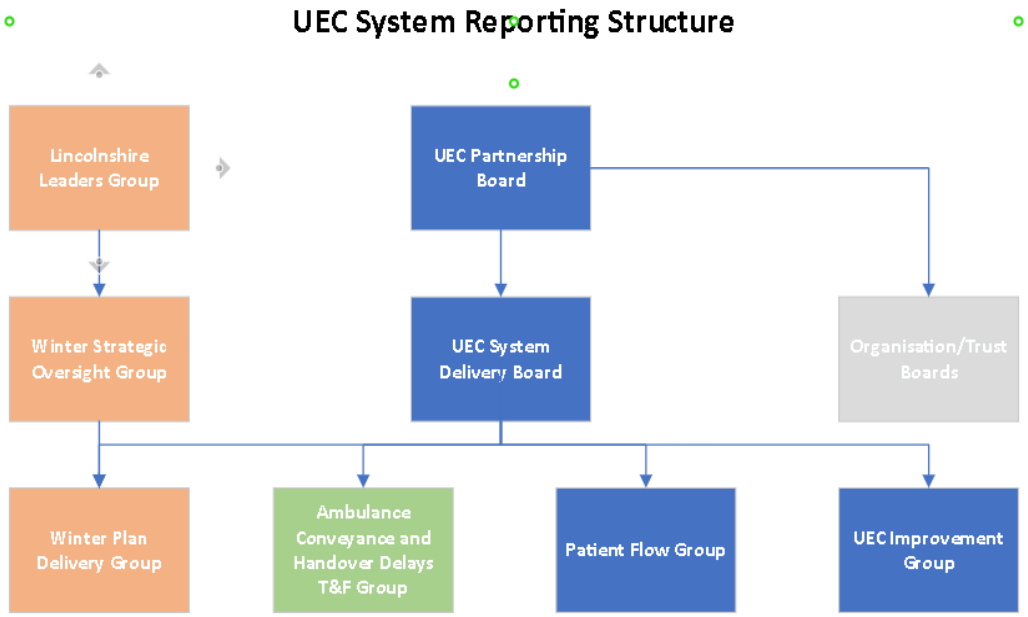
We are considering workforce through two lenses as part of the winter planning, firstly how our workforce feel, particularly when under pressure and making sure they have the right support to remain well and in work and secondly how we will move our workforce around where needed if critical services are understaffed. This is particularly a risk in relation to a possible nursing strike which could see large numbers of the workforce being absent.

Keeping our staff well this Winter is part of supporting residents and patients across the system. All organisations are putting a strong emphasis on the importance of having wellbeing conversations with team members to support their physical and mental health and signposting them to our collection of services across the system where necessary. We are providing the following support to our people:

- ✓ **Leadership development of managers to ensure that they are having the right conversations with their teams and signposting appropriately.**
- ✓ **Flu vaccination will be made available to all eligible staff via our Hospital Hubs, via GP, or Pharmacy**
- ✓ **COVID vaccinations to front line teams across the system.**
- ✓ **Continuing to operate a hybrid way of working which includes, for those that can, a mixture of working from home and office based.**
- ✓ **Our system Wellbeing Hubs, provided by our Mental Health Trust have a range of support from financial wellbeing to mental health support and ideas for physical activity.**
- ✓ **Each organisation has an Employee Assistance offer which staff can access as well as Occupational Health.**
- ✓ **We have a number of cultural ambassadors, Mental Health First Aiders and Mentors across the system who are all offering their support for one-to-one conversations where needed.**

We have a Memorandum of Understanding in place across the Lincolnshire health and care system which allows the sharing of workforce across individual organisations. This was used successfully within the Covid pandemic and would be utilised again to mitigate against any potential industrial action threats.

7.Governance and Escalation



The ICS Urgent and Emergency Care Partnership Board has strategic responsibility for overseeing the development and mobilisation of robust winter capacity and resilience plans. To ensure adequate governance controls are in place we have reviewed the governance structure in readiness for winter.

Lincolnshire has a system-wide escalation management plans which sets out the operational management arrangements when part(s) of the Health and Care System experience pressure, over and above business as usual. Formal trigger points are set out in the plan, in line with the Escalation Management System, with agreed actions that each partner within the system must take to maintain patient safety, quality of care and expedite patient flow in a proactive as well as a reactive way. There are four levels of escalation:

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
PLANNED OPERATIONAL WORKING	MODERATE PRESSURE	SEVERE PRESSURE	EXTREME PRESSURE

Triggering of levels 2-4 result in each organisation taking steps to de-escalate the pressures. Each system will use an operational, tactical, or strategic level of meeting to bring people together to focus on improving the position.

This escalation plan sets out the procedures across the ICS to manage day to day demand and any significant surges by having a clear escalation and de-escalation plan where every system partner knows what they should be doing and when, taking responsibility for their individual and organisational actions and contributing to a shared risk management approach across the system.

8. Risk Management

As agreed at our clinical risk summit a system Urgent and Emergency Care risk register has now been developed and is overseen by the UEC Partnership Board. The Winter Plan Delivery Group has ownership of the specific risks in relation to the Winter Plan and these are detailed below.

Risk	Mitigations
That the modelling assumptions around demand are further impacted by infections and acuity.	Modelling of impact and projections to be monitored routinely for early warning
That the system capacity and demand model does not accurately identify gaps or pressured service areas/ periods	System information analysts collectively developing a single Capacity and Demand model with system agreed assumptions
That workforce constraints will mean the system is unable to recruit to deliver the planned changes and will rely on agency staffing and could exacerbate the risk around our inability to maintain safe staffing and service resilience across the whole system	Workforce and people team support as part of the winter oversight group, to deliver plans in respect of recruitment
Maintaining delivery of domiciliary and residential care to meet demand to support timely discharge	Discharge and flow plans in place to increase the level of capacity available Active recovery bed procurement and implementation
Inability to offload ambulances in a timely manner impacting on ability to respond to emergencies in community	System ambulance handover and conveyance Task & Finish group Revised ambulance handover plan including acute full capacity protocol pilot
Sub-optimal discharge outcomes for patients due to supported discharge capacity resulting in alternative discharge destination	Plans include health and care in-reach to patients who are discharged to an alternative setting to their originally identified pathways.
The system may not be able to effectively manage the conflict between dealing with system recovery and the winter demand	Establishment of a System Control Centre to monitor both elective and non-elective performance routinely for early warning

9.Communication

We have developed a specific communications plan for Winter 2022/23 which has been agreed by our UEC Partnership Board. The plan builds upon previous plans and aims to coordinate the joined-up communications work already happening across Lincolnshire into a single point of reference for stakeholders. Many of the messages will be based upon national guidance from NHS England and focus on empowering and engaging people with self-care, staying well and choosing the right service, at the right time These messages run throughout the year with strong emphasis on calendar events which have the potential to increase demand on our local health services.

Inn Lincolnshire we will:

- ✓ Speak as one local Lincolnshire voice & seek to influence behaviour through behavioural change/ social marketing techniques
- ✓ Signpost alternatives when Emergency Departments and Urgent Treatment Centres are busy
- ✓ Assure our residents that the NHS is open for business
- ✓ Promote self-care and the use of pharmacy
- ✓ Ensure that mental health is part of our key messaging

In addition we have developed a range of specific messaging we will use when the difference OPEL levels are reached as detailed in the table below:

OPEL ONE	Promote self-care & Use your Pharmacy Promote NHS 111 online & NHS 111
OPEL TWO	Promote self-care & Use your Pharmacy Promote NHS 111 online & NHS 111
OPEL THREE	Increased promotion of actions from OPEL One and Two How to access services locally Discharge messaging internally across the system
OPEL FOUR	Increased promotion of actions from OPEL One, Two and Three Call for staffing support across the system Paid targeted social media

10. Conclusion & Evaluation

The Winter Plan will be monitored via our governance routes and operationally, daily, through the System Control Centre activities and specifically via:

- ✓System oversight through the UEC Partnership Board and associated sub governance groups
- ✓Weekly monitoring of the Winter Plan initiatives via the weekly Winter System Oversight Group with escalation where targets are not achieved requesting urgent improvement plans.
- ✓Weekly monitoring of UEC KPIs across the ICS
- ✓Ongoing monitoring of Demand and Capacity to understand performance and delivery over the winter period and the impact of any further change levels.
- ✓Use of the SHREWD System to support daily oversight by the System Control Centre.

We will review the plan early next year to ensure we can identify the learning and impact.

Appendix One

Predicted EMAS activity at Lincoln County Hospital

EMAS predicted top 15 dates | Predicted Busiest Dates based on 01/11/2021 to 31/03/2022 | Busiest Dates (2020_2021)

Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed
01/11	02/11	03/11	04/11	05/11	06/11	07/11	08/11	09/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11
73	71	80	76	77	82	88	72	73	82	84	79	76	77	79	87	77	86	72	74	81	64	56	87	86	71	78	80	72	81
96	94	90	98	78	86	93	87	83	90	95	72	74	82	82	92	75	94	79	67	85	80	80	86	76	86	72	74	70	67

Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
01/12	02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12
68	65	68	70	66	73	80	77	74	69	77	81	57	66	79	62	69	81	83	85	89	79	84	68	69	81	70	78	58	90	73
69	94	80	86	88	100	80	77	93	84	72	87	75	73	69	78	79	72	83	82	74	78	80	71	92	86	93	75	82	90	74

Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue
01/01	02/01	03/01	04/01	05/01	06/01	07/01	08/01	09/01	10/01	11/01	12/01	13/01	14/01	15/01	16/01	17/01	18/01	19/01	20/01	21/01	22/01	23/01	24/01	25/01	26/01	27/01	28/01	29/01	30/01	31/01
85	74	73	74	76	79	68	72	78	73	83	70	80	66	73	82	71	63	74	77	72	76	79	68	96	67	77	82	76	78	75
91	74	69	79	78	65	81	70	75	87	70	79	90	81	74	75	72	78	71	74	73	75	76	75	75	77	82	76	93	75	79

Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue
01/02	02/02	03/02	04/02	05/02	06/02	07/02	08/02	09/02	10/02	11/02	12/02	13/02	14/02	15/02	16/02	17/02	18/02	19/02	20/02	21/02	22/02	23/02	24/02	25/02	26/02	27/02	28/02
74	83	62	66	78	69	83	78	76	75	74	69	67	63	87	68	69	60	62	82	59	68	63	75	69	73	88	66
87	76	81	59	89	84	74	78	71	77	59	61	64	85	69	64	82	70	68	81	73	76	71	84	92	64	78	78

Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
01/03	02/03	03/03	04/03	05/03	06/03	07/03	08/03	09/03	10/03	11/03	12/03	13/03	14/03	15/03	16/03	17/03	18/03	19/03	20/03	21/03	22/03	23/03	24/03	25/03	26/03	27/03	28/03	29/03	30/03	31/03
70	62	63	63	80	79	63	80	76	75	67	57	81	76	64	72	63	56	72	62	68	60	72	65	67	73	65	17	39	71	69
91	90	77	73	81	80	83	84	93	86	75	85	87	73	82	75	86	77	77	74	81	77	75	101	76	83	88	89	101	88	67

Predicted EMAS activity at Pilgrim Hospital, Boston

EMAS predicted top 15 dates | Predicted Busiest Dates based on 01/11/2021 to 31/03/2022 | Busiest Dates (2020_2021)

Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed
01/11	02/11	03/11	04/11	05/11	06/11	07/11	08/11	09/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11
54	42	58	64	51	60	56	51	52	58	55	50	58	55	49	60	50	41	52	63	43	63	69	41	52	48	49	54	58	46
47	56	53	56	50	61	60	63	53	61	61	39	55	56	55	54	66	65	49	49	52	67	55	57	57	58	52	51	59	49

Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
01/12	02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12
44	53	53	38	55	55	55	61	58	50	48	48	55	62	56	55	57	48	56	63	67	55	48	52	42	56	64	59	60	49	52
53	64	57	54	55	62	65	61	53	57	62	60	56	48	59	59	51	46	67	51	40	39	59	66	47	59	53	74	64	47	60

Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue
01/01	02/01	03/01	04/01	05/01	06/01	07/01	08/01	09/01	10/01	11/01	12/01	13/01	14/01	15/01	16/01	17/01	18/01	19/01	20/01	21/01	22/01	23/01	24/01	25/01	26/01	27/01	28/01	29/01	30/01	31/01
56	42	50	55	49	53	36	57	52	53	49	52	58	51	52	54	58	62	48	48	47	61	55	58	54	55	50	45	45	61	51
63	77	63	68	66	60	50	50	65	64	50	62	49	54	68	55	49	53	50	61	60	64	54	53	52	56	56	46	41	59	53

Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue
01/02	02/02	03/02	04/02	05/02	06/02	07/02	08/02	09/02	10/02	11/02	12/02	13/02	14/02	15/02	16/02	17/02	18/02	19/02	20/02	21/02	22/02	23/02	24/02	25/02	26/02	27/02	28/02
56	55	56	47	54	51	57	56	58	53	44	46	55	59	55	44	53	57	64	44	51	53	66	61	56	51	60	49
62	63	64	54	62	59	64	51	65	63	50	60	57	61	72	47	55	60	53	55	61	67	64	52	49	56	58	55

Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
01/03	02/03	03/03	04/03	05/03	06/03	07/03	08/03	09/03	10/03	11/03	12/03	13/03	14/03	15/03	16/03	17/03	18/03	19/03	20/03	21/03	22/03	23/03	24/03	25/03	26/03	27/03	28/03	29/03	30/03	31/03
45	63	53	49	47	63	63	61	49	50	52	51	46	49	53	48	53	54	45	42	52	56	58	49	39	40	45	67	66	58	45
63	62	67	53	52	63	60	61	72	64	66	67	61	58	59	63	70	72	49	57	60	60	59	59	55	53	69	57	64	73	61

Appendix Two	Winter Resilience Group	Clinical Summit	Winter Resilience Letter	C&D monies	Action Owner	On / Off Track
Care Homes						
Work with care homes to promote use of CAS, existing services & pathways & use of POC testing to reduce conveyances.	√		√		Wendy Martin	
Digital Tele Health to be fully deployed within care home settings to support conveyance avoidance	√				Wendy Martin	
Care Home staff to be trained to administer IVs and rehydration therapy as previously agreed		√			Wendy Martin	
Care Homes should have access to specialist nursing support to care for terminal patients in their preferred place of care		√			Reva Stewart	
Primary & Community Care						
Consistent Risk Stratification of patients to proactively identity and support those that are vulnerable and High Frequency Users		√	√		Sarah Jane Mills	
Achieve agreed trajectory for Virtual Wards (to include respiratory hub) and maximise opportunity to exceed agreed capacity		√	√		Anne – Louise Schokker	
Simplify admission avoidance options on Directory of Service with only 2 access points for onwards referral (one for acute and one for community). GPs to have direct access to ULHT consultants for advice and direct admission to SDEC	√	√			Reva Stewart, Simon Evans & Sarah Jane Mills	
Expansion of Outpatient Anti-Microbial Therapy Service	√	√		√	Simon Evans	
Additional Primary Care capacity to be available during peak xmas / new year demand		√		√	Sarah Jane Mills	
Implementation of a falls response service with full geographical coverage between the hours of 08.00 – 20.00, 7 days per week of community based alternatives for double crewed ambulance response for level one and two falls.			√		Reva Stewart	

Additional clinical staff to support triage and safety netting of those awaiting an ambulance				√	Sue Cousland	
Hospital Care & Discharge						
Implementation of Clinical Vision for Non-Elective Flow on 7th November 2022	√				Simon Evans	
Additional HALO support to assist with ambulance off loads at acute sites	√			√	Sue Cousland	
Discharge to Assess, minimise all delays across Pathway 0 and achieve agreed trajectories	√			√	Nikki Pownall	
Discharge to Assess, minimise all delays across Pathway one and achieve agreed trajectories	√			√	Nikki Pownall	
Procurement of 60 additional recovery beds by November 2022 including funding for GP Support	√			√	Nikki Pownall & Afsaneh Sabouri	
Enablers						
Deployment of SHREWD and launch of System Response Centre on 1st Dec 2022 to direct balance of risk across the system	√		√	√	Rebecca Neno	
Creation of system UEC Risk Register		√			Wendy Martin	

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22 November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	6 (i)
Title of Report:	System Financial Management Report October 2022 (Month 7)
Report Author:	Rebecca McCauley, Senior Finance Business Partner
Appendices:	Appendix 1: System Financial Position Appendix 2: ICB Financial Position Appendix 3: System Risks and Mitigations Appendix 4: ICB Financial Performance Targets Appendix 5: Delivery against System Agency Expenditure Limits

1.	Key Points for Discussion:

This report sets out the financial position of the Lincolnshire Integrated Care System (ICS) and the Lincolnshire Integrated Care Board (ICB) on 31 October 2022 (Month 7).

2.	Recommendations

The members of the Board are asked to consider and note the reported financial position of the Lincolnshire ICS and the actions that are in progress within NHS Lincolnshire Integrated Care Board and system Provider executive teams.

3.	Executive Summary

Summary System Financial Position

This paper shows the financial position of Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care System as it was reported to NHS England. The position reported for the ICS includes financial information from 1st April 2022 to 30th June 2022 (the final 3 months of the Lincolnshire CCG and the first 4 months of the Lincolnshire ICB) to present a complete year to date and forecast outturn view for the ICS as reported on 31st October.

Lincolnshire ICS position is shown in Table 1, with further breakdown at Appendix 1. The system has a target of £2.9m deficit at month 7, and a plan to breakeven against allocations by the financial year end. The actual position is a deficit of £16.1m which is £13.2m adverse variance to plan. The full year forecast outturn position is unchanged from previous periods and is to break even, and this has been reported to NHS England. However, our ability to recover the shortfall that has materialized in the first half of the year over the remaining 5 months is extremely unlikely, and as reported in the risk section of this report there are further material risk in the second half of the year; the ICS is therefore preparing for an adverse forecast position. As it stands the risk adjusted position (year to date actual plus unmitigated risk) stands at a £35.1m adverse variance to plan; the forecast process will seek to confirm to what extent the risks can be mitigated by further action.

NHS England have introduced a strict process which will be required for systems or organisations who wish to forecast an overspend to follow.

This brings about a rigorous process for moving away from an approved financial plan with formalised layers of key lines of enquiry and monitoring and management of key controls. Communication has been sent to NHS England to enact the protocol for the system to be able to report a position adverse to plan, and we therefore expect to report a c£35.1m deficit at Month 8 reporting round.

Table 1: Lincolnshire system planned and actual net expenditure

Lincolnshire ICS Surplus (+) / Deficit (-)	Year to Date			Forecast Outturn		
	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
NHS Lincolnshire Integrated Care Board (and former CCG)	-5.0	-6.4	-1.5	-3.2	-3.2	0.0
United Lincolnshire Hospitals NHS Trust	0.0	-12.7	-12.7	0.0	0.0	0.0
Lincolnshire Partnership NHS Foundation Trust	2.1	2.9	0.8	3.3	3.2	-0.0
Lincolnshire Community Health Services NHS Trust	0.0	0.1	0.1	0.0	0.0	-0.0
Total	**-2.9**	**-16.1**	**-13.2**	**0.0**	**0.0**	**-0.0**

The expenditure run rate at Month 7 is off plan due to:

1. The continued impact of Covid-19 costs particularly in ULHT
2. Excess bed costs related to delayed discharges
3. Bank staff and agency volumes and rates of pay mainly within acute settings
4. Delivery on waste reduction and efficiencies reflecting the high level of unidentified improvement schemes against the plan ambition

Efficiencies

The ICS reported a year-to-date waste reduction value at Month 7 of £20.7m which, against a plan of £25.3m, represents an adverse variance of £4.7m. The system is reporting that the full year waste reduction plan of £63.8m will deliver by the end of the year with the small expected adverse variance to plan of £0.6m.

The slippage in the efficiency delivery at ULHT is the principal reason for the £4.6m year-to-date shortfall against the year-to-date target which is offset by a £1.6m favourable adverse variance to plan within he ICB. The forecast for the end of the year is that this under-delivery is fully recovered. However, it should be noted that this is subject to system risks which are detailed below; the main risk being £19.9m unidentified system efficiencies.

Table 2: System Efficiencies

ICS Efficiencies	YTD Plan £m	YTD Actual £m	YTD Variance	FY Plan £m	FOT £m	FOT Variance
Lincolnshire Community Health Services NHS Trust	2.5	2.5	0.0	4.7	4.7	0.0
Lincolnshire Partnership NHS Foundation Trust	4.9	4.7	-0.2	8.4	7.7	-0.6
United Lincolnshire Hospitals NHS Trust	13.4	7.3	-6.1	29.0	29.0	0.0
NHS Integrated Care Board	4.5	6.1	1.6	21.7	21.7	0.0
Total ICS Efficiencies	**25.3**	**20.7**	**-4.6**	**63.8**	**63.1**	**-0.6**
Recurrent / Non-Recurrent Split:						
Recurrent	18.5	8.0	-10.5	51.2	27.6	-23.6
Non-recurrent	6.8	12.7	5.9	12.5	35.5	23.0
Total ICS Efficiencies	**25.3**	**20.7**	**-4.6**	**63.8**	**63.1**	**-0.6**

The programmes identified through the System Improvement Plan to close part of the c.£19.9m unidentified waste reduction schemes are yet to realize the required benefits. Three programmes are in phase 1: Care Closer to Home (CC2H), MSK and Prescribing.

Progress on system efficiencies is shown in more detail in Appendix 3.

Risks and Mitigations

There are substantial risks to be managed if the system is to deliver the reported breakeven position.

Appendix 2 provides a summary of the risks. Most notable is the £19.9m unidentified efficiency target. Whilst the ICB has £10m of non-recurrent fortuitous benefits to offset this, £9.9m remains and still requires the development of schemes to deliver this saving.

The system has £69.1m of risk identified to date, which has been mitigated down to £35.1m. Without further action the system could therefore fail to meet its financial target by £35.1m in year.
In addition to unidentified efficiencies there continues to be cost pressures throughout the system. At ULHT these are crystallized in the year-to-date overspend due to delays in achieving savings, bank and agency cost pressures and additional costs from continuing to manage the Covid-19 pandemic.

The Lincolnshire system faces additional risk of £22.7m which is dependent on the two-year performance (2022/23 and 2023/24) of the Lincolnshire system in delivering a balanced financial position. Failure to do so would trigger the imposition of cumulative former CCG's deficit for repayment. The impact of this risk has been omitted from the 2022/23 position.

ICB Financial Position and Statutory Requirement

Table 1 above shows that the ICB and former CCG combined is reporting a year-to-date adverse variance to plan of £1.5m by delivering a Month 7 deficit against allocation and income of £6.4m against a year-to-date planned deficit of £5.0m. The reason for the reported variance at Month 7 results from material increases in drugs costs and diagnostics costs within acute commissioning and the risk reported at M6 relating to emergency ambulance risk share now included in the position.

The ICB is however forecasting to deliver the planned deficit of £3.2m as the combined financial performance across the CCG and ICB in 2022/23.

Although the ICB is expecting to meet its financial plan, this is still expenditure greater than allocations and so is a breach of statutory financial performance targets. Recovery of this deficit will be expected in future. The ICB has a statutory obligation to achieve its statutory targets which includes expenditure is not greater than allocations and revenue. The current financial position therefore means that the ICB is in breach of this statutory requirement. This is, however, in line with the plan set for the financial year that has been agreed with NHS England.

All the ICB financial targets are presented in Appendix 3. The ICB is expecting to meet all targets other than the revenue expenditure limit.

Capital

The ICS has utilized £19.7m against its £34.4m year-to-date capital plan therefore reporting a £14.7m variance. It is expected that £51.3m of the full year allocation of £57.9m will be fully utilized by the financial year end resulting in a £6.6m underspend primarily associated with the Community Diagnostics Centres.

Table 4 Capital Expenditure Summary

Capital Expenditure	Year to Date			Forecast Outturn		
Scheme Summary	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
NHS Lincolnshire Integrated Care Board	0.7	0.2	0.5	1.5	1.5	0.0
United Lincolnshire Hospitals NHS Trust	18.9	10.4	8.4	38.4	31.8	6.6
Lincolnshire Community Health Services NHS Trust	2.3	0.6	1.7	3.5	3.5	0.0
Lincolnshire Partnership NHS Foundation Trust	13.2	8.7	4.5	16.0	16.0	0.0
NHS Lincolnshire Integrated Care Board (and former CCG)	0.7	0.4	0.4	1.5	1.5	0.0
Total	**34.4**	**19.7**	**14.7**	**57.9**	**51.3**	**6.6**

Mental Health Investment Standard (MHIS)

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. This along with other drivers has meant that Mental Health spend is less than plan.

There is therefore a significant risk that the Lincolnshire ICS will not meet the MHIS target by £9m.

There has been a reduction in cost and volume of individual packages of s117 and mental health continuing health care and locked rehabilitation packages relative to prior years. The current estimate is c.£9m which equates to a 6.6% shortfall against target.

The ICS is continuing discussions with NHS England to understand the parity of Mental Health services for Lincolnshire against national targets and benchmarks. For Month 7 the ICS has reported delivery of the MHIS target but with a £9m risk of required investment to achieve the standard, mitigated by the potential of non-delivery.

Underlying Position

The system continues to firm up understanding the underlying exit rate position for 2022/23. Initial work shows that the underlying deficit is in the region of £70m. This is before the application of the historic former CCG deficit brought forwards and November's fiscal statement being issued.

Next Steps

The considerable level of identified and unmitigated financial risk threatens the system's intention to deliver a breakeven position by the 2022/23 financial year-end. The following actions are underway:

1. The internal audit review managed by Grant Thornton is nearing completion and the outcome and next steps will be known early December.
2. Building on the work already undertaken regarding the underlying position of the Lincolnshire system to support the development of a three-year financial plan by mid-December.
3. Continuation of senior leader review of the progress of flow improvement programmes.
4. Continuation of winter plans to manage pressures greater levels of understanding regarding the underlying position of the Lincolnshire system.

