



Lincolnshire
Integrated Care Board

**MEETING OF THE NHS LINCOLNSHIRE
INTEGRATED CARE BOARD
TO BE HELD ON
TUESDAY, 26TH JULY 2022
BRIDGE HOUSE, THE POINT, SLEAFORD
at 9.00 AM TO 12.30 PM**

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 Lincolnshire Integrated Care Board Public Meeting

Date: Tuesday, 26th July 2022

Time: 9.30 AM to 12.30 PM

Location: Bridge House, Sleaford

AGENDA

ITEM NUMBER	ACTION	ENCLOSURE/ VERBAL	LEAD	TIME	
1. INTRODUCTION					
i)	Welcome and Apologies		Verbal	Sir Andrew Cash	0930
ii)	Declarations of Interest		Verbal	Sir Andrew Cash	
iii)	Minutes of Meeting held on 1 st July 2022	Approve	Enclosure	Sir Andrew Cash	
iv)	Matters Arising, including Action Log	Note	Enclosure	Sir Andrew Cash	
2. CHAIR AND CHIEF EXECUTIVE UPDATES					
i)	Chair <ul style="list-style-type: none"> • Update and Overview • Richard Medding's letter of 9 June 2022 • NHSE CCG Assurance letter of 30 June 2022 	Note	Verbal Enclosure Enclosure	Sir Andrew Cash	0945
ii)	Chief Executive Update	Note	Verbal	John Turner	1000
3. KEY UPDATES					
i)	Public Health	Note	Verbal	Professor Derek Ward	1015
ii)	Healthwatch	Note	Verbal	Dean Odell	1025
4. CORE PURPOSE 1: HEALTH INEQUALITIES (tackle inequalities in outcomes, experience and access)					
i)	High Level Report: Lincolnshire Health Inequalities Approach	Note	Enclosure	Sandra Williamson	1035

ITEM NUMBER	ACTION	ENCLOSURE/ VERBAL	LEAD	TIME	
5. CORE PURPOSE 2: HEALTH OUTCOMES (improve outcomes in population health and healthcare)					
i)	Integrated Performance Report	Note	Enclosure	Clair Raybould	1050
ii)	Quality Section	Note		Martin Fahy	1105
BREAK 1120-1145					
6. CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY					
i)	Finance Report	Note	Enclosure	Matt Gaunt	1145
7. CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE (help the NHS support broader social and economic development)					
i)	High Level Report: Towns Funds Partnerships	Note	Enclosure	Pete Burnett/ Jacqui Bunce	1200
8. GOVERNANCE					
i)	To Receive and Note CCG Committees End of Year Reports	Note	Enclosures	Jules Ellis-Fenwick	1215
9. DATE, TIME AND VENUE OF NEXT MEETING					
	Tuesday, 27 September 2022 at 9.30 am at Bridge House, Sleaford	Note	Verbal	Sir Andrew Cash	1225

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.

**MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD
MEETING HELD ON FRIDAY, 1ST JULY 2022 AT 9.30 AM**

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
	Mr Matt Gaunt	Director of Finance
	Mr Martin Fahy	Director of Nursing
	Dr Sunil Hindocha	Interim Medical Director
	Dr Gerry McSorley	Non-Executive Member, Chair of Primary Care and Delegated Functions Committee and Remuneration Committee (joined via MS Teams)
	Mrs Julie Pomeroy	Non-Executive Member, Chair of Finance Committee
	Mr John Turner	Chief Executive
	Professor Sir Jonathan Van-Tam	Non-Executive Member, Chair of Quality Committee
IN ATTENDANCE:	Ms Sarah Bates	Deputy ICB Board Secretary
	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mrs Sarah Fletcher	Healthwatch Representative
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board
	Professor Derek Ward	Public Health Representative
APOLOGIES:	Mr Pete Moore	Non-Executive Member, Chair of Audit and Risk Committee

22/01 WELCOME AND INTRODUCTIONS

Sir Andrew Cash welcomed everyone to the first inaugural meeting of the ICB.

The Board was advised that this meeting would be predominantly governance based with a number of key documents to either be noted, considered and/or approved. This would not be the usual case going forward but was required on this occasion as part of the ICB establishment process, adding that as set out in national guidance and section 3.15 of the NHS Lincolnshire ICB Constitution, the ICB Establishment Committee, which was a 'one-off' had met immediately prior to this meeting and confirmed the appointment of the Non-Executive, Executive and Partner Members into their roles on a substantive basis.