4.	**Management of Conflicts of Interest**
None to be noted.	
5.	**Risk and Assurance**
As noted within the paper.	
6.	**Financial/Resource Implications**
As noted within the paper.	
7.	**Legal, Policy and Regulatory Requirements**
None	
8.	**Health Inequalities implications**
None	
9.	**Equality and Diversity implications**
None	
10.	**Patient and Public Involvement (including Communications and Engagement)**
None	
11.	**Report previously presented at**
Not Applicable	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Matt Gaunt, Director of Finance, m.gaunt@nhs.net	

APPENDICES

Appendix 1 – Lincolnshire ICS Financial Position

Lincolnshire ICS Position	Year to Date			Forecast Outturn		
Income	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
ICB & CCG Allocation	525.6	525.6	0.0	1,186.2	1,186.2	0.0
Provider Patient Care Services	74.5	86.2	11.7	126.7	156.2	29.5
Provider Non-Patient Care Services	28.4	36.2	7.9	49.5	56.6	7.1
Top-Up Funding	0.3	0.6	0.3	0.8	0.3	-0.5
Total Income	**628.7**	**648.6**	**19.8**	**1,363.1**	**1,399.3**	**36.2**
Expenditure						
Provider Staff	362.1	390.0	-27.9	628.3	668.2	-39.8
Provider Drugs & Supplies	92.0	86.5	5.5	154.2	0.0	154.2
Other Provider Non-Pay	78.9	88.8	-9.9	141.4	293.4	-152.0
Primary Care Services (Incl. Prescribing)	185.4	181.1	4.3	318.8	314.5	4.3
Continuing Healthcare	37.4	31.7	5.7	62.8	55.6	7.2
Community Health Services (Excl. LCHS)	26.1	27.5	-1.4	48.7	50.1	-1.4
Mental Health Services (Excl. LPFT)	44.2	38.3	6.0	80.4	70.7	9.8
Acute Services (Excl. ULHT)	170.5	174.6	-4.1	296.8	302.2	-5.4
Other Commissioning Spend	5.8	17.8	-12.0	4.5	19.0	-14.4
ICB/CCG - Technical Adjustment (planned deficit)	-5.0	0.0	-5.0	-3.2	0.0	-3.2
Total Expenditure	**1,002.5**	**1,036.3**	**-33.9**	**1,736.0**	**1,773.7**	**-37.6**
Operating Surplus/Deficit	**-373.7**	**-387.7**	**-14.0**	**-372.9**	**-374.3**	**-1.4**
Less Non-Operating Items/Technical Adjustments	370.8	371.6	0.8	372.9	374.4	1.4
Net Surplus/Deficit Position	**-2.9**	**-16.1**	**-13.2**	**0.0**	**0.0**	**-0.0**

Appendix 2 – ICB Financial Position

Lincolnshire ICB Position (from Month 4)	Year to Date			Forecast Outturn		
Allocations	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
Total Allocations	**525.6**	**525.6**	**0.0**	**1,186.2**	**1,186.2**	**0.0**
Expenditure						
Acute Services	281.0	283.5	-2.5	630.2	634.0	-3.8
Community Health Services	52.4	53.6	-1.2	120.0	121.2	-1.2
Mental Health Services	61.0	58.8	2.2	143.7	137.7	6.0
Continuing Care Services	21.5	18.7	2.8	46.9	42.6	4.3
Primary Care Services	48.2	47.5	0.7	110.3	112.7	-2.4
Primary Care Co-Commissioning	59.8	61.1	-1.3	133.0	134.8	-1.8
Other Programme Services	-5.4	4.5	-10.0	-13.0	-1.0	-12.0
Running Costs	5.1	4.4	0.7	11.4	11.1	0.3
Total Expenditure	**523.5**	**532.0**	**-8.5**	**1,182.4**	**1,193.0**	**-10.5**
Operating Surplus/Deficit	**2.0**	**-6.4**	**8.5**	**3.8**	**-6.8**	**10.5**
Adjustment to position for ICB	0.0	0.0	0.0	0.0	3.6	3.6
Net Surplus/Deficit Position (ICB)	**2.0**	**-6.4**	**-8.5**	**3.8**	**-3.2**	**-7.0**

Lincolnshire CCG (to Month 3)						
Total Allocations	**376.0**	**376.0**	**0.0**	**376.0**	**376.0**	**0.0**
Expenditure	**383.0**	**376.0**	**7.0**	**383.0**	**376.0**	**7.0**
Operating Surplus/Deficit (CCG)	**-7.0**	**0.0**	**7.0**	**-7.0**	**0.0**	**7.0**

Net Surplus/Deficit Position (ICB & CCG)	**-5.0**	**-6.4**	**-1.5**	**-3.2**	**-3.2**	**0.0**

Appendix 3 – System Risks and Mitigations

Figures are forecasts for the full year 2022/23.

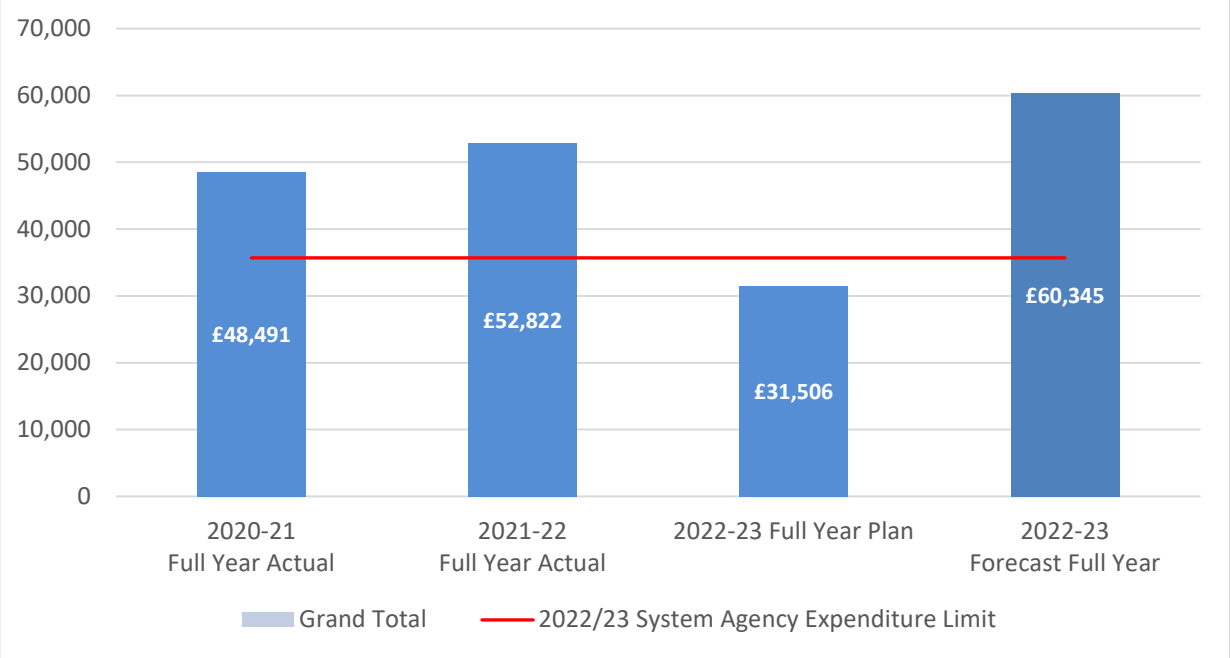
Org / System Wide	Description of risk	Likelihood	Potential Financial Impact before mitigations £m	Description of mitigating actions being taken by system	Potential Financial Impact after mitigations £m
System Wide	Delivery of waste Efficiency schemes	High	-19.9	ICB commissioned expenditure run-rate underspend	-8.9
United Lincolnshire Hospitals NHS Trust	Delivery of waste Efficiency schemes	High	-12.2	Efficiency and Productivity review within ULHT	-12.2
United Lincolnshire Hospitals NHS Trust	COVID-19 costs	High	-6.6	Efficiency and Productivity review within ULHT	-2.2
System Wide	Reductions in agency spend via escalation bed closures	Medium	-8.3	Creation of out of hospital capacity in community and social care to enable the discharge of hospital patients who are either on Pathway 1 or Pathway 0 to enable bed closures.	-8.3
System Wide	Risk of the return of the funding received to address the elective backlog.	Medium	-9.6	Non clawback of ESRF funding	0.0
United Lincolnshire Hospitals NHS Trust	Continued increase in inflation levels	Medium	-2.1	Efficiency and Productivity review within ULHT	-2.1
Lincolnshire ICB	Demand pressures in Ambulance services	Low	-1.4	Mitigation to be confirmed	-1.4
System Wide	Investment in Mental Health Services to achieve Mental Health Investment Standard	High	-9.0	If the system is unable to identify, invest and implement schemes before the end of the financial year, there will be an underspend, however, the MHIS target will not be met.	0.0
Grand Total			**-69.1**		**-35.1**

Appendix 4 – ICB Financial Performance Targets

Overview – Key Targets	Limits	Year To Date	Forecast year end position	Comments
Revenue resource (programme cost) must not exceed the amount specified in directions	£1,186.2m revenue resource limit (including Running Cost allowance) based on current ICB allocations (9 month period).	Red	Red	The ICB is planning a £3.25 million deficit, so it will be exceeding the revenue resource limit.
Revenue administration resource (running cost) used must not exceed the amount specified in directions	£11.4m 2022/23 Running Cost allowance based on ICB allocations (9 month period).	Green	Green	The year end forecast outturn is within the Running Costs allocation.
Capital resource used must not exceed the amount specified in directions	£1.478m capital allocation for GP IT has been allocated to the ICB.	Amber	Green	The ICB has plans in place to spend all GP IT capital allocation in year although this is underspent year-to-date.
To manage cash payments within the annual cash drawdown requirement (ACDR)	£1,1827.4m 2022/23 9 month cash drawdown requirement	Amber	Green	At Month 7 (44.4% of the 9 month period), the ICB has utilised 44.7% of the annual cash requirement.
Period end cash balance is less than 1.25% of drawdown value	No more than 1.25% of the drawdown value	Green	Green	October cash balance was £112k (0.5% of drawdown), so within tolerance. Target delivered every month.
Better Payment Practice Code: 95% of NHS and non-NHS invoices by value and volume paid within 30	95% of invoices paid within 30 days of receipt	Green	Green	All targets achieved cumulatively.

Appendix 5 – Delivery against System Agency Expenditure Limits (£'000)

The chart below shows the in-year increases of agency expenditure across the system and the distance from the prescribed agency expenditure limit of £35.7m; the current forecast is that spend will exceed the target by £24.6m.



7 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22nd November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	7 (i)
Title of Report:	The Lincolnshire System Greener NHS Plan
Purpose:	To present the system Greener NHS Plan for approval Jacqui Bunce Programme Director – ICB Strategic Estates, Partnerships and Planning - System SRO Sarah Connery – Chief Executive LPFT - Executive Sponsor
Appendices:	The Lincolnshire System Greener NHS Plan Presentation on the System Greener NHS Plan

1.	Key Points for Discussion:

- The NHS has statutory responsibilities for Net Zero, emissions and environmental targets. NHS Trusts are required to have Green Plans. The detail is set out in national guidance and targets are embedded within NHS contracts.
- There is a requirement to have a System Greener NHS Plan that draws on the individual Trust plans.
- The attached presentation sets out the context and reporting and governance requirements. It sets out how the NHS in Lincolnshire Greener NHS structures and includes the draft Plan on a Page.
- The draft Lincolnshire System Greener NHS Plan is also attached.

2.	Recommendations

- To note the statutory responsibilities as set out in the Health and Social Care Act with reference Net Zero, emissions and environmental targets.
- To note the governance and assurance structures.
- To approve the Lincolnshire System Greener NHS Plan.

3.	Executive Summary

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

To support this net zero ambition, each trust and integrated care system should have a Green Plan which sets out their aims, objectives, and delivery plans for carbon reduction. In each case, this should be signed off by the Trust Board, with a board-level 'net zero lead' responsible for overseeing its delivery. The three Provider Trusts in Lincolnshire each has their own approved Green Plan. The system plan has been developed in collaboration with the Provider Trusts supported by expert additional capacity funded through the Region who also supported ULHT in the development of their plan. There was national guidance to set out what to include.

The attached presentation sets out the areas within the plan, the key priorities and the governance structure including the links to the Regional priorities and Board.

4.	Management of Conflicts of Interest

No conflicts of interest to note

5.	Risk and Assurance

Assurance and delivery are being coordinated through the System Greener NHS Group which will report into the Service Delivery & Performance Committee. There is a requirement to provide reports to the Region. There is a quarterly national reporting process on a number of standards.

6.	Financial/Resource Implications

Each Trust is responsible for delivering their own Green Plans and looking at the most sustainable and environmentally friendly options needs to be embedded in all business cases and transformation workstreams.

Administration support is needed within the ICB to help with the coordination and the system assurance.

7.	Legal, Policy and Regulatory Requirements

The Health and Care Act 2022. This places duties on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets.

The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets. It also covers measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

8.	Health Inequalities implications

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.
- Reducing emissions will mean fewer cases of asthma, cancer and heart disease.

9.	Equality and Diversity implications

We are currently exploring, using as a system, an Environmental/Sustainability Impact Assessment from the Black Country & West Birmingham ICS, which is an exemplar in the Region.

10.	Patient and Public Involvement (including Communications and Engagement)

Sustainability and the NHS Green Agenda is reported at individual Trust Boards and has been referenced in the former CCGs Annual Reports. A communications plan to support the Green Plan is being developed. There are national communications which are cascaded through organisations to staff and externally where appropriate.

11.	Report previously presented at

Lincolnshire NHS Leaders Board September 2022

12.	Sponsoring Director/Partner Member/Non-Executive Director

Jacqui Bunce – ICB Programme Director Strategic Estates, Partnerships & Planning System SRO
Jacqui.bunce@nhs.net
Sarah Connery – Chief Executive LPFT and System Sponsor
Sarah.connery@nhs.net

NHS

Lincolnshire
Integrated Care Board

Lincolnshire System Greener NHS Plan

Contents

Foreword

Climate change and its effects on the environment, and the health and wellbeing of the population is now recognised on a global scale.

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.

On 1 July 2022, the NHS became the first health system to embed net zero into legislation. 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 the Lincolnshire County Council three guiding principles:

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

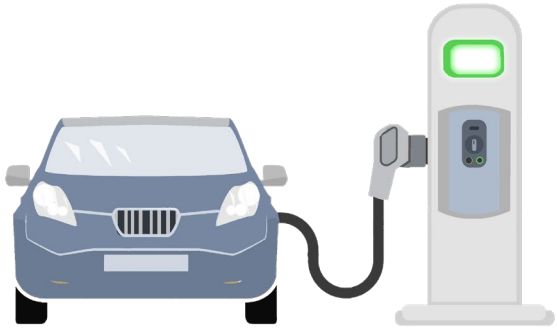
The key messages for us all are Reduce wastage, Reuse wherever possible, and Recycle as much as we can. These are things that we can all do and contribute to individually and collectively. Ideas and suggestions from our staff across the NHS and partners will always be welcomed.

With the energy and commitment of all departments and individual members of staff within the System, we will endeavour to look at every aspect of our business and the services we provide, taking a holistic approach to reducing every aspect of our environmental footprint, whilst working hard towards to provide sustainable high-quality services for the present and future generations.

Lincolnshire is fully committed to playing our part in tackling climate change, not only to benefit the environment globally, but also to contribute to, promote and support the health and wellbeing of the community we serve.

- John Turner, Chief Executive of NHS Lincolnshire Integrated Care Board

Highlights

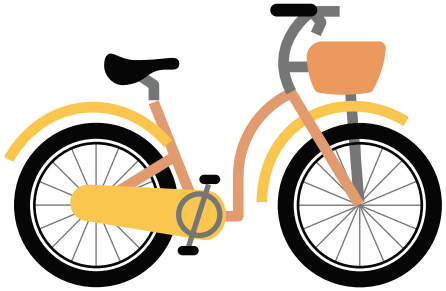


LPFT have installed **24 electric vehicle charging points** across five sites.

ULHT has received a **commendation from the Carbon Trust**.

ULHT, LCHS and LPFT work in partnership with Stagecoach to provide **discounted bus travel**.

LCHS and LPFT offer salary sacrifice **cycle to work schemes**.



LCHS has delivered **17% of all community contacts through digital means**.

Introduction

In 2020, the former NHS Chief Executive Sir Simon Stevens said;

"While the NHS is already a world leader in sustainability, as the biggest employer in this country and comprising nearly a tenth of the UK economy, we're both part of the problem and part of the solution.

That's why we are mobilising our 1.3 million staff to take action for a greener NHS, and it's why we have worked with the world's leading experts to help set a practical, evidence-based and ambitious route map and date for the NHS to reach net zero."

These sentiments have been echoed by his successor, Amanda Pritchard;

"Because we are the NHS, we already have a world-leading drive to reach Net Zero by 2045, leveraging the ingenuity of our colleagues locally, binding in supply chains, and securing hundreds of millions of pounds of capital to support local energy reduction plans. Continuing this incredible progress is a 'must do' if we want a resilient health service for the future."

NHS Lincolnshire is proud to share our Green Plan that seeks to embed sustainability and low carbon practice in the way that the system delivers vital healthcare services.

The Lincolnshire System Greener NHS Plan allows us to set out our current position in addition to our goals for the next three years, with a view to helping the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions.

The climate crisis is also a health crisis, as rising temperatures and extreme weather will disrupt care and impact the health of our communities.

As health and the environment are inextricably linked, climate action is not about sacrificing the quality of our patient care. Instead, it is about building new norms and establishing a green thread throughout our activity.

This plan outlines how we will reduce our environmental impact whilst improving health outcomes across Lincolnshire. The system is best-placed to achieve this, as the wellbeing of the populations that we serve is tied to the existence of our anchor organisations. This plan can achieve this twofold task, as many of the actions needed to reduce our carbon footprint have additional benefits for health.

For example, the reduction of air pollution can decrease incidence of COPD. By reducing our system carbon footprint, we can improve the environment at the regional scale and therefore extend these additional health benefits across Lincolnshire.

There are three Trusts within NHS Lincolnshire:

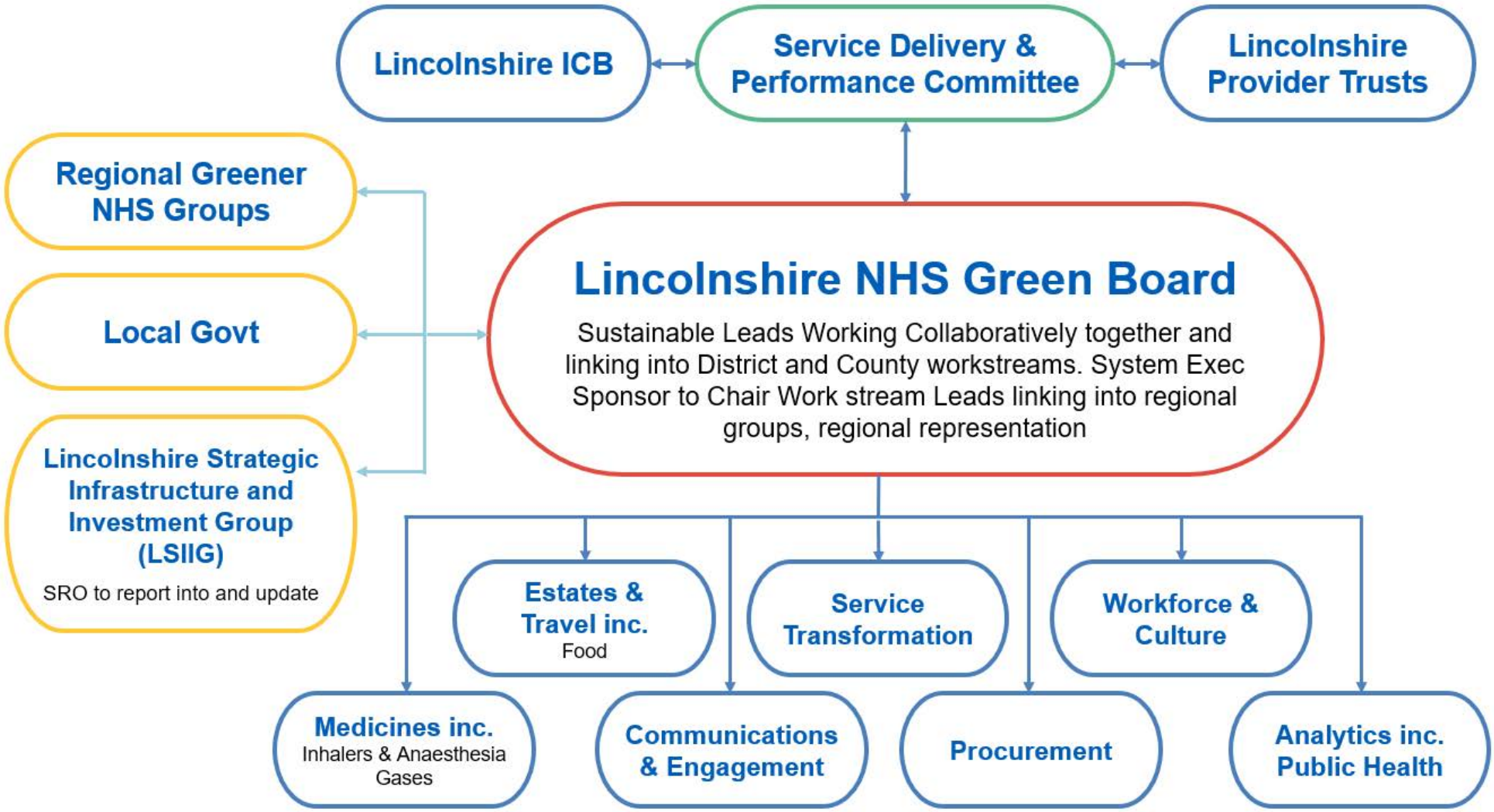
- Lincolnshire Community Health Services NHS Trust (LCHS)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- United Lincolnshire Hospitals NHS Trust (ULHT).

Primary care is linked into our Green Plan through the Primary Care Networks and the Primary Network Alliance through the Integrated Care Board.

In this document we will summarise the Green Plans of our member organisations and contextualise them within the wider system.

Delivery of the Green Plan will be overseen by the Integrated Care Board (ICB), monitored by the workstream Green Leads, and reviewed internally on an annual basis.

NHS Lincolnshire Organogram



System Overview

There is a GP-registered population of approximately 800,645 people across the system. Lincolnshire is the fourth largest county in England with a diverse and growing population. It has more than 30 towns, including the main towns: Boston, Bourne, Gainsborough, Grantham, Holbeach, Lincoln, Louth, Skegness, Spalding, Stamford and several hundred parishes.

The Integrated Care Board is co-terminus with one upper tier local authority and there are seven district councils. In August 2021, East Lindsey, Boston Borough Council and South Holland District Council partnered in the South & East Lincolnshire Councils Partnership, allowing the sharing of expertise, teams and resources.

Lincolnshire County Council is the main local authority, which has committed to become carbon neutral by 2050. Their Green Masterplan was launched in 2020. The council has also set an additional goal to reduce emissions by 68% by 2025 from a 1990 baseline. This aspirational target sets out a reduction for 5 years earlier than the government target of 2030. This level of ambition has laid the foundations for our net zero ambitions. A considerable aspect of Lincolnshire's carbon footprint is our health services, as overseen by our system.

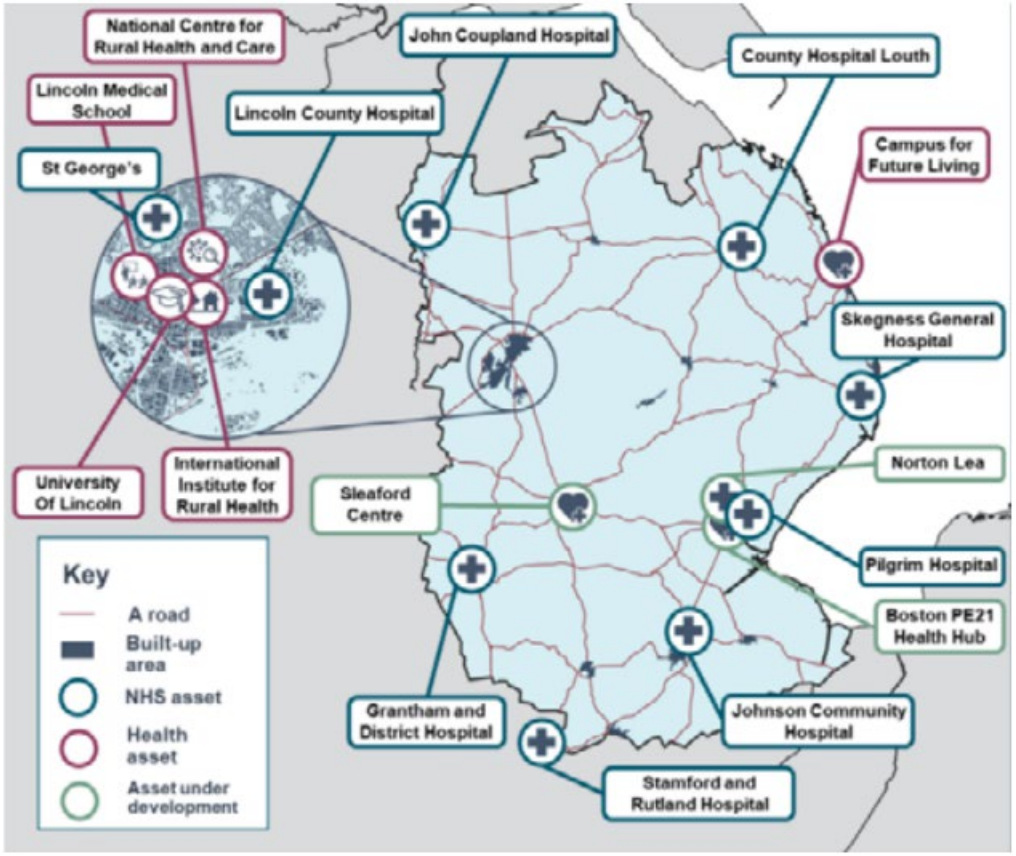


Figure 1: NHS Buildings across the system and how they are linked. Taken from Lincolnshire – Healthcare, the NHS and the local economy.

Partner organisations

NHS Lincolnshire binds our partner organisations together with common purpose to improve the health of our population. Our Integrated Care Board (ICB) works with our Integrated Care Partnership (ICP), which has been formed jointly with Local Authority Partners. Together the ICB and ICP form the ICS.

Healthwatch Lincolnshire is the independent consumer champion for health and social care in Lincolnshire as part of the ICB. The Health and Wellbeing Board (HWB), which brings together key leaders from the NHS, Public Health and social care systems, also takes part in this work. Members of the HWB collaborate to agree priorities based on what local communities need. The HWB has a duty to encourage integrated working, including commissioners working in a joined-up manner.

The Lincolnshire Voluntary Engagement Team (VET) is a collective of Voluntary, Community and Social Enterprise (VCSE) organisations working together with a specific focus on developing and delivering health, care, and wellbeing services in Lincolnshire working with partner agencies.

Voluntary Centre Services (VCS) supports volunteers, voluntary and community organisations across Lincolnshire and works to ensure that the voluntary and third sector are informed about local health service and involved in any key decisions that we make about the services commissioned across the system.

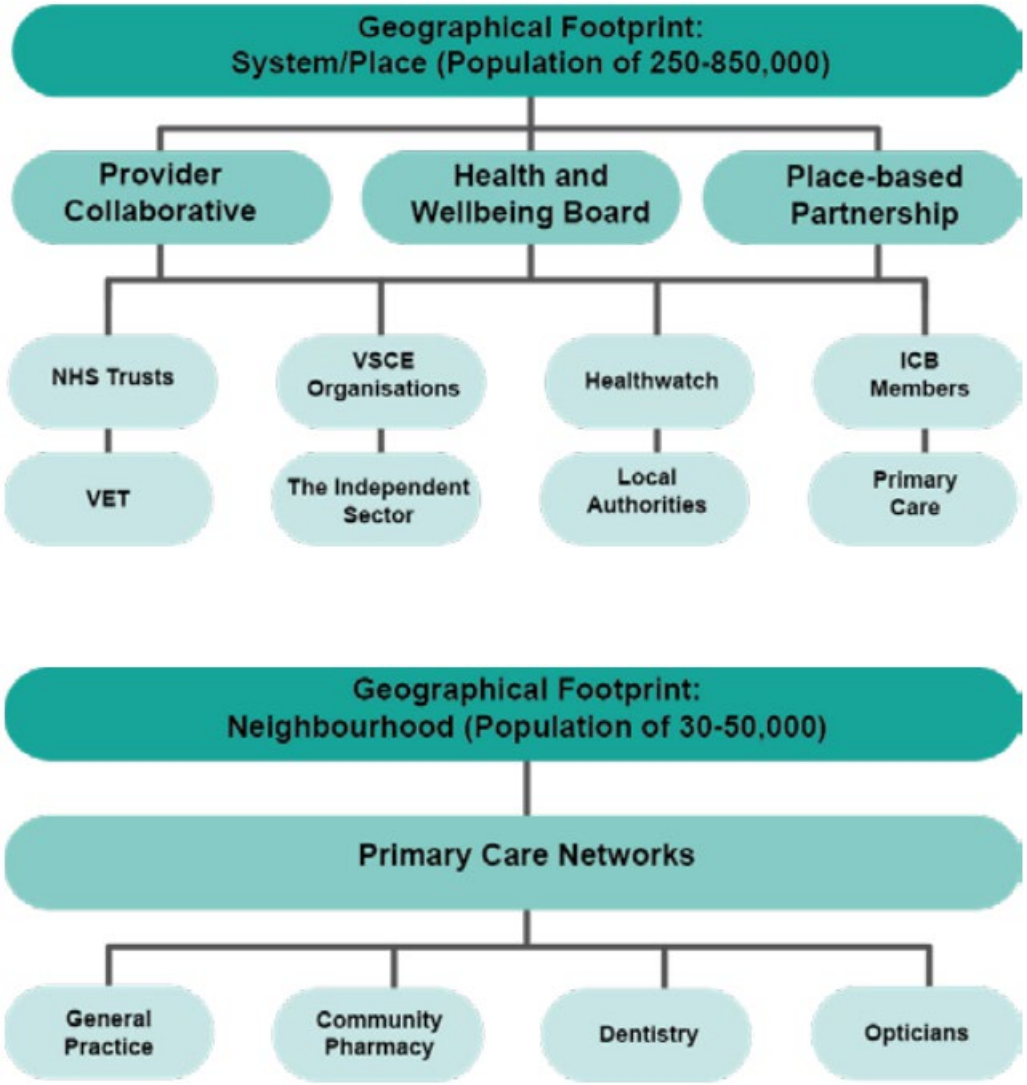


Figure 2: The NHS Lincolnshire structure broken down into place and neighbourhood.

Primary Care Networks (PCNs) are groups of GP practices working together with other local organisations, such as community, mental health, social care, pharmacy, hospital and voluntary services. GP practices across Lincolnshire have been working together for several years through federations, networks, clusters and partnerships.

The NHS Long Term Plan and the new five-year framework for the GP contract have formalised this. In practice, PCNs will build on the work already undertaken and the current services offered by a GP practice. In Lincolnshire, there are 15 PCNs that provide total coverage across the region.

The Greater Lincolnshire Local Enterprise Partnership (LEP) aims to drive economic growth within the region, collaborating with private and public sector leaders. Members of the ICB sit on the Energy Board, representing the perspective of the NHS around clean energy and innovation.

Our Public Health colleagues based within Lincolnshire County Council form part of the system and as a result, the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and social prescribing have been worked on collaboratively.

Other partner organisations include the Lincolnshire Care Homes Association, East Midlands Ambulance Service, the private sector, third sector, and health and social care partners within and outside the footprint.

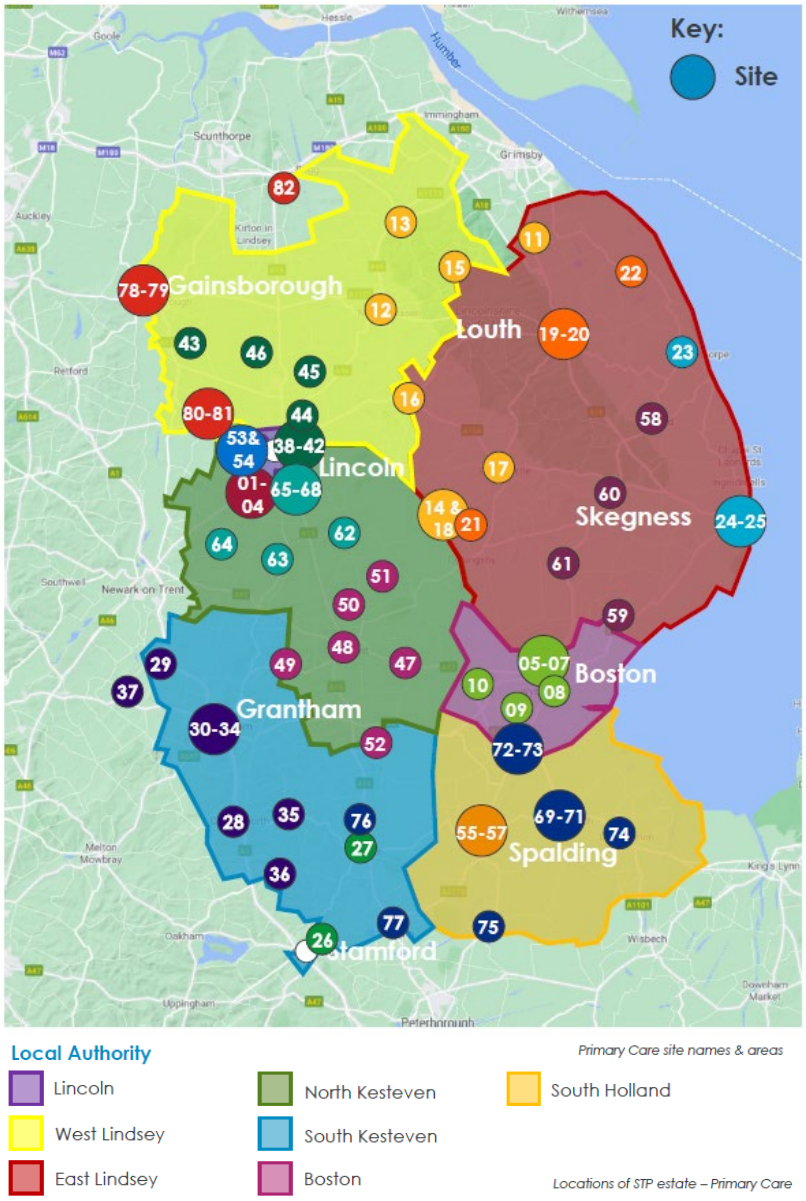


Figure 3: Map showing the locations of our Primary Care Networks.

NHS Greener Reporting and Assurance

The delivery of Net Zero will be supported by initiatives and working groups at the national, regional and System level. This often includes direct arrangements with individual Trusts, held accountable by the
National Sustainability Board and Regional Green Board.
The Green Agenda will connect our organisation across Trusts and Primary Care, linking to Sustainability Managers across Districts and County Council to maximise opportunities. Collaborative working is important, particularly surrounding communications, staff engagement and training.

Regional priorities

As NHS Lincolnshire sits within the Midlands Regional NHS, our Memorandum of Understanding and ongoing Net Zero goals reflect our regional and national priorities. We consequently submit regular highlight reports per the regional priority areas to the regional team. The activities covered by Regional Delivery Plans and the Regional Working Group are ascertained through the National Sustainability Board and reported into the Regional Green Board. Risks and issues managed at a regional level will be escalated to the National Team. The bi-monthly Regional Greener Board meetings that focus on regional delivery, risks and issues.

System priorities

The Midlands Greener team attend our Lincolnshire Green Board. They provide regional and national updates and allow for a route of escalation to assure Net Zero delivery at the System level. System Delivery Plans and System working group activities are assured through the Lincolnshire Green Board and reported to the Regional Green Board. Quarterly system meetings will also focus on system-specific delivery, risks and issues. Risks and Issues will be managed at the System level and when appropriate, will be escalated to the regional Team.

Trust priorities

Trust Delivery Plans are governed by Trust Boards and reported into System Green Board. Risks and Issues managed at Trust Level are escalated to the System. Internal organisational workstreams are governed with executive lead responsibility with an internal reporting procedure.

System Vision

Our Trusts have made considerable progress in their net zero journeys over the years. The challenge now is to set a long-term vision for sustainability within the System and define the actions that the System and our stakeholders will take to achieve it.

The end goal of the NHS Green Plans is to reach net zero by 2045. This plan will take us through the next three years. As the System develops and matures as an organisation, it will be possible to further develop our longer-term strategy and vision to get to 2045.

The pace of change within the system is beginning steadily, as there is new architecture around healthcare in Lincolnshire. However, as our relationships with stakeholders grow and develop, environmental progress is thought to increase exponentially. This will also allow conversations around budgets funding to develop further. Some financial saving will be feasible by choosing a more sustainable approach, but in many cases, investment will be needed too. Funding should therefore be of focus in the delivery of this Green Plan.

The net zero journey will require changes to infrastructure, policies, practices, behaviours, values and the alignments of activities with the green agenda. Therefore, it is important that a green thread persists throughout all our workstreams. Each area of focus details the actions NHS Lincolnshire will take to reach net zero within that workstream. The actions also need to ensure that the Green Plan will be rooted in the ‘place’ rather than the ‘provider’, meaning that it will bring broader Lincolnshire focus.

Below we have detailed our vision, objectives and targets that will be used to enact far reaching and impactful change on the environment and improved health outcomes.

Vision

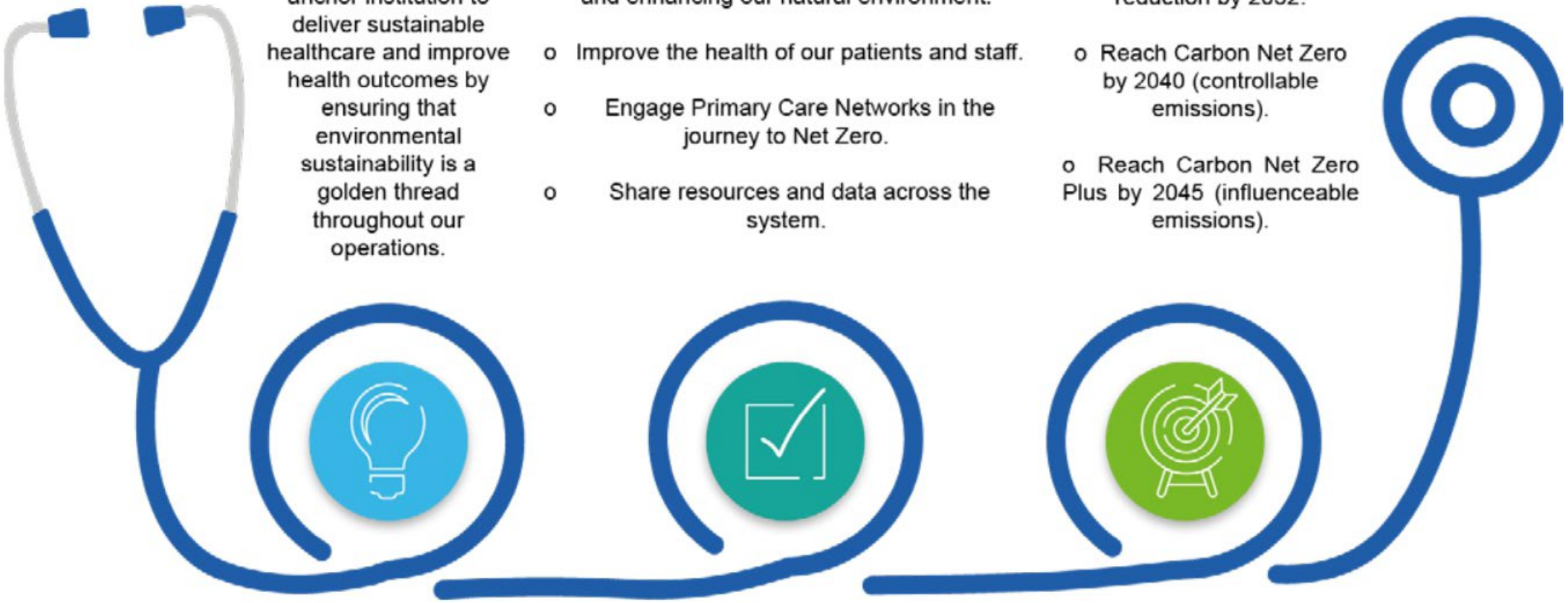
To use position as an anchor institution to deliver sustainable healthcare and improve health outcomes by ensuring that environmental sustainability is a golden thread throughout our operations.

Objectives

- Reduce our negative environmental impacts and enhancing our natural environment.
- Improve the health of our patients and staff.
- Engage Primary Care Networks in the journey to Net Zero.
- Share resources and data across the system.

Targets

- Achieve an 80% emissions reduction by 2032.
- Reach Carbon Net Zero by 2040 (controllable emissions).
- Reach Carbon Net Zero Plus by 2045 (influenceable emissions).



Drivers for Change

International Policy Drivers	Relevance to Green Plan
Intergovernmental Panel on Climate Change (IPCC) AR5 2013	Sets out the 'Net Zero National Health Service 2020' strategy and the 'Greener NHS' guidance
UN Sustainable Development Goals (SDGs) 2016	Sets out the 'Five Year Forward View 2014' strategy
World Health Organisation (WHO) toward environmentally sustainable health systems 2016	Sets out the 'Sustainable Development Strategy for the Health and Social Care System 2014-2020'
World Health Organisation (WHO) Health 2020	Sets out the 'Adaptation Report for the Healthcare System 2015'
The Global Climate and Health Alliance. Mitigation and Co-benefits of Climate Change	Sets out 'The Carter Review 2016'
	Sets out the National Institute for Clinical Excellence (NICE)'s 'Physical Activity; walking and cycling 2012' strategy
	Sets out the 'Health Technical Memoranda' and 'Health Building Notes'
	Sets out the 'Sustainable Transformation Partnership' plans
National Policy Drivers	**Relevance to Green Plan**
Climate Change Act 2008 (Amended 2015)	Sets out emissions reduction targets
HM Treasury's Sustainability Reporting Framework	Sets out sustainability targets
Public Health Outcomes Framework	Sets out health & wellbeing targets
Integration and Innovation: Working together to improve health and social care for all	Sets out legislative proposals for the subsequently approved Health and Care Bill 2021
Health and Care Bill 2021	Sets out Integrated Care Systems as statutory bodies
Health and Care Act 2022	Places duties on NHS England and all Trusts, Foundation Trusts, and Integrated Care Boards to contribute towards statutory emissions and environmental targets and address net zero emissions targets.

Regional Policy Drivers	Relevance to Green Plan
Lincolnshire County Council Green Masterplan	Lincolnshire's plan to reduce greenhouse gas emissions.
Lincolnshire County Council Carbon Management Plan 2018-2023	Lincolnshire's plan to reduce greenhouse gas emissions.
Lincolnshire Local Transport Plan 2013/14-22/23	Lincolnshire's plan to improve access to transport.
Lincolnshire Council Corporate Environmental Policy	Lincolnshire's ten principles for environmental policy.
Lincoln Climate Commission	The Lincoln section of the Place-Based Climate Action Network.
Joint Lincolnshire Flood Risk and Water Management Strategy 2019-2050	Climate change adaptation: impact of climate change on flood and drought risk.
Lincolnshire County Council Strategy for Waterways Development	Environment, flood risk management and water security.
Greater Lincolnshire Nature Partnership	Actions to conserve and enhance the geological heritage of Greater Lincolnshire.
Lincolnshire Food Partnership	Promotes greener, healthier food across the region.
Lincolnshire HWB Joint Health and Wellbeing Strategy 2018	Plan to reduce health inequalities and improve overall health.
Lincolnshire People Plan 2021-2022	ICS plan for staff and patients.
Better Lives Lincolnshire Alliance: Digital, Data and Technology Strategy and Governance	Joint digital strategy for Lincolnshire Digital and Lincolnshire County Council.
Joint Working Executive Group: Health Inequalities Programme	Detailing health inequalities in Lincolnshire and some methods for tackling them.

Table 1: International, national and regional policy drivers and how they relate to the Green Plan.

The United Nations Sustainable Development Goals

NHS Lincolnshire is working meaningfully towards the United Nations (UN) Sustainable Development Goals (SDGs) through our Green Plan, which we have aligned to relevant SDG targets.

The SDGs underpin a global action framework to 2030, adopted by every UN member country to address the biggest challenges facing humanity.

Each goal has targets and indicators to help nations and organisations prioritise and manage responses to key social, economic and environmental issues. We have considered how the System can contribute to the SDGs as a whole, as well as how sustainability objectives contribute towards the delivery of this strategy.

The NHS and its people contribute to multiple SDGs through the delivery of its core functions, for example, target 3.8, to achieve universal health coverage. Established on 5th July 1948, the UK's National Health Service is the world's first modern fully universal healthcare system, free at the point of use, and celebrating its 75th year in 2023.

Figure 3: The Sustainable Development Goals (SDGs).

Linking the Green Plan to NHS Net Zero

The Net Zero journey will require changes to infrastructure, policies, practices, behaviours, values and alignment of other activities with the green agenda.

Contributing to around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act.

Two clear and feasible net zero targets for NHS England are outlined in the 'Delivering a 'Net Zero' National Health Service' report (aka NHS Net Zero Report):

- **The NHS Carbon Footprint** for the emissions under direct control, net zero by 2040.
- **The NHS Carbon Footprint 'Plus'** for the emissions under influence, net zero by 2045.

Integrated Care Systems are to align their Green Plans with NHS England's net zero ambitions. The emissions used in this Plan have been calculated from all the sources listed in the NHS Net Zero Report and should be reduced by approximately 4% year-on-year (akin to Science Based Targets) until each of the relevant target dates.

Greenhouse Gas Emissions

Greenhouse gas emissions are conventionally classified into one of three 'scopes', dependent on what the emission source is and the level of control an organisation has over the emission source. They are reported in 'tonnes of carbon dioxide equivalent' (tCO_2e).

The emission sources and their 'scopes' are shown in the infographic.

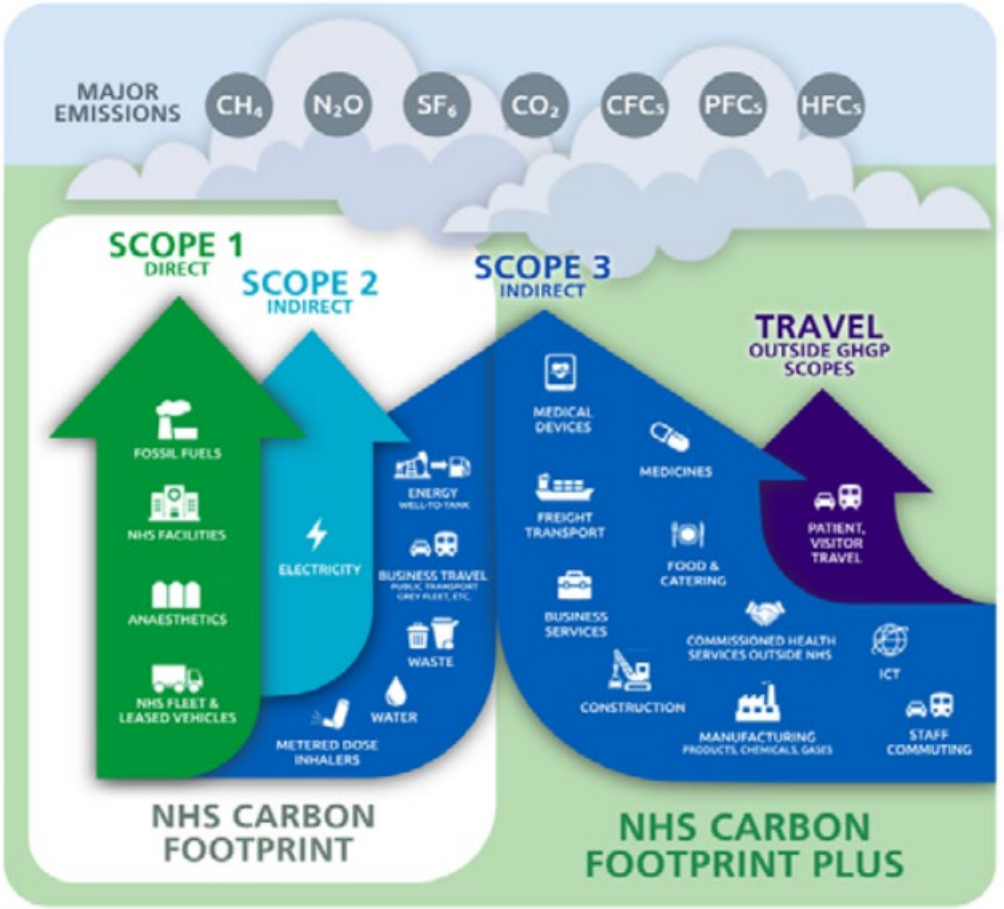


Figure 4: Greenhouse gas emission sources, and their 'scopes'

Data and Methodology

Carbon footprint

Energy and carbon footprint data for financial year 2019/20 were sourced from each individual NHS Trust and CCG, which was a statutory organisation at the time. These data were analysed in a carbon footprint report commissioned in 2021, that used primary data (utility bills, waste report data and fuel card data) and secondary data (mileage expense claims and business travel receipts) to produce a carbon footprint for the System, comprising of the CCG, LCHS, LPFT and ULHT.

Energy, travel, waste and carbon data from this report was further scrutinised for completeness in alignment with the GHG Protocol for Corporate Reporting and with the ISO 14064:1 methodology, and to ensure the correct carbon emission factors had been used (for the correct year, energy type etc.).

Emissions have been apportioned according to their scope (1, 2 or 3, as described in the previous section).

Anomalies were addressed and rectified. Scope 3 well-to-tank (WTT) factors have been used in some emission calculations for energy and travel.

The consolidated carbon footprint does not include information or emissions relating to medicines (volatile anaesthetic agents or inhalers), commuting, patient and visitor travel, and supply chain and procurement emissions. This is due to a lack of methodologies to enable Trusts to collate or report this information during the baseline year. However, future carbon footprints will include this data, as per more recent guidance.

One of our Trusts did calculate the above emissions, though the results are excluded from the consolidate carbon footprint to avoid skewing of data.

Financial year 2019/20 is used as the baseline for this Green Plan.
It is hoped that as data collection and reporting methods evolve, we will incorporate medicine, procurement, and additional travel data into our footprint. At this stage, we may change the footprint year and readjust targets accordingly.

Regional and policy drivers

Integrated Care Systems span a variety of geographies and political boundaries. To understand regional and local issues pertaining to sustainable models of care, climate change and other environmental issues, an analysis of regional and local socio-environmental data and local authority policies/strategies was undertaken ('policy scan').

The policy scan has been used to inform the Green Plan narrative and action plans.

The SHAPE Atlas tool and other governmental datasets were used to provide additional information or detail to the policy scan.

Maturity Matrix

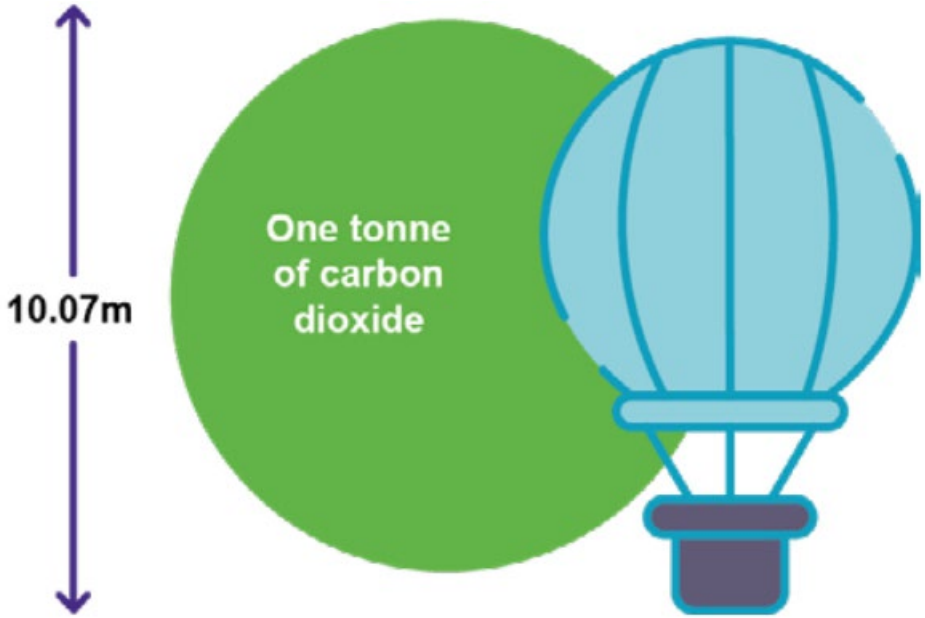
Each Trust's Green Plan has been assessed in terms of alignment with the NHS' 'How to produce a Green Plan' guidance and the robustness of Trust's action plans.

The assessment and scoring used the metrics as follows:

- Data completeness and presentation
- Existing strategies and narrative
- Future targeting

A radar graph for each Trust has been produced and amalgamated into a radar graph to show the maturity of the Trusts' respective Green Plans.

The weighting for future targets remains equal across all areas of focus, the other two metrics fluctuate depending on how much data is needed in that area.