Sir Andrew Cash advised that Integrated Care Systems (ICS) are part of a fundamental shift in the way the health and care system is organised.

They exist to achieve four aims:

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

Sir Andrew Cash provided a short summary on the four strategic aims and the three key aspects of an ICS which is comprised of an Integrated Care Board (ICB) and a joint committee known as an Integrated Care Partnership, which will be responsible for an Integrated Care Strategy setting out how the assessed needs in relation to its area are met. The Lincolnshire Integrated Care Partnership will be chaired by Councillor Sue Woolley.

The third element is that as of 1st July 2022 all Trusts providing acute and/or mental health services must be part of one or more provider collaboratives. For Lincolnshire this includes the following organisations:

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

Sir Andrew Cash advised that stepping into the ICB arrangements is done so with ambition, a positive mindset to meeting the challenges ahead, and a determination to use the opportunities of the Integrated Care System to best effect for our patients and communities and he was looking forward to working with everyone present as the ICB is developed and things are mobilised further in the months ahead.

Sir Andrew Cash expressed his appreciation to Mr John Turner, Mr Pete Burnett and Mrs Jules Ellis-Fenwick and their respective teams for the huge amount of work that had taken place over recent months to get to this stage and for producing the papers for the meeting within a challenging timeframe.

The CCG recently had its final Board meeting and reflected on the exceptional work which has been undertaken on behalf of Lincolnshire since its formation over the last two years. Sir Andrew Cash expressed his appreciation to the CCG Board, some of whom would be going forward with the ICB, but others had moved on and he wished them well.

At this point Sir Andrew Cash requested that all those present introduce themselves and provide a short briefing on their background, which promptly took place.

On a final note, the Board was advised that the running order of the agenda had changed slightly and Item 5 – Delegation Agreement was now Item 9. A paper copy of the amended version of the agenda was tabled for those present and it was noted that this version had been made available on the ICB website along with the papers for the meeting.

The Board agreed to:

- **Note the briefing and introductions.**

22/02 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

Sir Andrew Cash advised that all ICB Board Members are required to declare any pecuniary and non-pecuniary interests as per the Standards of Business Conduct and Conflicts of Interest Policy which would appear later on the agenda for approval.

To that effect Ms Bates would be sending round a Declaration of Interest Form later that day for all ICB Board Members to complete and all those present were asked to return this by Monday, 11th July 2022. The Declaration of Interest Register would then be established and published on the ICB website.

Separate to that all those present were asked if they had any interests to declare in relation to items on the agenda.

Dr Hindocha and Dr Baker both declared an interest in respect of the Primary Care Commissioning and Delegated Functions Committee Terms of Reference as they are both practicing GPs, which was duly noted for recording in the minutes. It was agreed there was no requirement for either individual to leave the room when that item was discussed.

The Board agreed to:

- **Note the Declaration of Interest Form would be circulated to ICB Board Members for completion and return.**
- **Note the interests as declared by Dr Baker and Dr Hindocha.**

Action: Ms Bates/All

22/03 INTRODUCTORY COMMENTS ON THE ESTABLISHMENT, CONTEXT AND CHALLENGES FOR THE LINCOLNSHIRE INTEGRATED CARE SYSTEM AND ICB

Sir Andrew Cash advised that he had asked Mr Turner to provide some introductory comments on the establishment, context and challenges for the Lincolnshire ICS and ICB.

Mr Turner reiterated the comments made earlier in the meeting about working together and taking forward a really important programme of work around integrated care. There is clearly an ambition in Lincolnshire to provide the best possible care for the people we serve.

The core focus of today's meeting was to consider a number of governance documents, which need to be formally put in place and the timescale was fairly challenging, so now was not necessarily the time for an expansive conversation about why we are here, what our role is and what integrated care is and the challenges facing the ICB. Those deep and thought provoking conversations would need to take place over the coming months, specifically in respect of how the ICB is going to meet the ambitions and the core purposes as outlined by Sir Andrew Cash.

In terms of setting the scene, under the Health and Care Act 2022, Integrated Care Systems (ICSs) were established on the 1st July 2022 along with 42 Integrated Care Boards (ICBs). ICSs have two statutory components, the first of which is the Integrated Care Partnership (ICP) which is concerned with the broader health and wellbeing of the population and working together on the social determinants and health inequalities. In Lincolnshire the Health and Wellbeing Board has made considerable progress with its work and core functions. The Health and Wellbeing Board and the Integrated Care Partnership in Lincolnshire will essentially be the same group of people with an interlinked agenda going forward.

The second statutory component is the NHS Lincolnshire Integrated Care Board (ICB) which has assumed the responsibilities and duties of the predecessor CCG but has a much wider and different role. Today is a great opportunity to emphasise the ICB as a new organisation with an ambitious mission.

The four core purposes of the ICB had already been outlined by Sir Andrew Cash, but to add the point of an integrated care system is to have integrated care and that is about a way of working, mindset and attitude as well as delivering care within two domains; The first is joined up at the point patients receive 'hands on care', not just across the NHS but also all elements of service provision in the county, be that between the NHS and social care, third sector services to ensure there is a clear wrap around for people and their families.

The second aspect is the broader care for the health and wellbeing of the Lincolnshire population and its communities. Moving forward it is important for the ICB to consider integrated care under those two domains and the ICB will need to scope this out over the coming months in terms of what that exactly means.

The challenges facing Lincolnshire are significant and well known, specifically including its size and dispersal of the population across the county and its rurality. Lincolnshire has very significant rural health inequalities which is separate from the coastal health inequalities and the ICB will need to be guided by these two separate, but related issues. The recent Chief Medical Officer (CMO) report about coastal towns and All Party Parliamentary Group report on Rural Health and Levelling up piece of work are all key areas of work and touchstone points for the ICB.

Professor Derek Ward and his team in Public Health produce the Joint Strategic Needs Assessment (JSNA) which contains a significant level of profound information on the Lincolnshire population and its demography. It will be a key guide and bedrock of information for the ICB going forward.

Mr Turner referred to the top twenty most deprived towns in the UK, of which number one and four were in Lincolnshire, which is Skegness and Mablethorpe. However, there are a number of assets in Lincolnshire one of which is being a relatively simple system in terms of coherence across the county with one County Council, one ICB, three NHS Trusts, one third sector organisation, one Care Sector organisation and one Primary Care Network (PCN) Alliance all with the word Lincolnshire in the title, which is relatively unique with only two other systems in the country with a very similar simplicity. A further key asset is the really positive and great relationships between different organisations in Lincolnshire.

There is a considerable amount of success to build on such as the Vaccination Programme, the elective care work, the recent agreement around acute service changes, work in terms of mental health and learning disabilities and cancer services – to name just a few.

As well as the statutory elements there are other areas for focus coming into the county such as the Provider Collaborative, Clinical Directorate, Primary Care Liaison Group and the Mental Health and Learning Disability and Autism Alliance, all of which the ICB Board would be briefed on over the coming months.

Lincolnshire is one of five patches in the East Midlands region along with Nottinghamshire, Leicestershire, Derbyshire and Northamptonshire and there is a considerable amount of work to be carried out on the regional footprint.

Lincolnshire's reputation is on the up and considerable progress has been made over the past couple of years with organisations working closely and jointly together to improve service provision, but there is still a considerable way to go.

In summary, there is a lot of work to be carried out and there will be some challenges going forward and no doubt difficult decisions to be made, but Mr Turner reinforced his earlier message about looking forward to working with all the ICB Board going forward and ensuring the needs of the people of Lincolnshire are front and centre in all decisions.

Sir Andrew Cash commented that the aspiration for Lincolnshire is to become the best delivery and transformation system in the country, and certainly in the East Midlands region.

Professor Sir Jonathan Van-Tam asked if the ICB could consider within its mission, not only about equality of access and outcomes but also comparability in terms of the wider East Midlands patch. In summary Lincolnshire could have very equal outcomes that could be poor in comparison to its neighbouring counties.

Sir Andrew Cash advised that the four key aims set out earlier for the ICB are national ones. Clearly there will be a need to establish local aims and objectives and in terms of comparability with the four other systems this is a really important factor but will need to be driven by the data available.

Professor Ward proposed that this was addressed in more detail at a future Board meeting but added that consideration would need to be given as to who Lincolnshire is compared against. It is important to recognise that Lincolnshire is different and would need to be considered in terms of where it sits in the NHSE infrastructure in the East Midlands region but also in comparison to other coastal and community areas.