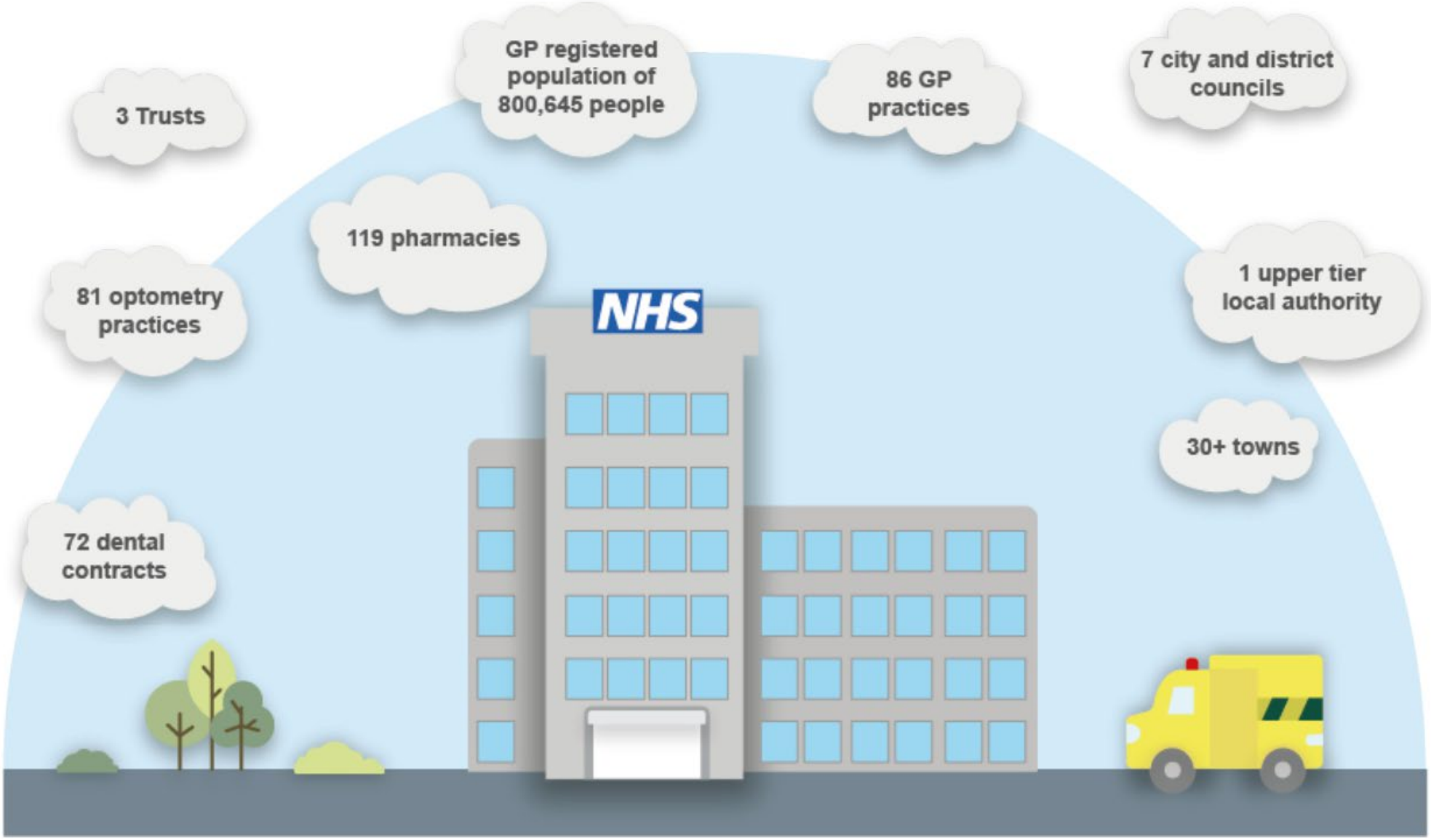
What does 1 tonne of carbon dioxide look like?

One tCO_2e can be visualised as a volume of gas the size of a hot air balloon – a sphere about 10 metres in diameter.

The average 3-bedroom semi-detached home emits around 1 tCO_2e per year from electricity consumption and almost 2 tCO_2e from the use of natural gas for heating and cooking.

Figure 5: Visualisation of a tonne of carbon dioxide.

Current Position



Health inequalities

There are social determinants of health determined by the broad social and economic circumstances into which people are born and live, which treatment alone cannot tackle. Local systems working together with strong leadership, joint planning, ambitions and scale have important roles to play in helping to untangle the complex web leading to health inequalities.

In Lincolnshire, the Indices of Multiple Deprivation (IMD) 2019 show a clear area around the coast with high levels of deprivation compared to the national picture. The local authorities were ranked in alignment with the national picture out of 326 areas (1 is most deprived and 326 is least deprived):

District council	Index of Multiple Deprivation
East Lindsey	30
Lincoln	68
Boston	85
South Holland	144
West Lindsey	146
South Kesteven	234
North Kesteven	268

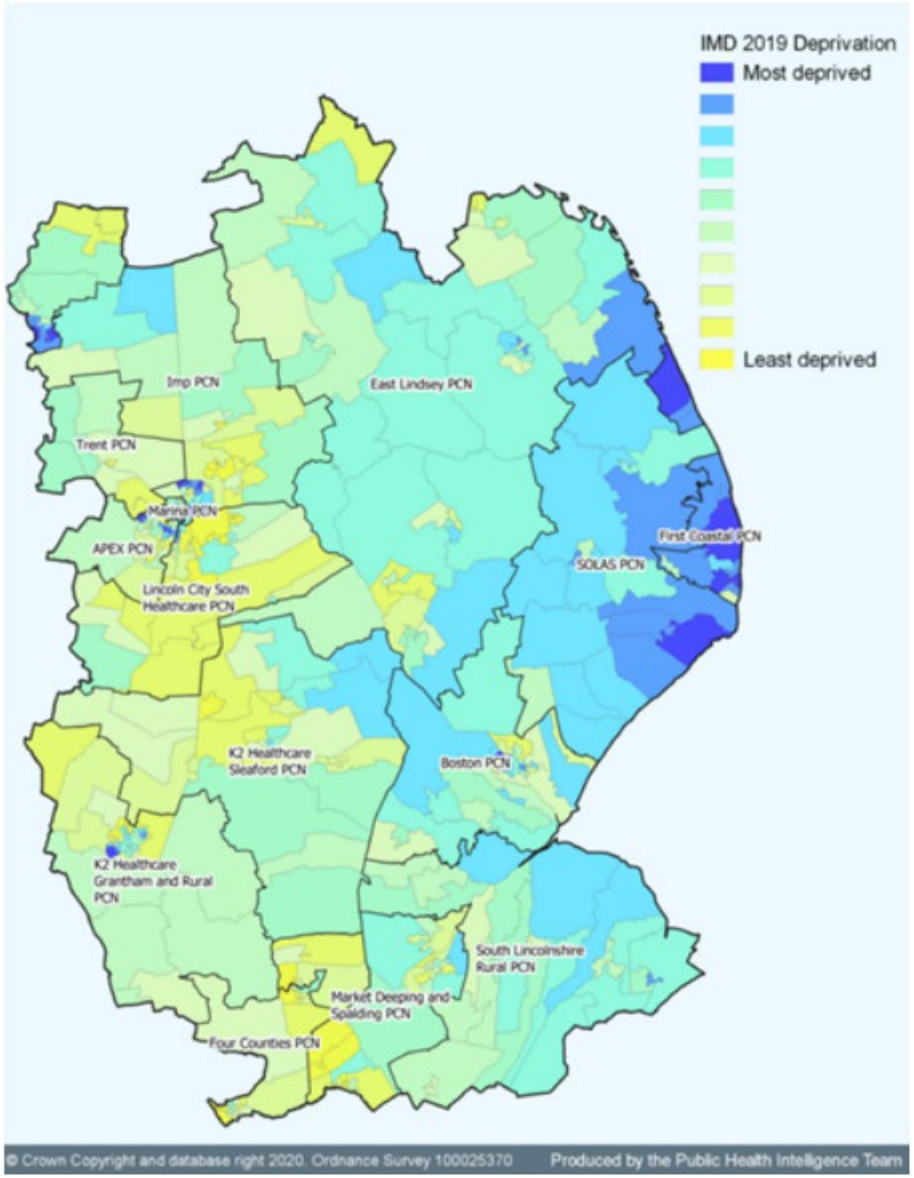


Figure 6: Index of Multiple Deprivation (IMD) across the System, grouped into primary care networks (PCN). Taken from the JWEG report on Health Inequalities.

The social and economic factors associated with IMD can result in increased occurrences of smoking and obesity. The JWEG Health Inequalities Programme sought to address health inequalities at the system level.

Smoking remains the greatest single contributor to health inequalities, accounting for half of the difference in life expectancy between those living in the most and least deprived communities.

Cardiovascular disease (CVD) and Alzheimers are also strongly associated with health inequalities and where the associated risk factors can be linked to modifiable lifestyle risks, awareness campaigns can be utilised across the system. If successful, these campaigns can reduce hospital admissions and therefore contribute to sustainable care models.

Where the risk factors for health issues are environmental, the actions in the Green Plan could reduce their occurrences across the system. Chronic obstructive pulmonary disease (COPD) is an example of this, as it has been linked not only to smoking, but poor air quality. This demonstrates the crossover between social, economic and environmental factors with health.

The Maturity Matrix below displays how comprehensively each area of focus has been portrayed by each Trust within their Green Plan. While this is a useful guide to highlight areas within each Trust which may benefit from further investigation and improvement, this only reflects how extensively each area has been covered within the Green Plan, not the actual performance of the Trust.

Maturity Matrix

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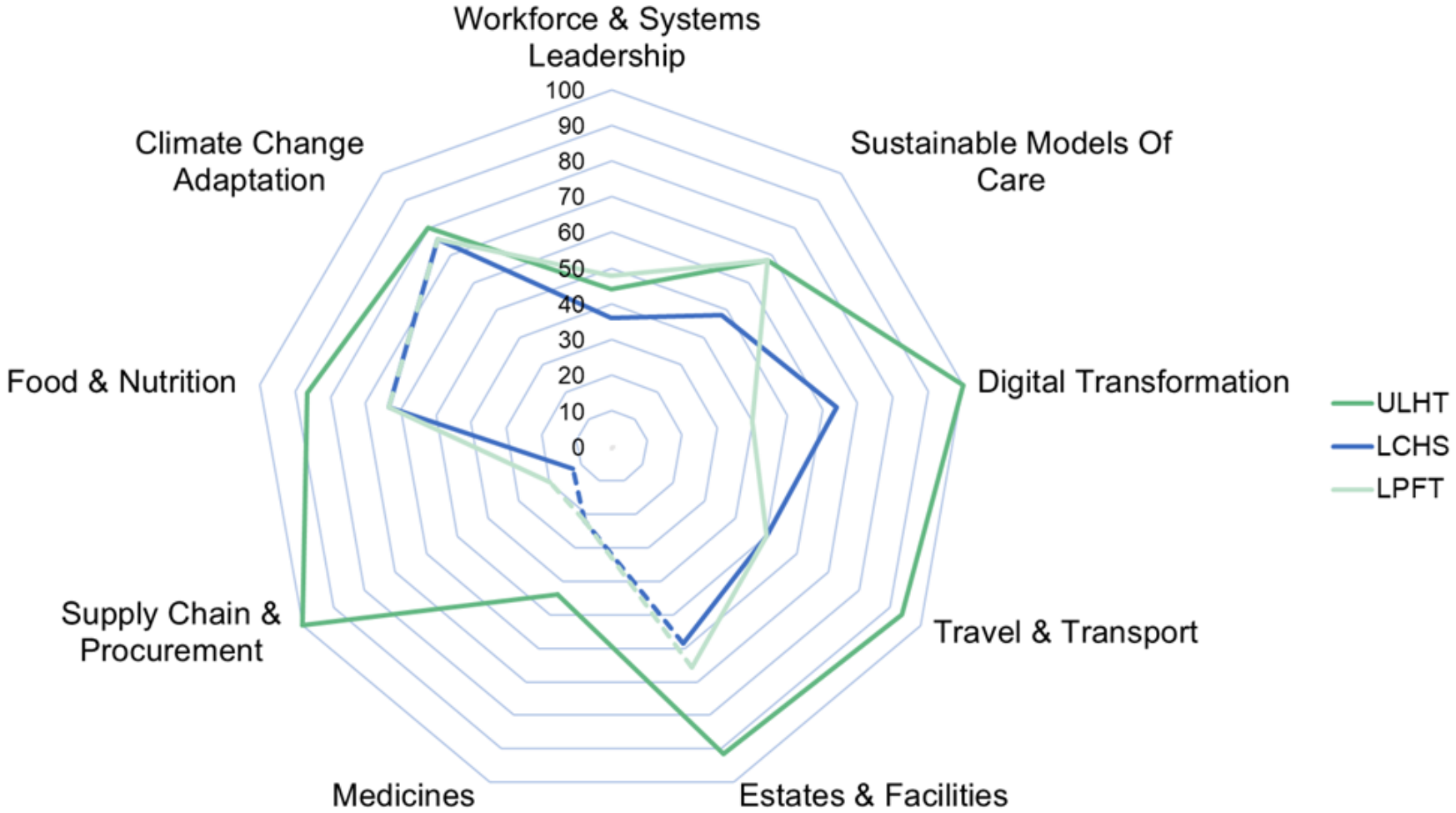


Figure 7: A radar diagram showing how each Trust scored for the completeness of their Green Plan sections.

We can see that all three Trusts showed strengths in different areas within their Green Plans. These differences in where Trusts are already succeeding allows for collaboration and sharing of best practice going forward.

In the area of Workforce and Systems Leadership, LPFT and ULHT scored well as they evidenced how staff are being engaged in sustainable action. Setting specific targets to take forward in this area would have increased the score for LCHS.

For Sustainable Models of Care, LPFT and ULHT both scored well, the former for providing good links to various inequalities that exist across their communities, and the latter for setting out their existing strategies to tackle these inequalities. To improve on how this area is presented in the Green Plan, LCHS could discuss their strategies and how these will address inequalities.

In Digital Transformation, ULHT provide a level of detail and links to existing strategies. Employing a similar level of detail would help to show the readers of LCHS and LPFT's Green Plans what is being done in this area. This presents an opportunity for facilitation at system level for best practice to be shared across the three Trusts.

ULHT scored particularly well in the Travel area of focus as they included travel emissions data across several years in their carbon footprint calculations, allowing them to set out a trajectory for their emissions reductions. LCHS and LPFT's Plans did not present this data, which is reflected in their scores for this section.

While data was present for all three Trusts in Estates and Facilities, LPFT and LCHS could have benefitted further from providing data for the last financial year and linking their Plan back to more of their existing Estates strategies and initiatives.

Procurement presents a good opportunity for shared learning. All three Trusts outlined their existing strategies, as they share a procurement service, and set targets for improvement in this area. ULHT also included emissions data and graphs related to their procurement activity, providing the opportunity to present this data as part of their overall carbon footprint and in an emissions trajectory. LCHS and LPFT could follow this example in order to present the good work that is already being done within their Plans.

For Medicines, the inclusion of inhaler and anaesthetic gas emissions within ULHT's Plan would have improved their score. This area of focus is not applicable to LCHS and LPFT, as they do not administer anaesthetics or provide inhalers to patients.

Under Food and Nutrition, all three Trusts had strong narrative sections. To go the extra mile, LCHS and LPFT could strengthen their targets and objectives by setting deadlines and methods for measuring progress.

For Climate Change Adaptation, every Trust identified climate risks and details of Risk Assessments and Heat Wave Plans, which made for strong sections. However, LPFT and LCHS can strengthen their performance by including target years for their objectives.

Over the next three years, the Trust Plans will continue to develop through collaboration, sharing of best practice, and facilitation through the System. This will allow Trusts to support one another to reach the targets that they have set themselves on their routes to achieving net zero.

NHS Lincolnshire Carbon Footprint: Wheel

The wheel represents the carbon footprint across our System. There are two broad groups that encapsulate these categories: emissions that are under our direct control, and emissions under our influence, as seen in the key for Figure 8.

As mentioned in the methodology section, this carbon footprint data was sourced from a report that excluded these data and therefore the above wheel reflects our emissions sources under direct control of the System. The two categories are therefore delivery of care and personal travel, both falling within our direct control.

Emission sources that are difficult to control include the supply chain and patient and visitor travel (commuting). As mentioned in the methodology section, this carbon footprint data was sourced from a report that excluded these data and therefore the above wheel reflects our emissions sources under our direct control.

46.1% of these emissions came from building operation, 0.9% from anaesthetic gas consumption, 43.1% from staff travel (Commuting), and 9.4% from business travel. In the future we plan to capture emissions from all sources in our carbon footprint to improve on its accuracy and to reach NHS Carbon Footprint 'Plus' by 2045.

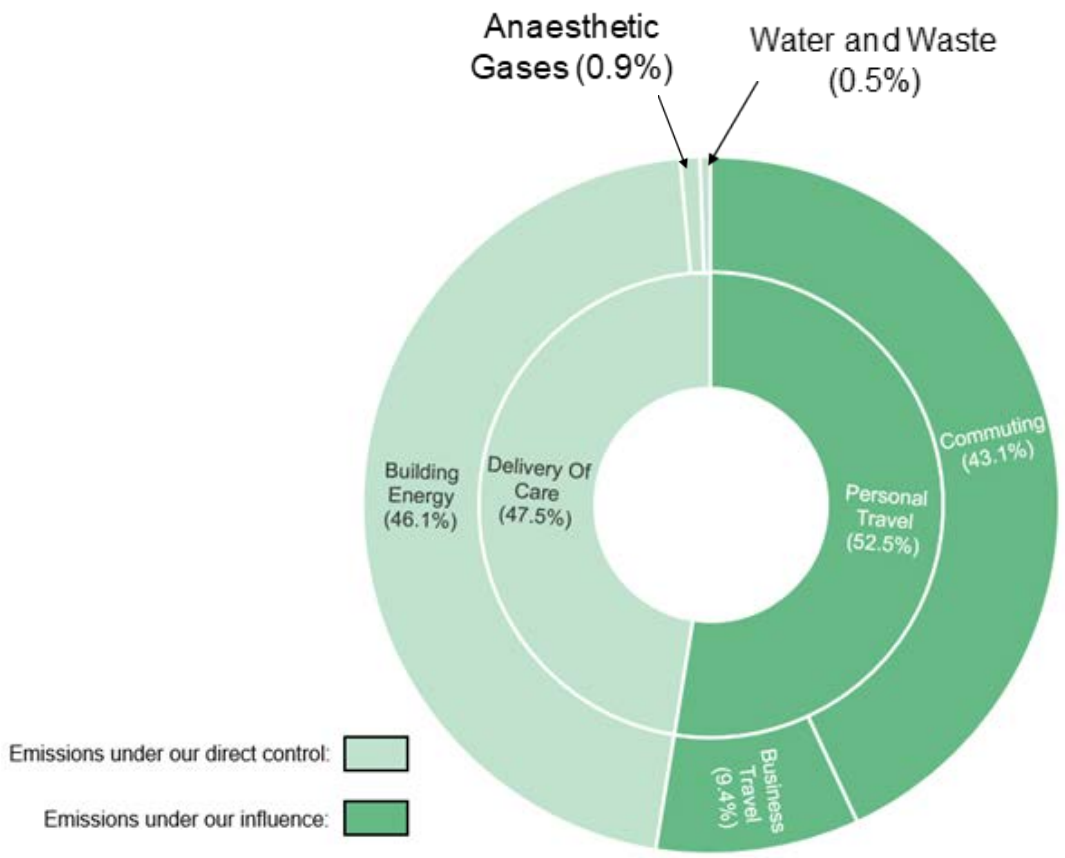


Figure 8: The wheel graphic shows what proportion of each category's emissions make up the total carbon footprint of the System.

Trajectory to 2045

To reach net zero by 2045, each of our member organisations will need to achieve a 4% year on year reduction if they fall into the ‘net zero by 2040’ category, and a 5% year-on-year reduction if they are in the ‘net zero by 2045’ category. The trajectory for this in each of the key areas of greenhouse gas emissions can be seen below.

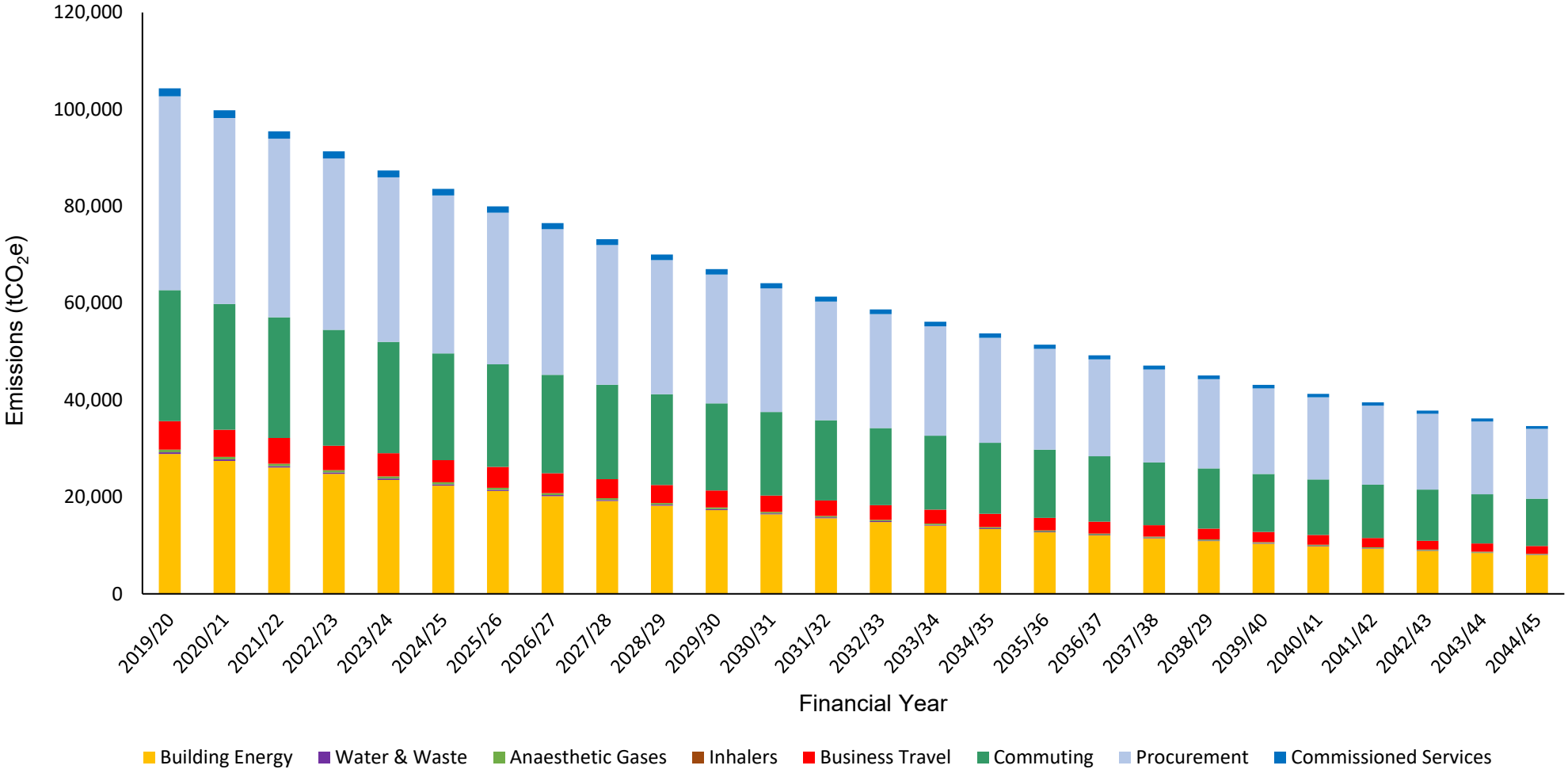


Figure 9: A graph showing the emissions reduction required for each category in order for our System to reach net zero by 2040 for emissions under our direct control and 2045 for emissions that we have influence over.

Areas of Focus Contents

The following ‘Areas of Focus’ give an overview of our current performance/status across the system.

Workforce and Systems Leadership

We will build our Green Plan into our strategic planning and governance, including our clinical and operational policies and procedures to ensure sustainable development is a part of our daily work and how we measure success.

Workforce

This is a shared journey, and we invite all our colleagues to be a part of it. To convey to our colleagues why the Green Plan is important, education is crucial, in addition to raising awareness of, and engagement with, net zero goals and sustainable development. A limited number of colleagues are certified to be carbon literate through carbon literacy training, which we plan to encourage across our ICB.

At the Trust level, all three Trusts have ambitions to recruit green champions to increase staff engagement around sustainability. With regards to training, LPFT and LCHS employ a hybrid approach to sustainability training and operate an intranet page. At LPFT, there is environmental training available on the electronic staff record (ESR) and the Trust is looking to further promote this across the workforce.

We will support our partner organisations in maintaining the health and wellbeing of NHS colleagues and taking action to ensure that they can encourage high rates of workforce recruitment and retention. This issue is of particular importance for Lincolnshire. We are working with local Higher Education Institutes to support the training and development of healthcare professionals to support recruitment and retention of a Lincolnshire-based workforce.

Across the system, we have a responsibility to consider all our member organisations in the decisions we make, including primary and secondary care, and how these link to our partner organisations.

The Lincolnshire Sustainability Officers are a cross-partnership group comprising of the District and County Councils and NHS representatives. The group discusses environmental issues and has discussions with various stakeholders such as the council on the changes occurring across the region. We have Trust and system-level representation at these meetings, allowing the System to represent healthcare in these discussions.

Systems Leadership

This Green Plan is approved by our ICB and will be reviewed (and revised if necessary) at least annually to keep us on track with the NHS net zero goals and our own targets. These reviews and our progress against the actions in the Green Plan will be submitted to our Coordinating Commission.

Each of our Trusts have internal structures and processes that allow the green agenda to be embedded systematically. Our other providers may seek to set up similar sustainability groups.

Working as part of a wider system is beneficial, as sustainability is an issue best addressed as a common purpose. Drawing expertise from across primary and secondary care alongside our partner organisations, including the University of Lincoln, will allow us to embed sustainability in everything that we do.

Integrated Care Systems have a pivotal leadership role, with the aim of progressively deepening relationships between the NHS, local authorities, and other social and healthcare organisations. NHS Lincolnshire proactively ensures quality governance arrangements, adhering to the National Quality Board's (NQB) quality commitments and position statement.

We will utilise our anchor institution status to maximise opportunities to collaborate on initiatives to support and deliver our collective Green Plan actions. Our system has considered how sustainability can be embedded across our strategies and plans. This Green Plan has been developed to align with our People Plan and Digital Strategy.

The Place-Based Climate Action Network (PCAN) focus on bringing together people and organisations from across the public, private and civic sectors to drive place-based climate action.

The Lincoln Climate Commission are part of the PCAN, which can be coordinated across Lincolnshire and engage with the integrated care system on common themes. Utilising our role as an anchor institution and partner helps to ensure that climate initiatives are joined-up and amplify the efforts across our region.

Sustainable Models of Care

The NHS Long Term Plan introduced sustainable care into the NHS service model. Sustainable models of care can reduce health inequalities by streamlining care pathways, making them more efficient, and focusing on preventative care. Relevance to the Green Plan comes with the emission reduction that is associated with these effects.

An example of this is our System priority of transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED) and reducing the length of stay. We are implementing these changes across the System whilst working to ensure that NHS111 is used as the primary route to access urgent care can help to streamline the process.

The National Patient Safety Improvement Programmes and the Investment Impact Fund indicators (IIF) provide underpinning principles for sustainable models of care. Staff training and empowerment are critical to deliver this.

Adhering to the Getting it Right First-Time programme (GIRFT) contributes to this area as it helps to avoid additional hospital bed days and patient and visitor travel to our clinics, and their associated environmental impacts. Strong interagency partnership working within the System enhances the principles of GIRFT.

The National Pathway Improvement Programme and GIRFT will be important in developing accredited plans for the national elective recovery programme. The System will be instrumental in ensuring that the NHS can reach the targets set in the elective recovery plan, which set out a vision to reduce wait times that have increased due to the COVID-19 pandemic.

Lincolnshire ICS will build on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services. We also commit to link Greenhouse Gas (GHG) reductions with our delivery of the Long Term Plan sustainable care model.

Community Diagnostic Centres can be used to make our care delivery more sustainable, as they facilitate earlier diagnoses, as well as reduced hospital visits, wait times and patient journeys. One of these centres is operated by ULHT in Grantham away from the main hospital, which opened in April 2022. A second CDC is being planned to open in 2022/23.

At the Trust level, our member organisations have contributed to sustainable care models by supporting flexible working for staff. LPFT managed to achieve 10,000 fewer inpatient bed days per annum compared with 2019/20 through the provision of virtual appointments since COVID-19 made in-person appointments less feasible.

The Trust is also looking to develop mental health crisis cafés and other community-based support services to further develop preventative care. Outside of secondary care, there should be an emphasis on expanding primary care capacity to improve access, local health outcomes and address health inequalities.

Digital Transformation

To fully utilise the potential of digital systems to improve patient outcomes, systems need to:

- Build smart digital and data foundations
- Connect health and care services
- Use digital systems to transform care
- Put citizens at the centre of care

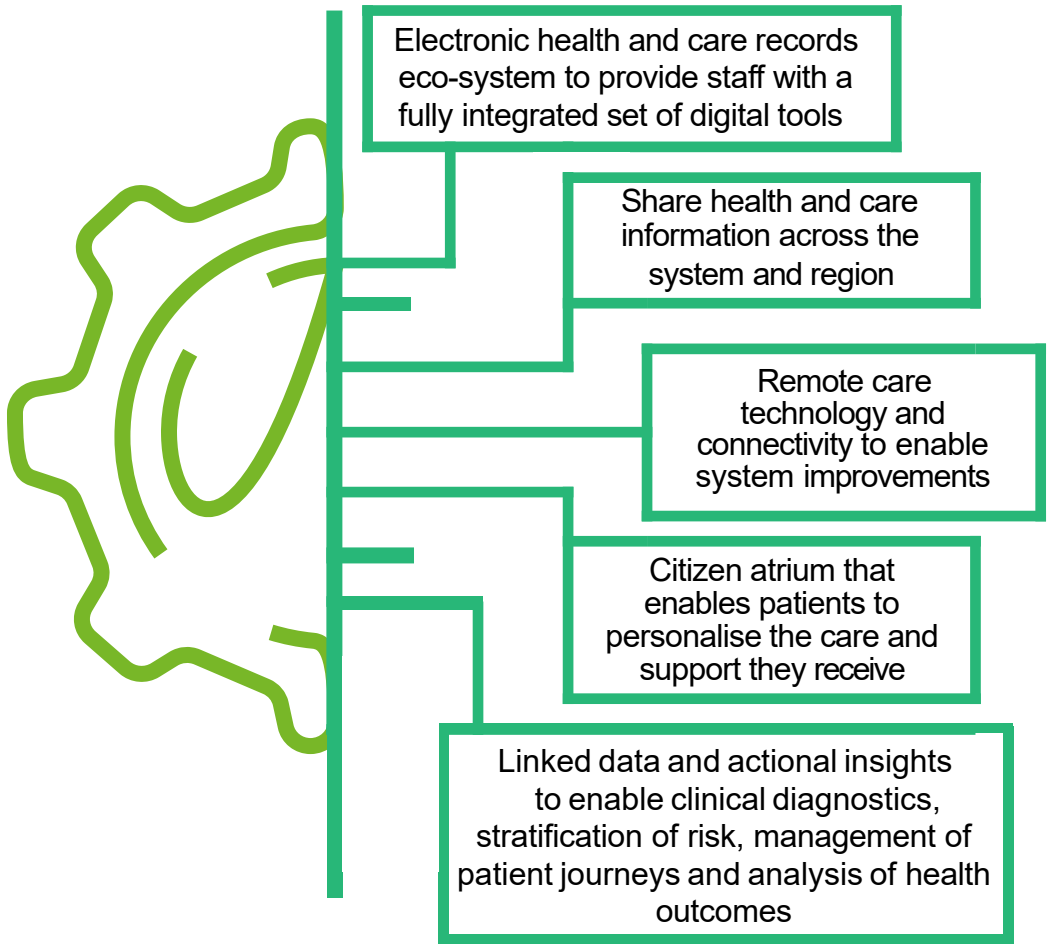
The NHS Long Term Plan commits all NHS bodies to focus on digital transformation by establishing a 'digital front door', enabling patients to be able to engage in 'digital first care'.

The NHS App is one example of this, providing patients with a simple and secure way to access NHS services on their smartphone.

The NHS Planning Guidance requires that at least 25% of all clinically necessary outpatient appointments should be delivered remotely by telephone or video consultation.

Streamlining and digitising administrative functions reduces paper waste and expedites processes. The Government's Greening ICT and Digital Services Strategy 2020-2025 is also taken into consideration when looking at the improvement of our digital care services.

Our DDaT Strategy (Digital, Data and Technology) sets out our five enabling priorities:



The What Good Looks Like framework describes how arrangements across a whole ICS can support success. There are seven success measures: well-led, ensure smart foundations, safe practice, support people, empower citizens, improve care, and healthy populations.

NHS Lincolnshire is well-placed to lead the development of digital care as a tool to promote inclusion and increase access to quality care in the region and is committed to ensuring that digital services are tailored to meet the needs of our different specific care groups.

Across our member organisations, progress has already been made on embedding digital services across the System. LCHS has delivered 17% of all community contacts through digital means following the introduction of more sustainable care models. The Trust has put a keen emphasis on the use of virtual meetings; this includes internal meetings, patient consultations, and even group exercise classes. Virtual wards are also being implemented at LCHS, which negates travel from patients' visitors and reduces hospital energy consumption, as longer term patients are cared for and monitored in their own homes. The Trust is also paper light and employs an Electronic Patient Record (EPR).

ULHT delivered approximately 40% of outpatient appointments remotely in 2020/21, including 6,429 video consultations and 240,145 telephone consultations.

ULHT's patient correspondence is increasingly automated and sent online and the Trust uses a Community Care Portal linking patient information systems with Lincolnshire provider partners to ensure that data is available to authorises persons and used for direct patient care.

Travel and Transport

The NHS Net Zero plan calculates that reaching UK ambitions on emissions reductions in line with Paris Agreement targets could save 38,000 lives with improved air quality: air quality forms a direct link between climate change and health outcomes.

According to the World Health Organisation (WHO), poor air quality leads to over 7 million deaths globally and that 9 out of 10 people worldwide breathe polluted air.

The Figure visualises the Level of PM10 Particulate Matter as sourced from the Consumer Data Research Centre: Access to Healthy Assets and Hazards (AHAH) (exported from SHAPE Atlas).

Travel is a key contributor to air pollution, and with as many as 1 in 20 road journeys in the UK attributable to the NHS, systematic intervention alongside local authority partners has the potential to have an significant impact both on our communities' air quality and therefore health outcomes.

Despite being a rural region, Lincolnshire displays high levels of PM10. This is a commonly used proxy indicator for air pollution, as it affects people's health to a higher degree than any other pollutant.

The system commits to tackle this issue through investment and engagement with staff, patients and our partner local authorities. We will give special consideration to the air quality across Lincolnshire and aim to mitigate the impacts whilst contributing to a reduction in air pollution across the region.

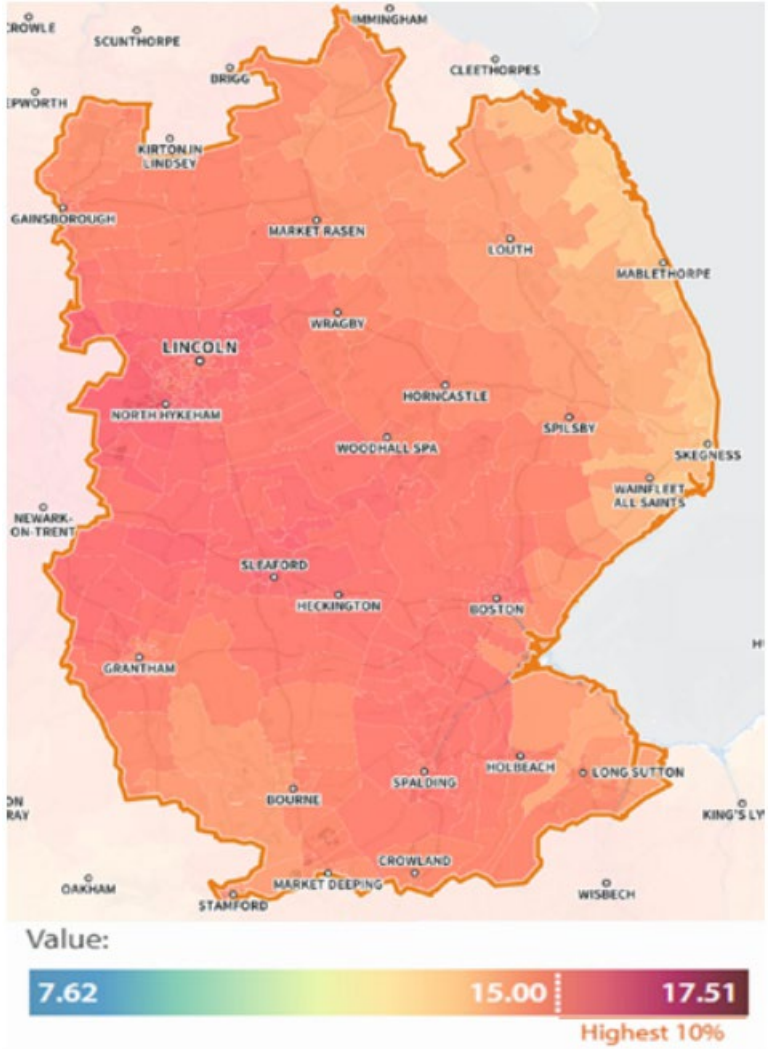


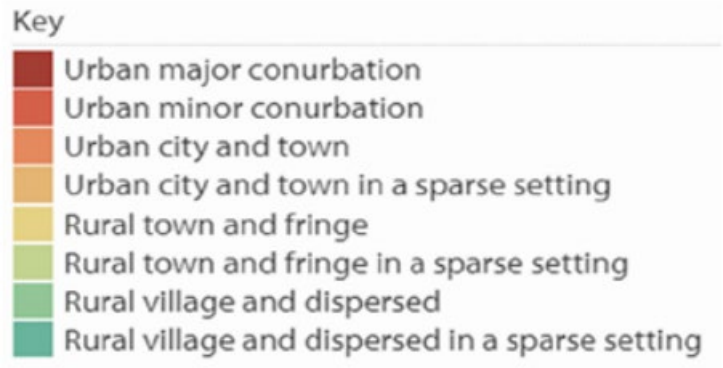
Figure 10: Level of PM10 Particulate Matter as sourced from the Consumer Data Research Centre: Access to Healthy Assets and Hazards (AHAH) (exported from SHAPE Atlas).

Public Transport

Bus and rail travel allow staff, patients and visitors that live far away from our sites to travel in a more sustainable manner. This requires infrastructure, which the System can help to develop through our partnership with Lincolnshire County Council.

Bus infrastructure across the region is disparate. Although our Trusts have formed relationships with Stagecoach, the access to public transport across the region differs based on where you live.

Rail travel is particularly less comprehensive on the east coast. We recognise that the rurality of the county and the lack of a strong public transport network means that there is a greater reliance on car journeys for patients and staff. There are no easy solutions, but we are committed to working with partners on ways to avoid travel, keep care as close to home as possible and to develop transport strategies that support the green agenda across the county.



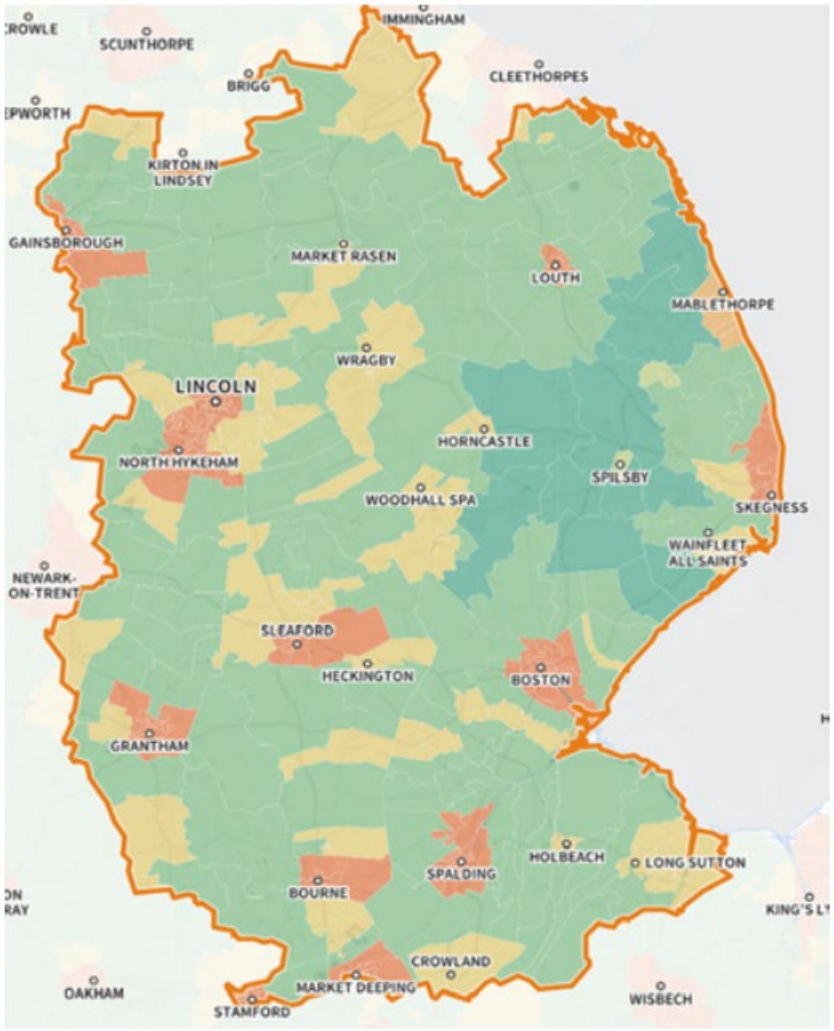


Figure 11: This map visualises the ONS 2011 rural/urban classification (exported from SHAPE Atlas).

Electric Vehicles (EV)

Before making decisions regarding the fleet, NHSEI suggests that Trusts undertake green fleet reviews to identify any petrol/diesel cars that are underutilised and can be removed from the fleet.

Once this has been done, appropriate transitions can be made to Ultra Low Emission Vehicles (ULEVs) and Zero Emission Vehicles (ZEVs).

Charging infrastructure is a potential barrier to encouraging electric vehicle uptake by patients, visitors, and staff. Although LPFT has 24 charging points across give of its sites, Lincolnshire is a rural region. This means that for some members of the population, EV charging access is disparate.

By partnering with Lincolnshire County Council and other partners, we seek to improve the region's charging infrastructure.

Active Travel

Travel on bikes and on foot produces the fewest carbon emissions in addition to being the lowest cost to the user as a method of transport, making active travel a key focus for decarbonisation of travel.

There are some barriers to active travel that can be addressed from a system perspective. Cycle lanes and streetlights are important as they ensure that cyclists feel safe on the roads. The rural nature of Lincolnshire can potentially create an issue, which could be addressed through collaboration with Lincolnshire County Council.

The Department for Transport (DfT) has awarded Lincolnshire £799,900 to provide more opportunities to choose walking and cycling for day-to-day journeys, to boost active travel and reduce traffic congestion.

The council has also developed four additional prospective schemes to take forward as part of an additional second round of DfT funding including low-traffic neighbourhoods and active travel zones. Further engagement with this kind of scheme would help to encourage our staff, patients and visitors to travel actively.

At our sites active travel can be supported using several methods. Cycle-to-work salary sacrifice schemes are an example of this. Their uptake can be encouraged through implementation of lockers and showers, and by offering Dr Bike sessions. LCHS and LPFT already employ salary sacrifice cycle-to-work schemes. Another consideration is making e-bikes available through these schemes, as some staff members may have longer distances to travel than others.

Travel plans

Travel surveys can be used to inform travel planning, as collecting data on cycling, public transport, electric vehicle use and car sharing can give a more accurate picture of travel and transport emissions.

Encouraging staff, patients and visitors to share cars through car sharing schemes could reduce greenhouse gas emissions. At the Trust level, priority parking spaces could be introduced whilst at the System level, the council could be encouraged to explore car sharing lanes.

Councils

Lincolnshire County Council's Local Transport Plan outlined a vision for transport in Lincolnshire that values providing good inter- and intra-regional access whilst maintaining the value of the natural environment in the region's sensitive rural areas. The council also outlined in their Carbon Management Plan that the decarbonisation of transport systems across the region is central to reducing carbon emissions, especially as demand for transport continues to rise across the region.

Carbon Footprint

The pie chart shows the carbon footprint for our member organisations' business travel during 2019/20. It will be necessary to reduce Transport emissions by 1,473 tCO_2e by 2024/25. This will facilitate the system to reach net zero by 2040.

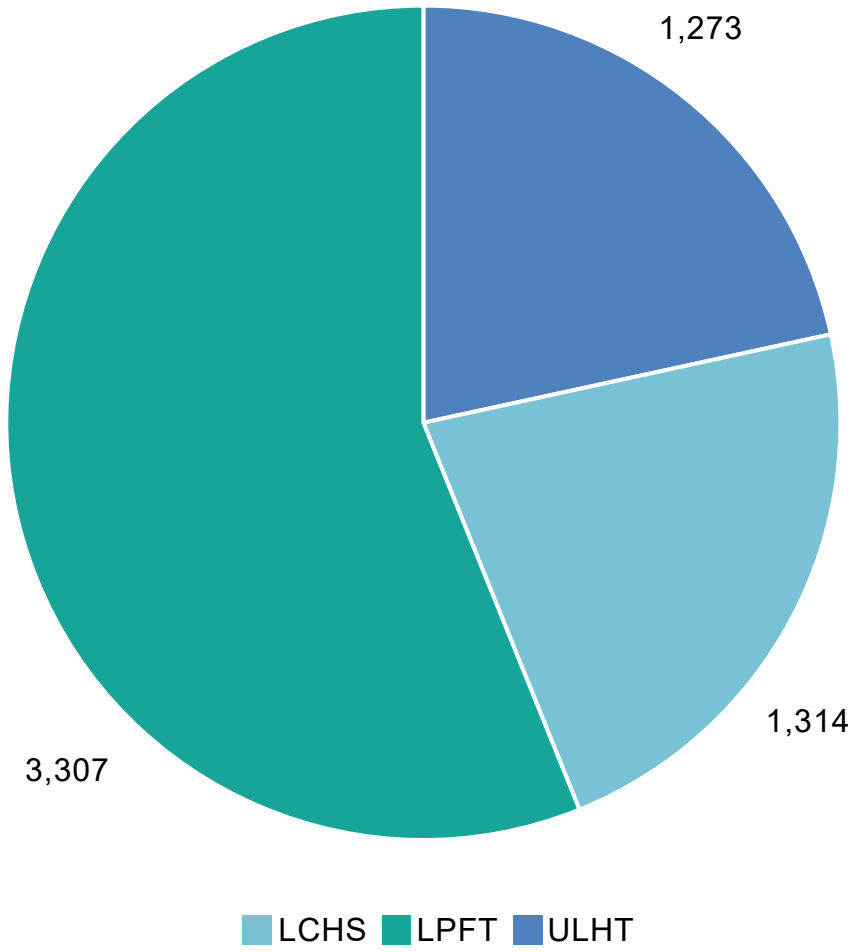


Figure 12: Emissions from business travel for member organisations in tCO_2e in 2019/20, at a time when the CCG was a statutory body.

Estates and Facilities

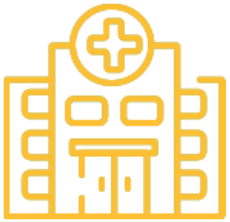
The carbon footprint across the built environment of the system is significant. Overall, the health and care system in England is responsible for an estimated 4% of the country's carbon emissions.

The ICS member organisations provide important services across numerous sites, meaning that our energy and resource consumptions are substantial. Therefore, we need to optimise energy use in our buildings, reduce waste, and move away from using fossil fuels to meet NHS net zero goals.

The estate comprises a mixture of buildings of different types, ages and usage, which presents challenges to retrofitting resource efficiency measures and heating improvements. Within the primary care estate there is a range of ownership models across individual GPs, GP partnerships, private sector, and NHS Property Services.. This presents challenges in the decarbonisation of the estate.

A potential method to reduce the environmental impact of our estate is improving utilisation of space, which can reduce running costs and potentially free up surplus land. One programme aimed at achieving this is One Public Estate (OPE), a collaboration between the Local Government Association (LGA) and the Cabinet Office's Government Property Unit.

OPE is a programme geared towards supporting locallyled partnerships of public sector bodies to collaborate on public service delivery strategies and estate needs.



There are regular Asset Challenge Workshops at a District Level to support the integration of services, opportunities to improve utilisation and estate rationalisation.

Through the Towns Fund we have also created partnerships with other partners to utilise their facilities to deliver care and services.

The NHS is an active partner in the Greater Lincolnshire OPE Board. Successes include the co-location of blue light services in Lincoln and Sleaford alongside the commitment to procure the same desk and meeting room booking software to support multi-agency working. GP staff already work out of District council space in South Holland, and our PCN Alliance has office accommodation within North Kesteven District Council offices.

The NHS in England is facing growing financial and service pressures at a time of rising demand. 'Placed-Based Systems of Care: a way forward for the NHS in England' proposes an approach to tackling these challenges. It argues that NHS organisations need to move away from a 'fortress mentality' whereby they act to secure their own individual interests and future, and instead establish place-based 'systems of care' in which they collaborate with other NHS organisations and services to address the challenges and improve the health of the populations they serve.

This has begun through a shared estates and facilities services partnership arrangement between LPFT and LCHS to deliver efficiencies, build resilience and reduce duplication in the management of our combined estate. This arrangement is now in its second year of full delivery mode. Further estates partnership opportunities with ULHT are now being explored.

We will be following the four-step approach within the NHS' 'Estates 'Net Zero' Carbon Delivery Plan' to address our estate:

1. Making every kWh count: Investing in no-regrets energy saving measures.
2. Preparing buildings for electricity-led heating: Upgrading building fabric.
3. Switching to non-fossil fuel heating: Investing in innovative new energy sources.
4. Increasing on-site renewables: Investing in on-site generation.

The pie chart shows the carbon footprint for our member organisations' building energy during 2019/20. The CCG was the statutory commissioning organisation at that time. It will be necessary to reduce building energy emissions by 7,221 tCO_2e by 2024/25. This will facilitate the system to reach net zero by 2040.

The Greater Lincolnshire Local Enterprise Partnership (LEP) aims to drive economic growth within the region, collaborating with private and public sector leaders. Members of the ICS sit on the Energy Board, representing the perspective of the NHS around clean energy and innovation. If these partnerships can establish the innovations most appropriate for use in Lincolnshire, they can be fed directly into the member organisations within the system to further decarbonise.

One potential energy solution for the decarbonisation of electricity and heat is the use of decentralised energy networks. When Lincolnshire County and District Councils explored heat networks, they established that seven multi-building heat networks already exist. These networks can be expanded, while their use in new developments is to be encouraged within 500m of an existing district heat network, or within 1km of renewable or waste heat source. New buildings across the integrated care system will take these considerations into account. At the Trust level, electrically powered heating systems, heat pumps, and infrared heating can be explored and implemented through a decarbonisation of heat plan.

At present our member organisations are encouraged to procure 100% renewable electricity and at present, all three Trusts have committed to this target. To go a step beyond, the procurement of Green Gas could also be explored and facilitated by the system.

Given the current geopolitical situation and extremely high energy costs, decreasing energy consumption is an immediate priority. This can help to reduce the associated cost of divesting from fossil fuel energy, which can be done through detailed building energy surveys. These can provide robust energy efficiency recommendations at each of our sites, building upon the works already completed.

On-site renewable energy systems such as solar photovoltaics and integrated large battery storage technologies can also be used to decarbonise and provide additional resilience in the event of a power outage.

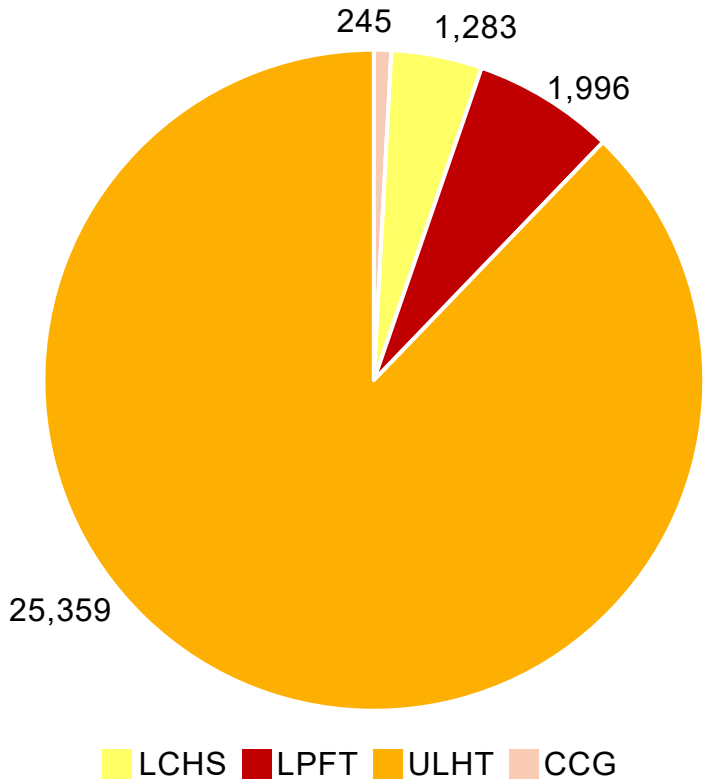


Figure 13: Emissions from our building energy for member organisations in tCO_2e in 2019/20, at a time when the CCG was a statutory body.

Capital Projects

The Built Environment of the NHS influences both the quality of our care and our environmental impact.

How we design and construct our buildings in the future will play a decisive role in our collective ability to achieve net zero. Buildings have significant environmental impacts in terms of emissions resulting from the use of gas, electricity and water. Improving the energy efficiency of a building is pivotal to reducing these impacts, as detailed in the previous section.