In Lincolnshire, there are four/five recurring areas where performance needs to improve, and these would need to be a core focus going forward and he was happy to provide detail/information on these at a future Board meeting.

This was discussed and it was agreed to pick this up for a future Board Development Session, which would be taking place on a bi-monthly basis, with a formal business meeting in between.

Action: Mr Turner/Professor Ward

Councillor Woolley added that it was worth noting that North East Lincolnshire does not sit within Lincolnshire itself and consideration is being given, particularly within the public health setting, to a Greater Lincolnshire footprint. However, currently only Lincolnshire sits within the East Midlands region. The ICB needed to be minded of this as there could be times when reference is made to aspects which relate more to the North of the county.

The Board agreed to:

- **Note the briefing.**

22/04

ICB CONSTITUTION, INCLUDING STANDING ORDERS

Mr Burnett advised that under the Health and Care Act 2022, Integrated Care Boards (ICBs) are required to have a Constitution and Standing Orders setting out the Board membership and governance arrangements for the organisation.

The Constitution and Standing orders are key documents for each ICB that sets out various matters including the arrangements that it has made to discharge its functions and those of its Board; its key processes for decision making, (including arrangements for ensuring openness and transparency in the decision making of the ICB and its board) and arrangements for managing conflicts of interest.

To support the process for the development of the ICB Constitutions NHS England developed a Model Constitution Template as a starting point. This was accompanied by a set of Supporting Notes and Transcript Numbers.

During the process of preparing for the establishment of the ICB, Lincolnshire Clinical Commissioning Group working with designate ICB leaders, have engaged with key local stakeholders in developing the constitutions for NHS Lincolnshire ICB before proposing them to NHS England. This included engagement with each of the NHS Provider Trust/Foundation Trusts, and the Local Authority.

Mr Burnett and Mrs Ellis-Fenwick both supported the process throughout, and the Model Constitution Template was updated on several occasions in recent months to reflect the latest changes to legislation as it has passed through the parliamentary process. It was also reviewed by the CCG legal advisors Capsticks.

The NHS Lincolnshire ICB Constitution and Standing Orders was submitted to NHS England in May 2022 and approved on 1st June 2022.

Following the approval of the Constitution and Standing Orders they were published on the NHS England website and NHSE have brought the Constitution into effect through the order that established ICBs on 1st July 2022, and as issued on the 29th June 2022.

Mr Burnett added that the Audit and Risk Committee will be requested to review the Constitution during the first nine months of the ICB and to recommend any amendments to the ICB Board.

The ICB Board was asked to note the process taken in developing the Constitution and engagement with other organisations in the ICS and approval of the Constitution and that it has now been brought into effect on the establishment of the ICB.

The ICB considered the document presented. Mrs Pomeroy referred to the reference in the Constitution to an annual assessment and criteria and whether that will involve pulling together a set of key performance indicators which demonstrate progression against those to ensure compliance. Mr Burnett confirmed that there will be an NHSE assessment process for all ICBs, although the details had not yet been published but the Board will receive performance information on a regular basis.

Dr Baker referred to 4.5.1 in the Constitution which referenced to ICB Board Members being able to nominate deputies where they were not able to attend a meeting and sought clarification on the process. Sir Andrew Cash and Mr Turner confirmed that attendance would be expected particularly at the formal Board meetings and particularly in light of there only being six a year but at the same time if individuals were not able to attend they should notify the ICB Chair a few weeks prior to the meeting, including the details of who would be attending in their absence. Any deputies would need to be compliant with the criteria for all ICB Board Members.

The Board agreed to:

- **Note the process taken in developing the Constitution and engagement with other organisations in the ICS.**
- **Approve the Constitution and that it has now been brought into effect on the establishment of the ICB.**

22/05

KEY GOVERNANCE DOCUMENTS

ICB Governance Handbook

Mrs Ellis-Fenwick advised that the ICB Constitution is supported by a number of documents which provide further details on how governance arrangements in the ICB will operate. This includes the Standing Orders (as referred to under the previous item) but also the following which do not form part of the Constitution but are required to be published:

- Scheme of Reservation and Delegation
- Functions and Decisions Map
- Standing Financial Instructions
- Terms of reference for the six Committees of the Board that exercise ICB functions and associated review dates
- Financial Procedure Limits
- Committee Handbook

The ICB Governance Handbook should also include key policies and hence the Standards of Business Conduct and Conflicts of Interest Policy was attached at Appendix A.