However, there are embodied carbon emissions within materials, such as cements, steel and glass which are used in the construction of buildings. These indirect 'Scope 3' emissions are generally much greater than emissions caused by the operation of a building. We can explore how these embodied emissions can be reduced alongside the County Council and other partners. Through our work with the Local Enterprise Partnership, Colleges and Team Lincolnshire we support the development of local businesses, skills and supply chains.

Cement and concrete production on its own accounts for a huge 8% of all global greenhouse gas emissions from all sources, according to the Dutch Environmental Assessment Agency.

The system's plans will focus on the reduction of building emissions from all sources, including Building Research Establishment Environmental Assessment Method's (BREEAM) 'Excellent' or above standards.

Water

Although it is a small percentage of emissions, saving water is important when reaching net zero and aligning with SDGs. Global warming is likely to put increasing pressure on clean water supplies, so sustainable water use will be an important way for the NHS to adapt to climate change.

As a water efficiency and leak preventative measure, we will look to facilitate the installation of Automatic Meter Readers (AMRs) to water networks across the primary and secondary estate.

This will help our member organisations to pinpoint areas of high water usage, understand how and where water is being used, locate leaks and take remedial action.

Water conservation and sustainable drainage shall also be explored. Rainwater harvesters collect rainwater for non-potable purposes, such as for flushing toilets. They will help reduce water stress and potentially alleviate flooding by attenuating surface water run-off in storm events.

Waste

For larger Trusts such as ULHT, a high waste output can contribute significantly to their total carbon footprint.

The most effective way of reducing waste emissions is by following the waste hierarchy: Reduce, Reuse, Recycle and Recovery.

- Reduce: Avoid disposal of items by reusing and redistributing products.
- Reuse: Reclaim medical equipment after use by patients.
- Recycle: Increase recycling rates through staff awareness campaigns and by implementing more dry mixed recycling bins.
- Recovery: Recover energy from waste by converting it to Refuse Derived Fuel (RDF).

These principles must be embedded across the ICS including across primary and secondary care. The ICS as an anchor institution and partner, also strives to ensure that we facilitate the move to a circular economy, continuously reducing waste and increasing what we can reuse.

Water and waste

The pie chart shows the carbon footprint for our member organisations' water and waste during 2019/20. It will be necessary to reduce building energy emissions by 83 tCO_2e by 2024/25. This will facilitate the system in reaching net zero by 2040.

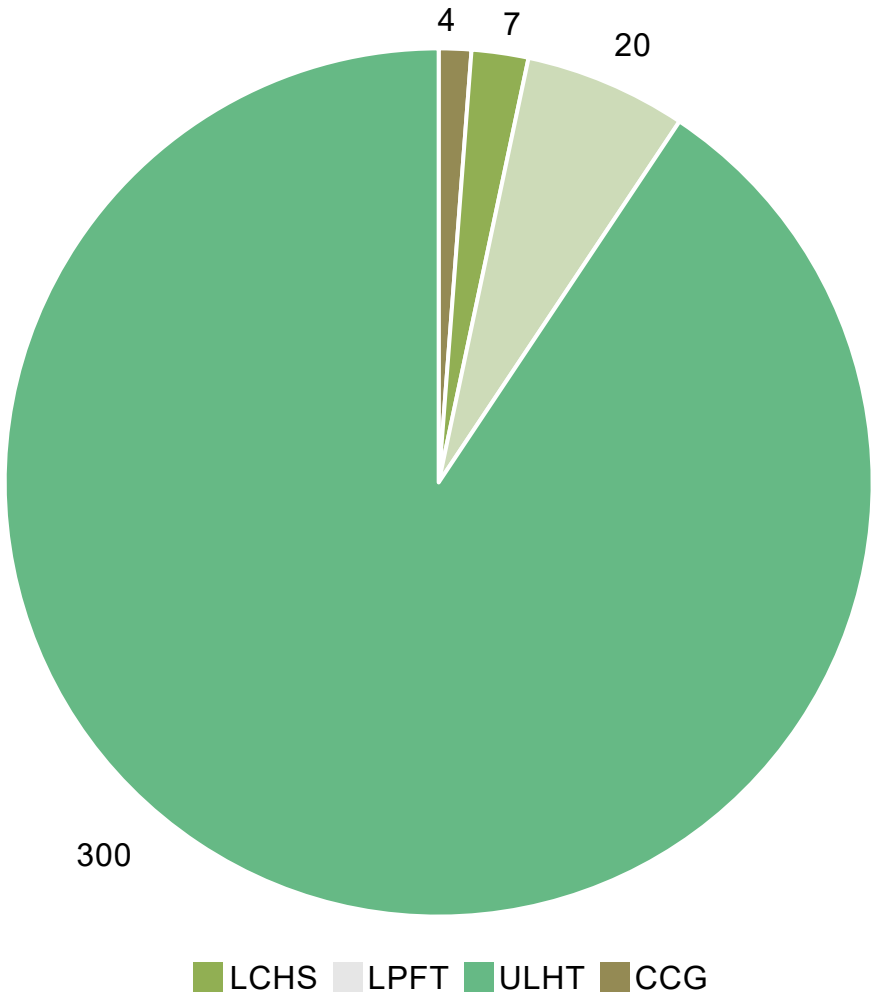


Figure 14: Emissions from our water and waste for member organisations in tCO_2e in 2019/20, at a time when the CCG was a statutory body.

Green Space and Biodiversity

"Access to greenspaces have positive mental and physical health impacts, and these beneficial effects are greatest for those from socioeconomically disadvantaged groups. However, these groups also have the least access to greenspaces." *– Delivering a Net Zero NHS*

Access to greenspace at a regional level has been linked to good mental health and wellbeing for our communities, whilst the plants in our greenspaces absorb carbon dioxide from the atmosphere.

Lincolnshire ICS will consider opportunities and risks for biodiversity in the areas we operate, such as our priority habitats: lowland mixed deciduous woodland, traditional orchards, wet woodland, and wood-pasture and parkland.

At the Trust level, biodiversity is encouraged through projects such as NHS Forest. This can be utilised by Trusts to improve the greenspace across our estates. Across the system we have implemented a recognition programme to say thank you to our colleagues for their commitment, endurance, and skill during the coronavirus pandemic. Working alongside the Woodland Trust, we have offered each NHS member of staff to plant a commemorative tree as part of the NHS Woodland Lincolnshire programme.

With respect to our stakeholders, The University of Lincoln has introduced a hedgehog friendly campus to help protect this species and maintain biodiversity. The Greater Lincolnshire Nature Partnership have set an ambitious objective to ensure that there will be no net loss of priority or other semi-natural habitat by 2025.

Medicines

The Long Term Plan commits the NHS to reduce GHG emissions from anaesthetic gases by 40% (which on its own could represent 2% of the overall NHS England carbon footprint reduction target that the NHS must meet under Climate Change Act commitments) and significantly reduce GHG emissions by switching to lower global warming potential (GWP) inhalers. We will support our member organisations in achieving these commitments across the system. Prescriptions written by GPs and filled by community pharmacies mean that primary care will be instrumental in decarbonising medicines.

Across medicines there will be a move away from polypharmacy, towards self-care to prevent medicines waste. This includes patients taking responsibility for ordering their own medication. It is important that our regional communications on this topic aligns with the rest of the NHS.

Nitrous oxide

There are innovations in capturing and catabolising exhaled nitrous oxide, including 'cracking' devices. Such devices are being trialled by other NHS trusts, and if rolled out, will dramatically reduce the amount leaking into the atmosphere.

Furthermore, nitrous oxide use is steadily falling in surgery, as more efficacious anaesthetic and analgesic agents are superseding its use. However, Entonox™ still plays an important role in maternity.

Methoxyflurane (Penthrox™) pen-inhalers can be used instead of nitrous oxide to treat moderate to severe pain associated with trauma. Methoxyflurane can be self-administered under medical supervision, in a similar fashion to nitrous oxide. It has a lower global warming potential (GWP) than nitrous oxide and switching to methoxyflurane would lessen emissions at point-of-use.

However, this comes at a cost, as methoxyflurane is delivered in non-reusable 3ml inhaler pens, creating additional non-recyclable waste.

Desflurane

Desflurane is a fluorinated volatile anaesthetic. Like many fluorinated compounds (such as refrigerants and propellants), it has a very high GWP. Desflurane has a GWP rating of 2,540, meaning it's 2,540 times more potent as a greenhouse gas than carbon dioxide.

Other volatile anaesthetics, such as sevoflurane and isoflurane have far lower GWP ratings, 130 and 510 respectively. Shifting away from desflurane to these alternatives will significantly reduce emissions. However, both sevo- and isoflurane use will have an impact on the atmosphere.

The NHS Standard Contract and engagement efforts with clinicians have targeted a reduction of desflurane as a percentage of all volatile gas use by volume, from 20% in 2020/21 to 10% in 2021/22. In line with Delivering a 'Net Zero' National Health Service, in 2022/23 the contract target for desflurane use has now reduced to 5% or less. across all NHS providers.

Inhalers

Inhalers help to open the airways and allow more air to move in and out of the lungs, helping people to breathe during asthma attacks. Asthma and other breathing-related health issues can often be attributed to air pollution, which this plan is seeking to reduce. In reducing greenhouse gas emissions, inhaler prescriptions may fall leading to a cycle of greenhouse gas emission reduction.

The NHS Standard Contract stipulates that 30% of all inhalers prescribed across NHS England should be Dry Powder Inhalers (DPIs), potentially saving 374 $ktCO_2e$ per year, according to the NHS Net Zero report.

New Impact and Investment Fund (IIF) indicators have been released, which provide an additional steer on prescribing lower-carbon inhalers. Dry-powder inhalers are an appropriate choice for many patients and contain as little as 4% of the GHGs emissions per dose compared with metred-dose inhalers (MDIs). Fluorinated gases in MDIs mean that each 10ml to 19ml inhaler cannister has the equivalent emissions of 30 to 80kg of carbon dioxide! ULHT and LCHS prescribe inhalers, whereas LPFT only continues to fill existing inhaler prescriptions, and thus have no direct control over the inhalers that the Trust prescribes.

We will need to work with PCNs and the Local Pharmaceutical Committees (LPCs) to reduce inhaler emissions across the system, including the use of inhaler return schemes. When inhalers decompose in landfill, the potent greenhouse gases in the canisters are released into the atmosphere. If all inhalers in the UK were returned for safe disposal, the NHS could save around 512,330 tCO_2e!

Supply Chain and Procurement

The NHS is a major purchaser of goods and services, with NHS England alone procuring around £30 billion of goods and services annually. Procurement has major potential social, economic, and environmental impacts both locally and globally.

This includes the use of local suppliers, the climate performance of our equipment and estate, and preventing modern slavery in supply chains. An ICS has a pivotal role in developing sustainable procurement practices within the System and its partner organisations.

Within the ICS, most items and services are procured through centralised NHS/government frameworks, such as the NHS Supply Chain. These centralised frameworks already provide best value through bulk purchasing power and consolidation of orders. LCHS and ULHT are pre-existing procurement partners, with a joint procurement strategy to reach net zero in their supply chains.

However, there is latitude to join forces with other public bodies and partner organisations across the Systemto increase buying power; achieving better economies of scale and influence over the environmental and social aspects of specialist and local products and services procured via the tendering process.

We are committed to engaging with our suppliers to meet Green Plan targets and support the sustainable procurement objectives of NHS England wherever practicable. We can support partner organisations enhance their own sustainable procurement practices and potentially create an System-wide sustainable procurement strategy that all partner

agencies can use.

The NHS, in line with recent government requirements, is mandated to adopt new social value and environmental standards now and in the future. The Evergreen Sustainable Supplier Framework was launched in January 2022, and from April 2022, all NHS tenders will include a minimum 10% net zero and social value weighting (as per Policy Procurement Note 06/20).

From April 2023, contracts above £5 million will require suppliers to publish a carbon reduction plan for their direct emissions as a qualifying criterion (as per Policy Procurement Note 06/21).

By 2030, all suppliers will be required to demonstrate progress in line with the NHS' net zero targets, through published progress reports and continued carbon emissions reporting.

These additional requirements will enable us to determine the carbon and social impact of the products and services we buy more accurately, and ensure suppliers are reducing the emissions associated with their operations and products.

In the interim, we will explore ways to reduce single-use plastic items and research how we can incorporate reusable items such as masks and aprons into our clinical practice. These products are currently purchased through the NHS Supply Chain, which holds the ambition to reduce plastics across the value chain. This will help us to facilitate the move away from a linear economy to a circular economy.

Product retainment and lifecycle extension

Ensuring best value for money and robust social and environmental benefits in our procurement processes will remain a core principle for the wider NHS and across the system.

Product lifecycle analysis will ensure products are kept in service for as long as possible, and maintenance and repairability, fundamental to a circular economy, drives down waste and may have economic benefits in the medium to long term.

NHS Trusts already maintain medical equipment in good working order, as per the manufacturer's and the Medical and Healthcare Products Regulatory Agency's (MHRA) guidance. Only when an item is no longer supported by the manufacturer, or is beyond economic repair, are items considered for disposal.

However, items such as mobility aids (walking frames, crutches and walking sticks), given to outpatients often are never returned to the issuing authority. This has a financial impact, as new items are continually procured to make up the loss, but also environmental impacts – the resources being used in the manufacture of equipment and the incorrect disposal of 'waste' mobility aids by the public.

Mobility aids are robust pieces of kit, with long service lives. Reclaiming, cleaning/refurbishing and reissuing mobility aids would negate useful items being scrapped. Furthermore, a pool of serviceable mobility aids could be used by partner organisations, with additional cost saving and social benefits for communities where care is delivered. LCHS is one of our Trusts that has begun to explore the re-use of walking aids at one of their sites, which they are looking to scale up further.

NHS England Sustainable Procurement Objectives		
Net Zero	**Modern Slavery**	**Social Value**
Achieve the NHS Supply Chain Net Zero Targets	Eliminate Modern Slavery in the NHS supply chain both domestically and abroad	Ensure NHS procurement is a force for good helping local economies and improves wider determinants of health

Table 12: Official NHS Sustainable Procurement Objectives Source: NHS website

Food and Nutrition

The NHS Long Term Plan commits us to promoting plant-forward diets and reducing unhealthy options like sugary drinks on NHS premises. Not only will these actions help prevent obesity and non-communicable disease, but they will also play a role in reducing our greenhouse gas emissions and environmental impact.

Food production accounts for up to 26% of global greenhouse gas emissions[1]. While promoting healthier foods and reducing emissions, the NHS can also source more food from local and regional producers where possible, increasing the positive economic impact for our communities and reducing the emissions associated with food transport.

We will work to fulfil Long Term Plan priorities for food provision on our premises, promoting plant-forward diets, higher welfare and more sustainable food options, and supporting regional producers wherever we can.

At the Trust level, LCHS and LPFT provide salads and sandwiches made and procured locally from the kitchen at ULHT. Both Trusts also have patient surveys for meals to ensure satisfaction and reduce waste and increased their menu choices to accommodate more vegetarian options. At LPFT, a Trust dietitian is producing menus to promote and support healthier eating across units to allow patients to cook for themselves using locally-sourced ingredients.

The Lincoln Food Partnership promotes fairer, greener and healthier food for all by reducing food miles, food citizenship, tackling food poverty, reducing food waste and its ecological footprint, and helping to implement community food growing. Any of the lessons learned from this partnership could be implemented across the system.

Climate Adaptation

"As climate change accelerates globally, in England we are seeing direct and immediate consequences of heat waves and extreme weather on our patients, the public and the NHS. Adaptation is the process of adjusting our systems and infrastructure to continue to operate effectively while the climate changes. It is critical that the NHS can ensure both continuity of essential services, and a safe environment for patients and staff in even the most challenging times."

- Greener NHS

Climate-related hazards that have been identified as posing a distinct threat to our region include sea level rise, an increase in seasonal extremes and rising temperatures.

The low-lying nature of Lincolnshire will contribute to exacerbating the effects of climatic change. This makes the region susceptible to increased storm activity and rising sea levels. Flooding can cause damage to the estate; therefore, it is vital that developments across our ICS are resilient in nature. To improve resilience across the region, it is imperative to integrate mitigation and adaptation climate policies, create a risk management process, and ensure that developments are aligned to latest climate projections.

As for the actions within Lincolnshire that have already been taken, over £200,000 has been secured by Lincolnshire County Council, Lincolnshire Chalk Streams Trust and the Lincolnshire Chalk Streams Project from the Government's Green Recovery Challenge Fund. This fund will enable the Lincolnshire Chalk Streams Team to install nature-based solutions in the River Rase catchment to allow the chalk stream to adapt to climate change. This 18-month project will enable the team

to install natural flood management schemes over 24.3 kilometres, including field bunds, leaky barriers, scrapes, ponds, re-profiling and two or more habitat enhancements, such as improving cattle drinking areas to reduce erosion of the banks.

The changing climate poses risks for vulnerable populations in our community, but also impacts the Trusts' estate, their ability to operate and the supply chain.

> Climate change has serious implications for our health, wellbeing, livelihoods and society. Its direct effects result from rising temperatures and changes in the frequency and strength of storms, floods, droughts, and heatwaves — with physical and mental health consequences (The Lancet, 2017).

The NHS Long Term Plan reinforces the requirement to embed resilience and sustainability into our healthcare services. Climate change adaptation is critical to achieving this. The impacts of climate change on our health, services, infrastructure and our ability to cope with extreme weather events will place significant additional demands on our services in the future.

Climate change adaptation in the NHS is about organisational resilience and the prevention of avoidable illness, embracing every opportunity to create a sustainable, healthy and resilient healthcare service. Reducing our impact on the environment may not only help to mitigate against climate change, but reduce our organisational running costs, ensure business continuity, and reduce health inequalities. Above all, it's about ensuring that the NHS, our buildings, our services, our staff and our patients are prepared for what lies ahead.

The ICS will analyse climate change risks and develop actions for our care delivery, estate planning and management, including flood risks across our estate and service area. The Local Climate Impacts Profile (LCIP) for Lincolnshire aimed to increase the council's understanding of the county's vulnerability to severe weather events.

The Green Masterplan as produced by Lincolnshire County Council set an objective to develop an Adaptation Strategy, which has been echoed by our ICS. The ICS and its partner organisations will develop a climate change adaptation plan to mitigate the consequences to health and service delivery of climate change.

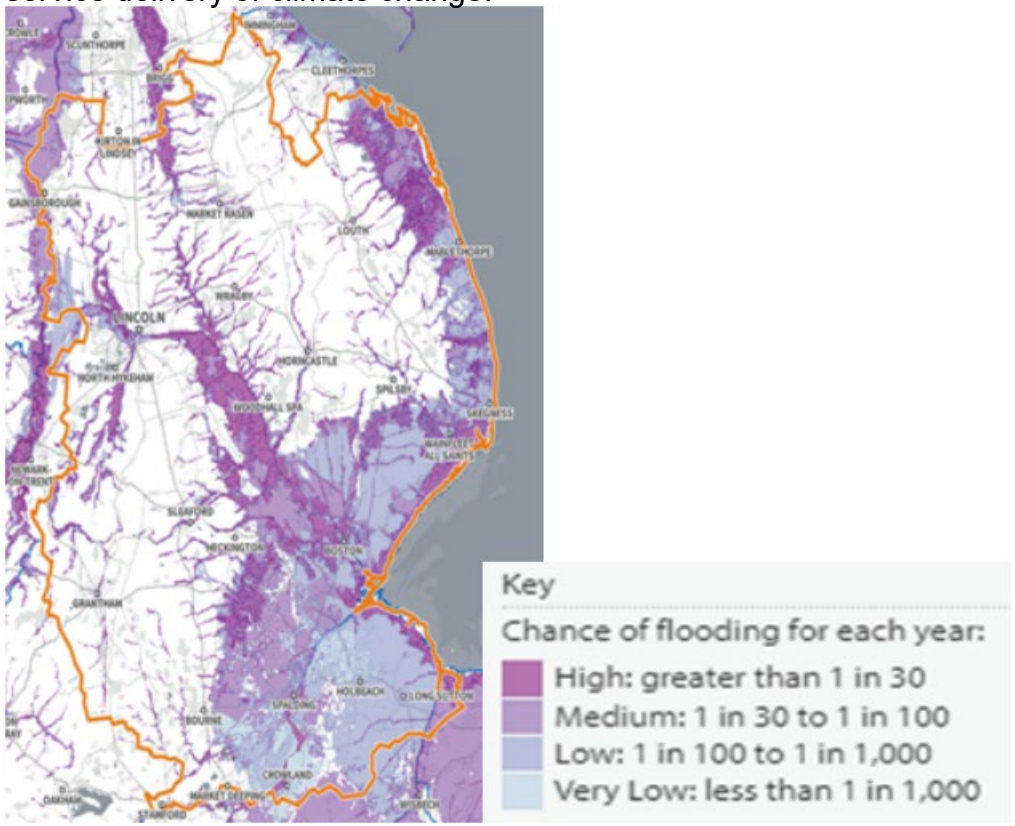
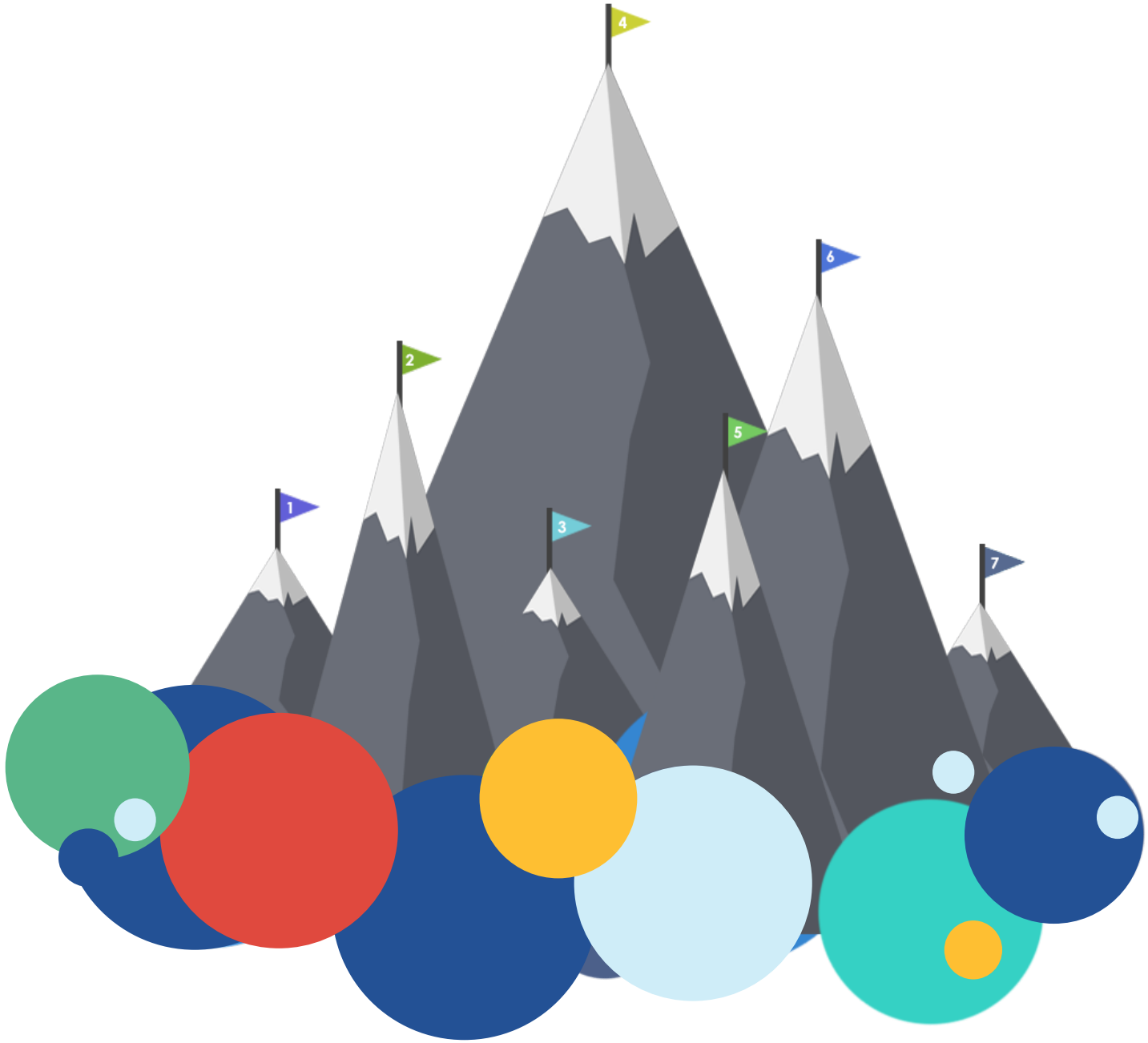


Figure 15: Map displaying the risk of flooding across Lincolnshire.

Challenges

1. Rurality
2. Digital Literacy
3. Workforce Retention
4. Access to Funding
5. Access to EV Charging
6. Deprivation
7. Access to Public Transport



In each of the areas of focus, there are barriers to achieving net zero, as shown in the Mountain Graphic above. The system will need to address these challenges and navigate the barriers that may stand in the way of fulfilling the targets set out in this Plan.

Many of these challenges are social barriers. Workforce retention is a national issue, and one that the NHS needs to address to maintain the quality of healthcare provided. This is a wider issue across Lincolnshire being dealt with through the People Board and through partnership working with local authorities, guided by the NHS at a national level.

Digital literacy was highlighted as a barrier to progressing the digital transformation of our services. Improving our digital infrastructure can only be practical if our patients continue to have equal access to care. Digital education is therefore vital in our efforts to continue to evolve our services, while maintaining standards of patient care.

Access to transport is another key challenge to overcome. EV charging availability is in part determined by local authority engagement and public demand. The same is true for accessibility to public transport, which is primarily facilitated by local governing bodies. Therefore, at a system level, collaboration with partners and local authorities will be needed to facilitate better, sustainable transport links across Lincolnshire. The rurality of the region is added barrier and means that much of the improvements to transport will need to focus on providing safe and efficient transport links to areas of lower population density.

Funding is an ongoing barrier to progress in reaching net zero, as many of the actions suggested within this plan will have a significant upfront cost. Retrofitting buildings and procuring reusable PPE for example, can add more monetary pressure on systems that already struggle to stretch budgets. These pressures can be alleviated by accessing government funding. An example of this is the installation of charging infrastructure through the On-street Residential ChargePoint Scheme, which is available to local authorities.

Socioeconomic factors underpin every one of these potential barriers. It is therefore vital to address the high levels of social deprivation in certain areas of Lincolnshire, and the impact this has on access to healthcare, providing safe transport, improving education, boosting employment, and securing project funding.

Social Sustainability Promotion

Equality, Diversity and Inclusion

NHS Lincolnshire has a commitment to design and implement policies, procedures and commissioning services that meet the diverse needs of our local population and workforce, ensuring that none are placed at a disadvantage.

The urgency to address health inequalities has never been greater, and our county faces unique challenges as we seek to ensure that our services reach every person in Lincolnshire, especially those most vulnerable.

Levels of health vary significantly across Lincolnshire, with stark differences between county areas as well as different groups within our diverse communities. As a rural county with poor public transport links, our local communities must also often rely on cars to attend appointments and access services.

Infrastructure matters such as internet and phone connection issues and low levels of digital literacy must also be recognised when assessing accessibility of digitalisation, such as phone and online appointments, so that these means seeking to increase accessibility do not unintentionally create further inequality.

Our system will address this challenge with a variety of collaborative work with our partner organisations. The Lincolnshire Health and Wellbeing Board brings together key people from the health and care system, with the aim to reduce health inequalities and improve health and wellbeing across the county. The Joint Working Executive (JWEG) set out a comprehensive review of the health inequalities in Lincolnshire in the Health Inequalities Programme.

Our Equality, Inclusion and Human Rights Objectives are reflective of those set by the CCG, which has since been absorbed into the NHS Lincolnshire ICB:

1. Workforce data and staff support

- Enhance the data quality held on staff via ESR, through an updated data-cleansed system to improve data recording and monitoring.
- WRES/WDES delivery of annual submissions to NHSE and implementation of action plans.
- GPG reporting – dependent on the workforce numbers (threshold 250 staff), the ICB will need to consider submitting gender pay gap data and so be responding to this data with an action plan.
- Introduce staff networks to support the development of different protected characteristics.

2. Visible leaders to champion EDHR

- Leaders to be at the forefront of improving engagement with vulnerable groups/populations with regards to service change.
- Managers to be more involved in implementing EDHR actions/initiatives as part of their roles and responsibilities.
- Support providers to address barriers to accessing services to by patients.

3. EDHR training

- Assess current EDHR training provision and staff professional development.
- Improve the contents and uptake of EDHR mandatory training for all staff.
- Introduce more face-to-face EIHR related training to support the work of staff from leaders to front line staff.

4. Standards and Charter Marks

- EDS version 3 – All future work will be done in line with the new framework which will be released in 2020 by NHS England and piloted over the year
- Disability Confident – to obtain Leader Status by 2022
- Identify other relevant EDHR Charter Marks and assess/update new policies and practices towards achieving these.

5. Equality Objective for Lincolnshire CCG to support BAME staff and communities in response to national reports.

- Objective: Implement actions to assess the disproportionate impact of Covid 19 on BAME staff and communities in line with the associated health inequalities issues raised in the PHE disparities report.

Social Sustainability

Social value quantifies the net value that our system can provide to society, including through employment, economic growth, communities, innovation and the environment. The last is of focus within this plan, although all five of these themes are considered.

The NHS is mandated to consider the economic, social and environmental wellbeing in procurement of services contracts per the Social Value Act (2013).

Creating social value can reduce health inequalities through action on the social determinants of health, for example through the improvement of employment and housing. In this Green Plan, we have considered how the planned actions will contribute towards the sustainability of a geographical area in addition to the project's direct benefit to the community and benefits to individuals.

Actions that result in the employment of local residents or target groups such as young unemployed people and requiring contractors to pay a living wage and minimising negative environmental impact can be found in the Workforce and Systems Leadership section. Building local supply chains and procuring with the voluntary, community and social enterprise (VCSE) sector are found in the Supply Chain and Procurement section.

We will also strive to roll out services first in the most disadvantaged areas to allow them more time to benefit from new services, whilst ensuring that there are additional efforts to assure equality of access to services for those living furthest from service provision. Embedding social value across the whole commissioning cycle and future procurements will allow it to become a golden thread throughout procurement activity.

Social Value

Social Value can be defined as the quantification of the relative importance that people place on the changes they experience in their lives.

Activities to deliver these changes can be categorised into economic, social and environmental benefits. Some examples are shown below.

Social	Economic	Environmental
upskilling	local recruitment	carbon reduction
training	employment	environmental sustainability practices
volunteering	apprenticeships	green space development
community engagement and support	local investment	waste reduction
	sponsorship	
	charitable donations	

With more than 60% of the NHS carbon footprint based within the NHS supply chain of over 80,000 suppliers, we need the support of every supplier if we are to reach net zero by 2045.

Supporting the NHS in reducing harmful carbon emissions offers suppliers the opportunity to play a part in improving health now and for future generations. Going forward the system will follow the NHS roadmap to help suppliers align with our net zero ambition between now and 2030. This approach builds on UK Government procurement policy (PPN 06/21).

Net Zero Supplier Roadmap

From April 2023

The NHS will adopt the Government's 'Taking Account of Carbon Reduction Plans' (PPN 06/21), requiring all suppliers with new contracts for goods, services, and/or works with an anticipated contract value above £5 million per annum, to publish a carbon reduction plan for their direct emissions.

From April 2024

The NHS will expand this requirement for all new contracts, irrespective of value.

From April 2027

All suppliers with contracts for goods, services, and/or works for any value, will be expected to publish a carbon reduction plan that takes into account the suppliers' direct and indirect emissions.

From April 2028

New requirements will be introduced overseeing the provision of carbon foot-printing for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.

From April 2030

Suppliers will only be able to qualify for NHS contracts if they can demonstrate their progress through published progress reports and continued carbon emissions reporting through the supplier framework.

Conclusion

The system Green Plan was composed to ensure a collaborative approach to health and sustainability would be taken across Lincolnshire. Some of our member organisations already work in partnership, such as the Joint Procurement Strategy between ULHT and LCHS, and the Estates partnership between ULHT and LPFT.

By facilitating this collaboration using our partner organisation connections we can achieve a more unified system, where learning can be shared when Trusts are making strides. Examples of this include the analysis of procurement emissions in ULHT's plan and working in partnership with health and social care services at LCHS.

Throughout this plan it has been established that there are some regional barriers to achieving NHS net zero. Each ICS has its challenges, and for Lincolnshire our rural location, health inequalities and social deprivation along the coast, and struggles with workforce retention will make delivering the plan more difficult. However, we can collaborate with our stakeholders to overcome these challenges as they are bodies that also want to deliver more sustainable practice. This includes Lincolnshire County Council, which has committed to a net zero target of 2050.

Lincolnshire ICB takes full ownership of this plan and commits to its targets. Each aspect of the health service has its role to play in the NHS net zero, and we can ease this journey by working together. By becoming a more sustainable ICS, we can help improve health outcomes across Lincolnshire through the impacts of our successes as we work through this plan target by target. Together we can become a greener, and healthier, NHS.

Glossary

Anchor institution
This refers to large, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchor institutions, who are rooted in their local communities, can positively contribute to their local area in many ways such as: widening access to quality work for local people; buying more from local businesses; reducing our environmental impact; using buildings and spaces to support communities; working more closely with local partners.

Clinical commissioning group
Clinically-led statutory NHS bodies responsible for the planning and commissioning of health services for their local area.

CO_2e
Refers to carbon dioxide equivalent emissions. The conversion of greenhouse gases into a singular 'currency' allows comparison of various greenhouse gases on the basis of their global warming potential.

Commissioning
The process of assessing need, planning, agreeing and monitoring services.

Equality, diversity and inclusion (EDI)
Refers to ensuring that our work and policies recognise diversity and allow fair treatment to all, creating equal opportunities for our colleagues and reflecting our diverse communities.

Greenhouse gas (GHG)
A group of gases that contribute to global warming. There are seven greenhouse gases:

Non-fluorinated gases:
Carbon dioxide (CO2)
Methane (CH4)
Nitrous oxide (N2O)

Fluorinated gases:
Hydrofluorocarbons (HFCs)
Perfluorocarbons (PFCs)
Sulphur hexafluoride (SF6)
Nitrogen trifluoride (NF3)

Health inequalities
The unfair and unacceptable differences in people's health that arise because of where we are born, grow, live, work and age.

Integrated Care Board
The most recent national guidance states that this is the new NHS organisation that will be established on 1 April 2022, subject to legislation. We expect this is likely to be known publicly as "NHS Lincolnshire", but this is subject to the legislation being agreed through Parliamentary processes.

Integrated Care System (ICS)
Refers to the health and care system across Lincolnshire. There are 42 ICSs across the country. Within each ICS there is an Integrated Care Partnership and an Integrated Care Board.

Integrated Care Partnership
The broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. This term has now started to be used in the most recent national guidance. However, this is different to how we have used this term previously. It was previously used to describe our five place-based partnerships.

Modern methods of construction (MMC)
The design, planning, manufacture and pre-assembly of construction elements or components in a factory environment, prior to installation on site at their intended, final location.

Model of care
This broadly defines the way health and care services are organised and delivered.

Neighbourhoods
Based on local populations of between 30,000 and 50,000. Neighbourhoods, in some instances, may align with Primary Care Networks.

Net Zero
Negation of the amount of greenhouse gases produced by an organisation, achieved by reducing emissions and implementing methods of absorbing carbon dioxide from the atmosphere.

Off-setting
The action or process of compensating for carbon dioxide emissions arising from industrial or other human activity, by participating in schemes designed to make equivalent reductions of carbon dioxide in the atmosphere.

Place
A defined population that partners convene around to improve health outcomes across a population. This concept signifies the move away from operation as individual organisations.

Place based commissioning
Commissioners organising themselves so that they collaborate together to address the challenges and improve the health of any defined population.

Place-based partnerships
Planners and providers working together across health, local authority and the wider community, to take collective responsibility for improving the health and wellbeing of residents within a place, with a population of up to 500,000.

Primary care
Primary care is the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners) but community pharmacists, opticians, dentists and other community services are also primary healthcare providers.

Primary Care Networks (PCNs)
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices. PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home. Find out more on PCNs on the NHS England website.

Provider Collaborative

Service providers will be collaborating at the various different levels of system, place and neighbourhood according to need. National guidance, Working together at scale: Guidance on Provider Collaboratives has been published and a Provider Collaborative Board (PCB) has been established to enable partnership working of the acute, mental health and community providers across Lincolnshire. The organisations that are involved as part of the collaborative are:

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

Social value

This is about how we secure wider social, economic and environmental benefits for our population in addition to providing health and care. As anchor institutions we want to make the greatest positive impact possible on the lives of our communities to improve health and wellbeing and reduce health inequalities.

Wider determinants of health

The diverse range of social, economic and environmental factors which influence people's mental and physical health. These include employment, housing, crime, education, air quality, access to green spaces and access to health and care services, among other things.

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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22nd November 2022
Location: Bridge House, Sleaford

Agenda Number:	8.
Title of Report:	System QPEC (Quality and Patient Experience) Committee Update
Author:	Professor Van-Tam, Chair Martin Fahy, Director of Nursing Sarah Bates, Deputy Board Secretary
Appendices:	Quality and Patient Experience Committee Terms of Reference

1. Key Points for Discussion:

This paper provides an update on the discussions that took place at the first System Quality and Patient Experience Committee meeting held on 13th October 2022.

2. Recommendations

The Board is asked to note the update.

3. Executive Summary

The System Quality and Patient Experience Committee focused on the following agenda items:

- **Minutes of the Previous Shadow ICS Committee Meeting dated 14th June 2022 and the Minutes of the Extraordinary NHSL CCG Quality and Patient Experience Committee dated 7th June 2022:** were received and approved. It was noted that the outstanding actions had been transferred to the ICB via the Committee Handover template.
- **NHSL CCG Quality and Experience Board Committee Handover:** a detailed update was provided on the transfer of the CCG Quality and Patient Experience legacy issues to the ICB. Areas that were discussed included: Urgent and Emergency Care, Cancer, Elective Care, Mortality, Maternity Services and Ockendon, Never Events and Serious Untoward Incidents, Infection, Prevention and Control measures, Lakeside Medical Practice, Safeguarding and the Covid Vaccination programme. It was noted that there are recovery plans and working groups in place to address the challenges.
- **Update from the System Quality Group:** an update was provided in relation to the System Quality Group which includes all main partners and providers who meet on a bi-monthly basis. It was noted that the Group receives thematic reviews and that a recent update had been provided on Cancer and Planned Care in order to fully understand the quality challenges in these areas. Particular focus was given to the harm review processes for patients with lengthy delays to treatment ensuring that robust review processes are in place. A review had also been provided from the Local Authority Health Protection Team on support given to Care Homes with Covid-19 outbreaks; PPE guidance changes and in July the work undertaken across the system to prepare for the heat wave. Lastly, Healthwatch had shared an analysis of issues raised by the public about communication breakdown which is a significant issue for the system. Discussions took place regarding undertaking a Deep Dive review into this area to ensure that patients receive consistent and timely information and that interfaces are streamlined across the system.

It was noted that the incidence of Pressure Ulcers remains an area of concern through Serious Incident Reporting rates of stage 3 & 4 Pressure Ulcers and that a Task and Finish Group has been formed to address this area. Furthermore, significant ambulance delays in the community remains a cause for concern, as do hospital ambulance handover delays and ED 12 hour waits.

The work being undertaken by Trusts to implement the new Patient Safety Incident Framework (PSIRF) was also noted. As a system preparation for this had been through the Serious Incident Review Group which meets monthly across system partners. A dedicated system Task group is now being progressed to further advance this work and to support Trusts with implementation.

Discussions took place regarding the recent Clinical Summit which focussed on Urgent and Emergency Care (UEC) pathways that had taken place and the discussions regarding the recently published evidence in relation to the association between delays to patient admitted from A&E departments. The research found that ddelays to hospital inpatient admission for patients in excess of 5 hours from time of arrival at the ED are associated with an increase in all-cause 30-day mortality. Between 5 and 12 hours, delays cause a predictable dose–response effect. For every 82 admitted patients whose time to inpatient bed transfer is delayed beyond 6 to 8 hours from time of arrival at the ED, there is one extra death. It was agreed to have a detailed update and presentation on this area at the next meeting.

- **Safeguarding Annual Report:** the Safeguarding Annual Report for 2021-22 was shared with members. It was noted that the report focusses on the CCG core responsibilities, governance arrangements and highlights the key themes for Lincolnshire which is consistent with the national position. It was highlighted that since the Covid-19 pandemic there has been an increase in the number of domestic abuse incidents reported. Furthermore, the impact on children and the isolation processes during the pandemic had also been highlighted.

  Discussions took place regarding the safeguarding arrangements for Asylum Seekers and the associated challenges of where they reside. It was noted that work is taking place with District Councils and that Lincolnshire is involved with the Kings Fund in the development of principles to support Asylum Seekers of which is due to be published in the Spring.

- **Proposed Quality and Performance Report:** a proposed report was shared with members for discussion and comment on the future format. An update was provided on the main areas to note including the progress being made against the Learning Disability Health Checks, improvements in the mortality metrics and the EMAS Cat 1 and Cat 2 standards. Concerns were expressed regarding the A&E 12 hour waits, EMAS handover response times of which was particularly challenging for the Pilgrim Hospital site in the summer months, performance of early intervention in psychosis (EIP) waiting times is now at 19% seen within 2 weeks, improving from 6% in June but still much lower than the 60% standard. An area of success was reported in relation to the Hereward Practice CQC report which was published on 18th August with an overall rating of 'Good'. The progress was noted in relation to the Covid vaccination Autumn booster campaign and that Lincolnshire is the top performing organisation within the Region.

  Discussions ensued regarding the proposed format and the inclusion of metrics based on patient experience, pathways and the provision of a compact data slide deck with supporting narrative. It was discussed that the report will evolve over time.

- **System Quality Risk Register and System Quality Group Risk Register:** a copy of the System Quality Concerns and ICB Risk Register were presented for information. The key areas to note included: cancer, elective care, A&E, handover delays, workforce challenges particularly within the Lincolnshire Community Health Services NHS Trust and domiciliary care which is impacting on patient flow out of hospital and discharge processes, provision of initial health assessments for Looked After Children however work is taking place between United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust to address this area. CHC reviews and that a backlog has been noted for the annual reviews and subsequent to this an external agency has been sourced to assist with this.

Discussions ensued regarding the provision of a single clinical risk register which is aligned across all organisations. It was noted that there was some disparity between the ratings of which provider organisations had rated risks. It was further discussed that the focus of the Register should be on pathways and not individual providers. It was agreed that further work would take place to streamline a single System Risk Register and a revised version presented at the next meeting.

- **ICB Quality Committee – Terms of Reference:** were presented for approval. A query was raised regarding the inclusion of an additional responsibility relating to system Equality Impact and Quality Impact Assessments. Discussions took place regarding the proposed membership and the functions and responsibilities. It was agreed to formally approve the Terms of Reference as they stand at present and that a detailed discussion take place with the Clinical Care Directorate regarding the future membership. An update would be provided at the next meeting.

- **Quality Schematic Diagram:** the ICB function map was shared with members. Discussions took place regarding the system oversight and assurance functions and the synthesis of reports to the Committee.

- **Suggested Cycle of Business:** a copy of the proposed Cycle of Business was shared with members. Discussions took place regarding the programme areas and those that should be prioritised and the role of the Committee. After considerable debate it was agreed that a Quality Operational Group would be formed to undertake the operational functions and that the System QPEC Committee would focus on the strategic elements.

- **Update from the Clinical Policies Subgroup:** it was noted that the Clinical Policies Subgroup is a Subgroup of the Committee and that its role is to review and sign off clinical policies. Discussions took place regarding the overlap with the functions of the Clinical Care directorate. It was agreed that a discussion would take place regarding the role of the Subgroup and if this function is better placed within the Quality Operational Group.

Items for escalation to the ICB Board:

- Urgent and Emergency Care standards and the concerns that were discussed relating to the delay in delivering the pathways, the committee wants to highlight to board the direct impact this is having on patient safety and it's potential to cause harm to patients, High volumes of A&E attendances can lead to over-crowding, rising pressure on A&E services and poorer experience for patients. Recent evidence points to the link between delays in urgent care pathways does cause harm to patients.
- Acknowledgement of the governance processes and ensuring that the Committee evolves and is fit for purpose.
- The formation and development of a Quality Operational Group to undertake the operational functions whilst the System QPEC Committee focusses on the strategic elements.

4.	Management of Conflicts of Interest

The management of conflicts of interest are dealt with in accordance with the agenda and items.

5.	Risk and Assurance

A System Risk Register and ICB Risk Register is in place. Going forward it has been agreed that the System Quality Risk Register will be streamlined, and a single source presented.

5.	Financial/Resource Implications

Nil to note.

6.	Legal, Policy and Regulatory Requirements

Nil to note.

7.	Health Inequalities implications

Health inequalities considered in all aspects of the work programme.

8.	Equality and Diversity implications
Equality and diversity implications considered in all aspects of the work programme.	
9.	**Patient and Public Involvement (including Communications and Engagement)**
Patient and public involvement and engagement is embedded within the System QPEC.	
11.	**Report previously presented at**
N/A	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Martin Fahy – Director of Nursing – m.fahy@nhs.net ☎ 07880157221	

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NHS LINCOLNSHIRE INTEGRATED CARE BOARD

QUALITY COMMITTEE
(SYSTEM QUALITY & PATIENT EXPERIENCE COMMITTEE)

TERMS OF REFERENCE

1. CONSTITUTION

The Quality Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) and will be a joint Committee between the ICB and NHS providers accordance with the Boards Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is an ICB non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2. AUTHORITY

The Quality Committee is a formal Committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Quality Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

3. PURPOSE OF THE COMMITTEE

The Quality Committee has been 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 Care Bill 2021. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

4. MEMBERSHIP AND ATTENDANCE

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three members of the Committee including one of which will be a Non-Executive Member of the Board (from the ICB) and Non-Executive Members from the NHS provider organisations (Acute, Mental Health & Community trusts). Other attendees of the Committee need not be members of the Board, but they may be attendees.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Committee Members are:

- ICB Non-Executive Member (Chair)
- ICB Director of Nursing
- ICB Medical Director
- System Non-Executive Members (Chairs of the System Quality Committees) Representatives (1 acute provider representative,1 community, 1 mental health and 1 primary care representative).
- ICB GP Clinical Lead
- LA representation (Chair of the Health Protection Board or Deputy Chair).
- An individual may represent more than one area.

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

Attendees are:

- Directors of Nursing & Medical directors in the NHS trusts and or their deputies
- Deputy Director of Nursing and Quality
- Chair/Deputy Chair of the System Quality Group
- Clinical Leads Localities
- Ambulance trust (EMAS)
- HealthWatch
- Public Health Representative
- University Representative
- Safeguarding Leads
- ICB IPC Lead
- Representative of the Primary Care Liaison Committee
- Subject matter experts will be invited to attend to support focused discussions on a 'as required' basis e.g., Patient safety lead, HEE, AHSN, LMNS lead or CYP lead. Individuals may represent more than one area for these focussed discussion topics.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw when the committee needs to attend to sensitive/confidential business in accordance with its constitution.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.

Committee members will appoint a Vice Chair of the Committee who will be one of the Non-Executive Members of the Board.

The Chair will be responsible for agreeing the agenda and ensuring that matters discussed meet the objectives as set out in the Terms of Reference.

5. MEETING QUORACY AND DECISIONS

The Quality Committee shall meet formally a minimum of eight times per year, along with two development sessions. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

There will be a minimum of two Non-Executive Members, plus at least the Director of Nursing or Medical Director, one NED NHS provider member and one Local Authority representative.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a ‘virtual’ basis through the use of telephone, email or other electronic communication.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Quality Committee will be authorised by the ICB Board. It is expected that the Quality Committee will:

- Be assured that there are robust processes in place for the effective management of quality in line with the National Quality Board (NQB) Shared Commitment to Quality.
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.
- Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care.
- Oversee and monitor delivery of the ICB key statutory requirements.
- Review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and high-risk operational issues which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g., CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.
- Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Preventing Future Deaths /reg 28 reports).
- To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for patient engagement and experience .
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.
- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g., System Quality Groups, Infection Prevention and Control, Safeguarding Boards / Hubs etc).

7. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

All committees and sub-committees are listed in the SoRD. Each committee and sub-committee established by the ICB operates under terms of reference and membership agreed by the Board or the relevant Committee who the Board has delegated the power to make further delegations to Sub-Committees. All terms of reference are published in the Governance Handbook.

The Quality Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded.

As a Committee that fulfils delegated functions of the ICB, the Quality Committee will be required to:

a) Provide a written report to the Board following each meeting outlining the key matters discussed, any points for escalation, assurance and/or decision and/or any new areas of risk. The Chair of the Committee shall attend the Board (public meeting) to present the report.
b) A Committee Chair may also request an Executive lead to attend the Audit Committee to discuss significant risks or matters or issue arising from internal audit reports in greater detail

The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

Where a member of the Committee is aware of an interest, conflict or potential interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflicts of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting.

Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.

Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing conflicts of interest, and may result in suspension from the Committee.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed a minimum of 5 working days before the meeting having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Membership will be considered as part of TOR review processes
- Accurate and accessible minutes are taken and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: July 2022

Date of review: November 2022

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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22nd November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	8 (ii)
Title of Report:	Update from Service Delivery & Performance Committee
Purpose:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	None

1.	**Key Points for Discussion:**

The purpose of this paper is to provide the Board with a summary of the ICB Service Delivery & Performance Committee meeting held in October 2022.

2.	**Recommendations**

The Board is asked to note and consider this report.

3.	**Executive Summary**

The meeting received information and background on:

- **Winter Plan 2022/23** – The winter plan describes the significant pressure that the whole system continues to experience as it transitions from the unprecedented summer pressures into the winter months. A letter (18/10/22) received from the NHSE national team advised of the need to go further with regards to winter resilience plans. A number of key areas were highlighted within the letter including the requirement to set up a System Operational Centre by the beginning of December 2022, with NHSE stipulating quite specific expectations.

  Mrs Raybould advised the committee that as SRO for UEC she did not feel assured that as a system we had, as yet a safe resilient plan to get through winter.

  A Clinical Summit was held on 7th October which considered the immediate actions to manage the risk in the UEC pathway in Lincolnshire for winter 2022 and a number of priorities were identified.

  Additional capacity and demand winter schemes have been established which include the implementation of 'SHREWD', a dashboard that would support operational oversight and assurance for the whole Lincolnshire system.

  Discussions took place on the need for services to be joined together more in order for resources to be utilised more effectively.

- **Urgent and Emergency Care** – The level of UEC demand remains high – T1 (A&E) activity continues to increase and T3 (UTC) activity was stable but remains higher than previously seen. This was also reflected across the community and mental health services. It was acknowledged that the patient numbers had increased but the level of acuity was also more complex.

  4hr and 12hr breaches remain high and the number of patients in ED for more than 12hrs continues to increase. The main reason behind this was sufficient hospital discharges not being achieved.

  Ambulance handover delays continue to track above the contracted trajectory. The system was fully sighted and very much aware that ambulance delays increase the level of risk within the community.

  Workforce availability and service demand are the biggest risks currently to the UEC pathways of care.

  Discussions took place about the Urgent and Emergency Care Partnership Board and the UEC programme priorities.

  There was also a piece of work that was underway to look at other implications to the Lincolnshire system such as the impact of the cost-of-living crisis.

- **Integrated Primary Care & Community Care** –Mrs Sarah-Jane Mills provided an overview of her portfolio.

  The key headlines included – Service delivery for General Practice, Primary Care Same Day Access, Development & Implementation of PCNs, Long Term Conditions, Primary Care Digital, Enhanced Health in Care Homes and anticipatory care DES.

  Mrs Mills highlighted that her ambition for the portfolio was to have a sufficient level of detail which provides the ability to share data between care homes, practices and ambulance services.

  Through the provider collaborative it has been identified that frailty was a priority.

  A planning event was arranged for 15th November to go through the plan for Primary Care, agree key milestones until the end of March 2023 and develop a more detailed plan for 2023/24.

- **Workforce** – Mrs Lennon's verbal overview was split into three key areas – NHS Provider Trusts headlines, Primary Care and Social Care. In-depth discussions took place about workforce and a number of suggestions were discussed such as offering career pathways for 16-18 years olds (in addition to graduates), to encourage them into Health & Social Care, targeting schools especially when pupils were selecting their exam options, exploring military leavers who might transition to the NHS and also considering flexible options for people who might want one last career move before retiring, as a large number of people move to Lincolnshire to retire.

  Discussions also took place on the need to have a collaborative bank of staff both locally and regionally in order to remain under the cap for agency spend and to avoid go off framework.

  Mrs Lennon advised that she had recently agreed a three year programme of work with KPMG on workforce planning and workforce data.

- **Lincolnshire System Performance Report 2022/23** – Discussions took place on the current performance report, and it was agreed that the report needed to be tailored for the committee to provide a summary document, a high level dashboard along with the facility to access more in-depth detail when required.

  Mrs Raybould highlighted to the committee that NHSE had recently produced a regional dashboard which highlighted key areas and it was felt that it would be advantageous if this was replicated for the Lincolnshire system. A request has been put forward to the performance team to look into providing a local framework for reporting into the NHS Oversight Framework.

  In terms of the regular agenda topics, it was agreed the committee needed to consider what each portfolio was intending to deliver, i.e., what each portfolio was planning and the key milestones for delivery, along with current performance levels against that trajectory and brief commentary by way of exception reporting and planned actions for improvement.

4.	**Management of Conflicts of Interest**
No conflicts of interest were declared at the committee.	
5.	**Risk and Assurance**
No escalations from the establishment committee meeting	
6.	**Financial/Resource Implications**
N/A	
7.	**Legal, Policy and Regulatory Requirements**
N/A	
8.	**Health Inequalities implications**
N/A	
9.	**Equality and Diversity implications**
N/A	
10.	**Patient and Public Involvement (including Communications and Engagement)**
Discussed the role of PPI in the committee – deferred to December meeting once established.	
11.	**Report previously presented at**
N/A	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Dawn Kenson – Non-Executive Director & Chair of System Delivery & Performance Committee – d.kenson@nhs.net Clair Raybould – Director for System Delivery – clair.raybould@nhs.net	

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NHS INTEGRATED CARE BOARD PUBLIC MEETING

Date: 22nd November 2022
Location: Bridge House, Sleaford

Agenda Number:	8 (iii)
Title of Report:	PCCC Public Committee Meeting Update
Author:	Dr Gerry McSorley, Chair Sarah-Jane Mills, Director of Primary Care, Community & Social Value Sarah Bates, Deputy Board Secretary
Appendices:	N/A

1. Key Points for Discussion:

This paper provides an update on the discussions that took place at the first Public Primary Care Commissioning Committee meeting that was held on 19th October 2022.

2. Recommendations

The Board is asked to note the update.

3. Executive Summary

The October Public Primary Care Commissioning Committee focused on the following agenda items:

- **Sidings Procurement Contract Award:** it was noted that following a procurement exercise the contract for the Sidings Procurement was awarded to Omnes Healthcare on 1st July 2022 with a mobilisation date of 1st September 2022. During the due diligence exercise it was noted that additional costs equating to approximately £100k was required to support the legacy TUPE contract arrangements. A query was raised regarding the additional locum costs detailed within the report, it was noted that these are currently being worked through and will be finalised at the end of the month.

- **Spalding Update including Expression of Interest Process:** an update was provided in relation to the managed dispersal and that the Expression of Interest process. An overview was provided on the outcome of the engagement events with the public and stakeholders highlighting the following areas:-

  - Understanding and rationale of the list dispersal process of which a significant number of queries were raised.
  - Quality and continuity of care is maintained and that there is no deterioration in service provision.
  - Transport and travel and understanding the location and that this is accessible.
  - Feedback received from the neighbouring Practices regarding capacity and previous patient experiences.
  - Suggestions regarding provision of new services given the expected population growth within the Spalding area. In addition, that the services are fit for purpose.
  - Praise for excellent service provision from the current staff.

It was noted that the Expression of Interest process had closed on Friday 14.10.22 and that the next steps were discussed including a review of the due diligence process through the Expression of Interest process. Subsequent to this a public announcement will be made within the next two weeks and each household written to informing them of the outcome.

- **Enhanced Access Update:** a report was presented regarding the Extended Access provision for Lincolnshire which commenced on 1st October 2022. It was noted that there is a requirement for Primary Care Networks to provide Enhanced Access to deliver evening and weekend appointments between the hours of 6.30pm and 8.00pm Monday to Friday and between 9.00am and 5.00pm on Saturdays. It was discussed that all PCN's are required to provide Enhanced Access and that there are different models in place such as rotational and hub based and that patient engagement has taken place with the PCN populations.

- **Primary Care Work Programme:** an update was provided on the Primary Care Work Programme which includes the detail of time limited activities. It was noted that in terms of the governance process where new investment is proposed from the programme a business case will be presented for approval to the ICB Senior Managers Operational Delivery Group and subject to approval presented at the Lincolnshire Investment Panel. Discussions took place regarding the RAG (red/amber/green) ratings and that it would be beneficial to have sight of the assurance processes and further detail of the elements contained in the work programme.

- **Winter Planning Update:** it was noted that there has been various national publications/letters regarding winter planning and that one of the issues with the funding streams for winter planning is the non-recurrent status of which makes it difficult to put sustainable plans in place. It was reported that there is a high level system approach being taken with a focus on Urgent and Emergency Care and that the role for Primary Care relates to the development of an ICB framework for supporting General Practice which includes rapidly assessing the needs of Practices/Primary Care Networks (PCNs), building on local knowledge, and identifying the practical and supportive interventions to boost resilience and patient access and priority to be given to where it is most needed, immediate changes to the Network Contract Directed Enhanced Service (DES) via contract variation and reducing bureaucracy for primary/secondary care interface. It was discussed that this is work in progress and detailed robust plans are being developed however there are a number of risks that have been identified that relate to funding, resource and the complexity of the programme.

  Discussions took place regarding the importance of data and that Lincolnshire has procured the new SHREWD (Single Health Resilience Early Warning Database) system, which is a powerful, real-time digital solution that provides simple visibility of whole system data.

  It was noted that Urgent and Emergency Care are leading the programme and that the ICB is co-ordinating all parts of the system and that there is a weekly System Oversight Group that meets to discuss the progress, risks and issues.

- **Pharmacy, Optometry and Dental Transition Update:** it was noted that Pharmacy, Optometry and Dental services will transfer to the ICSwith effect from 1st April 2023. An update was provided on the work taking place with NHSE to ensure the safe transfer of services and that as part of the process a Pre-Delegation Assessment Framework has been completed of which has been reviewed by a National Moderation Panel on 12th October 2022. It was noted that a Group has been formed of which includes clinicians and leaders from across all service areas to ensure the smooth transition of integrated services.

- **Performance Update:** an update was provided on the three main areas of focus which include:-

  - *Quality of Care* – review of the CQC ratings it was noted that currently there are four Practices that Requires Improvement and one that is rated as Inadequate.

- *Access to Primary Care including Enhanced Access* - the percentage of appointments offered by a GP Practice both face to face and digitally, it was discussed that Lincolnshire benchmarks well both nationally and regionally in terms of appointment availability.
- *Long Term Condition Management* – the inclusion of five indicators relating to Health Checks for patients with a Learning Disability/SMI, CVD, Hypertension, Asthma and Diabetes. It was recognised that there is good performance for CVD and Asthma but further work is required to improve the performance for Diabetes and the 8 core processes.

It was highlighted that the report is being refined and will evolve over the course of time and that data in relation to Pharmacy, Dental and Optometry services will also be included from April 2023.

- **Service Delivery and Performance** – in respect of ABCD (Ambulance, Backlog, Care, Doctors and Dentists) Priorities – an update was provided on the priorities and that for Primary Care there is an expectation that any patient requesting a GP appointment is seen within two weeks. It was noted that the current performance for Lincolnshire is at 80%. Discussions took place regarding the current challenges with patients attempting to contact GP Practices by telephone and that additional infrastructure will be provided to support this area.

- **Finance Update:** no issues for escalation.

- **Quality and Patient Experience and Effectiveness Update:** it was noted that the Marisco, Branston and Spalding Practices have been inspected by the CQC and rated as Requires Improvement and that the Marisco Practice has recently been re-inspected. It was discussed that the early findings are positive. The Merton Lodge Practice was also recently inspected and the findings made public on 13th September 2022 of which the Practice was rated as good across all domains.

- **Lakeside Medical Practice:** an update was provided that the Practice was initially inspected by the CQC in June 2021 and rated as Inadequate in five out of the six domains. The Practice was subsequently re-inspected in September 2021 and remained the same. It was noted that HealthWatch had undertaken a patient survey with the Practice of which 1,456 responses had been received raising a number of challenges and issues. A further CQC inspection took place in June 2022 of which identified progress and the Practice was rated as Requires Improvement and that the CQC has withdrawn the notice of proposals and is no longer in Special Measures. In addition, it was noted that a meeting has taken place with the new Chief Executive of Lakeside Healthcare.

- **Hawthorn Medical Practice CQC Inspection**: it was noted that the CQC had inspected the Practice on 23rd August 2022 of which has been rated as Inadequate overall with Inadequate in the Safety, Responsiveness and Well Led domains and Requires Improvement in Effectiveness and Caring of which places the Practice in Special Measures. It was noted that one area that had been highlighted related to the Practice not having a Patient Participation Group however plans are now in place to address this area.

- **Risk Register including an update in relation to Asylum Seekers:** an update was provided in relation to new risks that have been added to the Register including the APMS contract and the impact on pension arrangements for primary care staff that are employed by Federations, the pressures within the paediatric service, secondary care referrals and the associated delays, data sharing and the variation in GP Practice sign up to data sharing arrangements to support data flow and resettlement of refugees and that Primary Care may have capacity issues to respond to all of the health needs of people placed in Lincolnshire under the resettlement programmes and refugees.

Items for escalation to the ICB Board:

- Update on the Sidings and Spalding Practice.
- Hawthorn Practice and recent CQC inspection.

4.	Management of Conflicts of Interest
The management of conflicts of interest are dealt with in accordance with the agenda and items.	

5.	Risk and Assurance
Practices have been identified and placed on the ICB Risk Register.	

5.	Financial/Resource Implications
Where required additional funding has been provided by the ICB to facilitate additional support to vulnerable Practices as appropriate, where not covered via existing funding routes.	

6.	Legal, Policy and Regulatory Requirements

Legal considerations include:

- The statutory duty to consult and engage on service changes as set out above.
- Primary medical services contractual compliance and formalities.

The planning and implementation of this service change should have due regard for the principles and values as set out in the NHS Constitution.

7.	Health Inequalities implications
Include details of health inequalities implications.	

8.	Equality and Diversity implications
Include details of any equality and diversity implications.	

9.	Patient and Public Involvement (including Communications and Engagement)
Patient and public engagement processes are utilised to secure patient experience information for each Practice that informs the Quality Risk Rating and Quality Improvement actions.	

11.	Report previously presented at
Regular monthly progress reports have been provided at PCCC meetings.	

12.	Sponsoring Director/Partner Member/Non-Executive Director
Sarah-Jane Mills - Mobile: 07870 898428 sarah-jane.mills1@nhs.net	

8 (iv)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22 November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	8 (iv)
Title of Report:	Update from Finance and Resource Committee meetings held on 24.10.22 and 15.11.22
Purpose:	For information
Appendices:	Committee Terms of Reference

1.	**Key Points for Discussion:**

The purpose of this paper is to provide the Board with a summary of the ICB Finance and Resource Committee meetings held on 24 October 2022 and 15 November 2022.

2.	**Recommendations**

The Board is asked to note and consider this report.

3.	**Executive Summary**

The ICB Finance and Resource Committee was held on held on **24 October 2022**. The Committee focused on the following key areas:

- **Committee Terms of Reference and Ways of Working**
  - Wording around governance to be strengthened.
  - Agree the relationship/boundary with the provider committees.
  - Agreed for Murray Macdonald to become Vice-Chair of the committee.
  - Full revised terms of reference to be presented to the next committee.
- **System Financial Position Report**
  - The Month 6 report for the system was presented and the Committee noted an £11.3m adverse variance to plan; however still reporting to break even by the end of the financial year.
  - Unmitigated risks of £24.7m were noted thereby expecting a risk adjusted year end position of c£35m adverse variance to plan.
  - Mental Health Investment standard; currently reporting that we will meet that standard, however, we are at risk of not doing so by c£9.2m and are currently working with NHSE on how to mitigate this.
  - Strong winter plan underway.
  - Audit of the ICB's HFMA Financial Sustainability Assessment has commenced with Grant Thornton. Findings from the auditwill be reported by end of November along with an agreed action plan
  - The committee agreed for the report to be shared with provider committees.

- **Report on Efficiency Programme**
  - The committee require more visibility on the transformation schemes and the details behind them.
  - Deep dive to take place on two of the three existing schemes and SRO to attend the meeting along with finance support.
  - The committee wished to highlight to the Board the lack of resources for the transformation schemes which impacts on financial position.
- **Investment Panel Report**
  - The ICS Investment Panel met on 19.10.22 and the committee discussed this at length.
  - The Committee required a more detailed report going forward to enable them to ratify the decisions made at the Investment Panel.
  - It was proposed that ICB slippage be used to cover the investment for PEOL.
  - The committee agreed to accept the proposal for the PEOL investment at this time, however, stressed the need for a more detailed report going forward to include supportive narrative.

The ICB Finance and Resource Committee was held on **15 November 2022**. The Committee focused on the following key areas:

- **Committee Terms of Reference**
  - Revised version accepted by the Committee with a review date agreed of May 2023. To be approved by the ICB Board.
- **Finance Position and Risk Adjusted Outturn**
  - Drive pace in System Improvement Plan delivery
  - Specifics over objectives and priorities.
  - Upweight capability of PMO and remove resource blockers.
  - Refinement of 22/23 outturn position – explore all available mitigations.
  - Expand role of Investment panel to include a disinvestment focus.
  - Development of medium-term financial delivery plan by mid-December which delivers a sustainable financial position.
  - Rolling 18 month forecast position updated monthly with F&RC oversight.
  - Risk adjusted £35m deficit remains in place with all mitigations being explored as a system.
- **NHSE Protocol for Changes to Financial Forecast**
  - The protocol formalises the layers of assurance with individual provider deficits managed at an ICS level and ICS deficits are reviewed and managed by NHS England.
  - Should a System change its forecasted position to non-delivery of the plan, the following conditions will apply (some of these are on top of existing measures applied in Lincolnshire):
    - A double-lock sign-off for provider revenue investments above £50k (current limit £250k). A triple-lock sign-off process (i.e. sign-off from NHSE Regional Team) for ICB/System revenue investments above £100k.
    - A granular analysis of provider workforce describing changes in headcount and additional financial, and other, reporting requirements will be introduced for providers that are off-plan in the system.
    - Measures to reduce pay costs including further restrictions on recruitment, agency, consultancy and bank usage.
    - NHSE Regional Director of Finance to attend system Finance Committee.
    - Funding arrangements may change to include formal review of capital allocation by NHSE National Team with the potential restrictions. Historic legacy CCG deficit may be reinstated and further overspending likely to require payback.

        - SOF rating for the organisation and system is likely to be reviewed.

    - The Committee approved a timeframe for this process and will formulate a report to be agreed at the next meeting. A Board Assurance Statement (BAS) will be submitted by each relevant organisation confirming adherence to the protocol and commitment to delivery of the recovery plan signed by the Chair, CEO, DoF and a NED.

- **Medium Term Financial Plan**
    - The Committee received a presentation detailing the approach towards producing a medium-term financial plan for the system.
    - The plan will be produced by involving several key stakeholders.
    - The Committee will receive and discuss the plan at the next meeting.
    - The final version of the plan will be presented to the ICB Board on 20.12.22 and will be based on system assumptions. This will be updated following formal publication of the planning guidance from NHSE (expected late December).
- **System Improvement Plan and CIP Update**
    - The Committee received a presentation and report from the System Improvement Director which detailed the approach to be taken:
        - The SOF4 Recovery Support Programme exit criteria will be reviewed to establish which have and have not been met.
        - The current position linked to the realisation of savings associated with the 22/23 System Delivery Plan.
        - Outline of the steps that should be taken to develop the 23/24 saving scheme pipeline.
    - The Committee noted that the system is unlikely to exit SOF4 in the next 6 months.
    - The Committee noted the urgency and pace needed and the lack of capacity within transformation teams.
- **Mental Health Expenditure Position**
    - The Committee received a report on the current Mental Health expenditure position for the system and the impact on Mental Health Investment standard (MHIS):
        - The current forecast position indicates total applicable MHIS spend at £130.9m is broadly flat year on year and showing no growth when the standard is for differential growth of at least 5.7%.
        - The policy of setting differential investment rates into MH services has led to an expansion of services operating in the county ranging from inpatient services (Ash Villa), community rehabilitation and improved access to psychological therapies (IAPT).
        - This has been successful in driving down expenditure in out of area costs, and some aspects of high-cost packages of care (referred to as locked rehabilitation).
        - The ICB is working closely with LPFT to explore all options open to continue to maximise service delivery opportunities, through working more with third sector providers and explore services not reliant on staffing, whilst recruitment plans are embedded.
    - The Committee noted the position and the need to declare that the MHIS will not be met in 2022/23.
    - The Committee also noted the excellent work undertaken by the CHC and Mental Health Teams around repatriation of patients back into the county.

4.	**Management of Conflicts of Interest**

No conflicts of interest were declared at the Committee.

5.	Risk and Assurance
No escalations from the establishment committee meeting	
6.	**Financial/Resource Implications**
As per the reports presented.	
7.	**Legal, Policy and Regulatory Requirements**
N/A	
8.	**Health Inequalities implications**
N/A	
9.	**Equality and Diversity implications**
N/A	
10.	**Patient and Public Involvement (including Communications and Engagement)**
N/A	
11.	**Report previously presented at**
N/A	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Julie Pomeroy – Non-Executive Member & Chair of Finance & Resource Committee – julie.pomeroy1@outlook,com Matt Gaunt, Director of Finance – m.gaunt@nhs.net	

NHS LINCOLNSHIRE INTEGRATED CARE BOARD

FINANCE AND RESOURCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The Finance and Resource Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) and will be a joint Committee between the ICB and NHS providers accordance with the Boards Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is an ICB Non-Executive Chaired Committee of the Board, and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. AUTHORITY

The Finance and Resource Committee is a formal Committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Finance and Resource Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

The Finance and Resource Committee is authorised by the Board to:

- Investigate any activity within its Terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow the procedures put in place by the ICB for obtaining legal or professional advice.
- Create sub groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

3. PURPOSE OF THE COMMITTEE

The ICB Finance and Resource Committee role has been established to support 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.

The financial performance of the ICB and the financial performance of NHS organisations within the ICB footprint are within the scope of this committee.

The Finance and Resource Committee will provide oversight and assurance on:

1. The development and delivery of a viable and sustainable system financial plans covering the short medium and long term.
2. Service change proposals and investments and oversight of the Lincolnshire 'double lock' and risk and gain share mechanisms.
3. The management of risks to plan delivery.
4. Resource distribution and funds flow arrangements for revenue and capital.

4. MEMBERSHIP AND ATTENDANCE

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution. When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Committee Members are:

- Chair: ICB Non-Executive Member
- NED who chairs the Finance Committee from each Lincolnshire NHS trust (one of whom will be the Vice Chair).
- ICB Director of Finance
- ICB Clinical representative
- ICB Quality representative
- Director of Finance from each Lincolnshire NHS trust
- Nominated Director responsible for Operations from an NHS trust

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- ICB Associate Directors of Finance

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board. In the event of the Chair of the Committee being unable to attend all or part of the meeting, the Vice-chair shall Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring that matters discussed meet the committee purpose as set out in the Terms of Reference.

5. MEETING QUORACY AND DECISIONS

The Finance and Resource Committee shall usually meet on a monthly basis over the financial year. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

There will be a minimum of two Non-Executive Members, plus two Directors of Finance.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. RESPONSIBILITIES OF THE COMMITTEE

Strategic Financial Framework

- To recommend for approval the ICS and ICB financial governance arrangements and the policy and financial delegations framework and provide oversight of their operation.
- Make decisions within the scope of the Committee's delegation arrangements, through the ICB SoRD, to devise supporting frameworks and financial mechanisms such as pooled arrangements, system risk and gain arrangements, and NHSE delegations.
- Oversee the operation of relevant financial mechanisms.

Revenue Resource Allocation Framework

- To develop and recommend an approach to distribute ICB resources to drive change that is supportive of the ICB strategy.
- Promote a collaborative approach to ICS and ICB financial delivery which prioritises those outcomes which maximise system return on investment.

- To ensure health and social inequalities considerations are incorporated into financial resource allocation.

Financial Planning

- To oversee the development of medium and long-term ICB and ICS financial plans which demonstrate patient and population value and sustainability and recommend them to the ICB Board for approval.
- To scrutinise and provide assurance on the ICS annual operational plan which is a consolidation of organisational annual plans and ensure these are aligned to the ICS medium term plan.
- To consider business cases for major investments / disinvestments for material service change or efficiency schemes and make recommendations to the ICB Board.

Assurance and use of resources

- Oversight of the financial performance reporting of the NHS Lincolnshire System, so that there is “one version of the truth”.
- To provide oversight of the delivery of ICS and ICB financial targets and ICS operational targets with financial implications and agree and monitor any actions taken to improve financial performance.
- To monitor financial performance and report to the Board the ICS and ICB financial position, highlighting areas of concern.
- Promote approaches which put patient value at the core of system decision making.
- Provide scrutiny of, and make recommendations based on conclusions and reporting from, the Investment Panel.

Efficiency

- Provide oversight for the development of the System Improvement Plan and recommend its approval by the ICB Board.
- Monitor the delivery of the System Improvement Plan and highlight areas of concern to the ICB Board.
- Provide scrutiny of the delivery of system wide efficiency savings and organisational efficiency plans with system implications.

Risk

- Review and monitor those risks on the ICB Board Assurance Framework and Corporate Risk Register which relate to finance.
- Assess ICS risk based on organisational risk positions.
- Provide scrutiny and challenge so that financial outcomes are delivered with associated risks identified and mitigated.
- Ensure that the ICB is kept informed of significant risks and mitigation plans, in a timely manner

Other

- NHSE oversight framework and wider NHSE performance management.
- Assist the Lincolnshire Leaders Group and organisational Boards in reaching a common position on all other aspects of policy relevant to financial and performance issues affecting the NHS Lincolnshire system.
- Agree key messaging on financial and operational performance through to NHSE as required.

7. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

All Committees and Sub-Committees are listed in the SoRD. Each Committee and Sub-committee established by the ICB operates under terms of reference and membership agreed by the Board or the relevant Committee who the Board has delegated the power to make further delegations to Sub-Committees. All terms of reference are published in the Governance Handbook.

The Finance and Resource Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded.

As a Committee that fulfils delegated functions of the ICB, the Finance and Resource Committee will be required to:

a) Provide a written report to the Board following each meeting outlining the key matters discussed, any points for escalation, assurance and/or decision and/or any new areas of risk. The Chair of the Committee shall attend the Board (public meeting) to present the report.
b) Each organisation's NEM/NED (supported by their organisational Executives) will report back to their own Finance and Performance Committee (and therefore upwards to their Board) using the Board report produced immediately after the meeting and will also share the latest approved set of meeting minutes.
c) The Chair of the Committee will send a report on the Committee's activity to the Lincolnshire Leaders Group monthly.
d) The Committee Chair may also request an Executive lead to attend the Audit and Risk Committee to discuss significant risks or matters or issue arising from internal audit reports in greater detail

The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

Where a member of the Committee is aware of an interest, conflict or potential interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential

conflicts of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting.

Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.

Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing conflicts of interest, and may result in suspension from the Committee.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed a minimum of 5 calendar days before the meeting having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Membership will be considered as part of TOR review processes
- Good quality minutes are taken and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: Approved by Committee on 15.11.22. ICB Board approval required

Date of review: May 2023

8 (v)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: 22ND November 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	8 (v)
Title of Report:	Audit & Risk Committee Update
Purpose:	Mrs Margaret Pratt – Interim Chair of the Audit and Risk Committee (Non-Executive Director) Mr M Gaunt – Director of Finance & Contracting
Appendices:	N/A

1.	**Key Points for Discussion:**

This paper provides an update on the discussions that took place at the latest Audit & Risk Committee meeting held on Monday, 14 November 2022.

2.	**Recommendations**

The Board is asked to note the update and progress.

3.	**Executive Summary**

The Audit & Risk Committee meeting held on 14 November 2022 focused on a number of areas including the following:

- External Audit Update
- Internal Audit Progress Report
- Audit Action Update
- Counter Fraud Progress Report
- Procurement Policy
- Risk Progress Report
- Information Governance Q2
- Write Off's (Losses)

Key points for noting were as follows:

External Audit Update
Two audits will be undertaken, one for the first quarter and a second, new audit, for the remaining three quarters of the ICB.

Meeting to be scheduled for January 2023 to receive a clear planning timeline from an Ernst and Young (EY) perspective in terms of Quarter One CCG accounts and Quarter to Quarter Four ICB accounts and the ICB planning document in terms of delivery.

The EY contract is due to end this year and a meeting to discuss this will take place outside of this meeting.

Internal Audit Progress Report
The finance review terms of reference had now been approved and the review will commence next week. The CHC/PHB review has been approved and will begin this week.

There had been 15 days held for cancer and 15 days that were not allocated to a review. Two areas were flagged, business continuity and EPRR; Execs requested that there was a preference for the days to be allocated to the business continuity element. PwC will provide an additional level of assurance around the EPRR self-assessment.

Audit Action Update
There are now 11 open actions. Nine actions were closed following the last Committee meeting. Four of the open actions have not yet reached the due date, four have passed the deadline and one is an old Better Care Fund (BCF) action. There were some long-standing items that had not been progressed / resolved. The Committee requested that the action owner should be invited to the next meeting of the committee to explain current status.

Counter Fraud Progress Report
Proactive work is underway. This week is fraud awareness week and comms have been shared. There were two new concerns/referrals raised since the last meeting. One was an attempted mandate fraud, which had no exposure for the ICB, and one is an active COVID-19 fraud case which has been shared with NHS England.

Procurement Policy
Approval for the policy was sought, which was on the back of an audit recommendation from July 2022. The Committee agreed to adopt the policy as a work in progress taking assurance from PwC.

Risk Progress Report
Kevin Street is working with the risk lead on a set of key deliverables; namely updating of the Risk Management Strategy, the Board Assurance Framework, the Corporate Risk Register and training. The Board Assurance Framework will be looked at as part of the work being undertaken at the Board Development Session to align to the Board strategic objectives which is scheduled to take place on the 22nd November 2022.

Information Governance Q2
Currently at 84% for mandatory training for ICB employed staff. The DSPT toolkit changes have been identified and shared with the ICB.

Write Offs (Losses)
There were two write offs which had been agreed by the ICB Executives: one for Orchard House Care Home for £2,158.76 and two for NHS North East and North Cumbria ICB totaling £87,352.73. The Audit and Risk Committee approved these recommendations.

4.	**Management of Conflicts of Interest**

The management of conflicts of interest is dealt with in accordance with the agenda and items.

5.	**Risk and Assurance**
As indicated in the report.	
6.	**Financial/Resource Implications**
Detailed in individual reports, if applicable.	
7.	**Legal, Policy and Regulatory Requirements**
Nil specific to note.	
8.	**Health Inequalities implications**
Nil specific to note.	
9.	**Equality and Diversity implications**
Nil specific to note.	
10.	**Patient and Public Involvement (including Communications and Engagement)**
Nil specific to note.	
11.	**Report previously presented at**
Regular updates provided to the Board	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Margaret Pratt – Non-Executive Director and Chair of the Audit and Risk Committee Matt Gaunt – Director of Finance & Contracting – m.gaunt@nhs.net	