Mrs Ellis-Fenwick added that the six Committee Terms of Reference were written at a point in time, and it was expected that these would be reviewed by the relevant Committees when they first meet in the coming weeks. In addition, the Committee Handbook includes a series of proposed templates for the Board and its Committees, again these were written at a point of time and Mrs Ellis-Fenwick advised that these would no doubt need reviewing.

If there were any comments she would be happy to receive them for inclusion, noting that she had already been made aware of some typographical changes which would be picked up.

It was noted that any changes to the documents contained within the ICB Governance Handbook would need to be presented to the Board for approval.

The ICB Board considered the document presented. Dr Hindocha advised that as the Board was being asked to approve this document, it was worth noting there would be changes required in terms of primary care membership and delegated responsibilities and functions, e.g. for PCNs, which was duly noted.

Professor Ward advised that in respect of the ICP there is an interface between some of the statutory functions of the County Council and bodies such as the Health and Wellbeing Board and statutory responsibilities of the predecessor CCG which has transferred to the ICB. Currently the detail has not yet been articulated at a national level in terms of how that will work going forward. As such, there are gaps in the governance model, and this will need to be picked up as and when the details became available, which was duly noted.

Mr Burnett added that secondary legislation to the Health and Social Care Act 2022 is still going through Parliament and further information and regulations will be published in due course, which include detail on the ICP.

Councillor Woolley added that earlier that day she had received an email which included draft ICP guidance that is in the process of being worked up.

Mr Turner reiterated Mrs Ellis-Fenwick's comments that the documents presented were written at a point in time and were certainly sufficient but acknowledged that the information would need to be reviewed in around six to nine months' time when the ICB had the opportunity to test it and taken on board all the national guidance which was yet to be published.

Standing Financial Instructions and Scheme of Reservation and Delegation

Mr Gaunt presented both of these documents together and advised that the SFIs set out the arrangements for managing the ICB's financial affairs and covers a number of technical aspects such as treatment of losses and special payments and procurement and purchasing and how the ICB will work with external audit.

The ICB SFIs had been produced using the template provided by NHSE.

The Scheme of Reservation and Delegation (referred to as the SoRD) sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

Mr Gaunt reiterated the previous comments about the content being robust but acknowledged the detail would need modifying as further information and regulations become available.

The Board agreed to:

- **Approve the ICB Standing Financial Instructions**
- **Approve the ICB Scheme of Reservation and Delegation**
- **Approve the ICB Governance Handbook, including Functions and Decisions Map and Committee Handbook subject to the typographical changes identified.**

22/06

ICB COMMITTEES

Mr Turner advised that the ICB will have six Committees. Two of those are statutory to the ICB:

- Audit and Risk
- Remuneration

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

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

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

All six Committees will be Chaired by an ICB Non-Executive Member (NEMs) but will include additional NEM members from within the ICB (only applicable to statutory Committees). The Joint Committees will include Non-Executive Director representatives from the three provider organisations (ULHT, LPFT and LCHS).

As previously referred to, the Terms of Reference for the Committees are included in the ICB Governance Handbook but there is an expectation these will be reviewed over the coming months by the respective Committees.

The Audit and Risk Committee will be Chaired by Mr Pete Moore. The Remuneration Committee and Primary Care Commissioning and Delegated Functions Committee will be Chaired by Dr Gerry McSorley.

The Service Delivery and Performance Committee will be Chaired by Mrs Dawn Kenson, Finance Committee by Mrs Julie Pomeroy and the Quality Committee Chaired by Professor Sir Jonathan Van-Tam.

Mr Turner advised that the ICB Remuneration Committee will consist of all of the ICB Non-Executive Members (NEMs) with the exception of Mr Pete Moore as Chair of the Audit Committee, which is standard governance practice.

The membership of the rest of the Committees was set out in the document presented.

Mr Turner added that work on the ICB Committees had been taking place for a number of months with several operating in shadow form, and each one was supported by an ICB Executive Director.

The ICB Board considered the paper. Mrs Connery advised that the Committees would need to review their frequency of meetings to ensure the right balance was achieved between the governance being proportionate and not completely taken up by transformation and delivery, which was duly agreed and noted.

The ICB Board agreed to:

- **Approve the proposed membership for the ICB Committees.**

22/07

ICB POLICIES

Standards of Business Conduct and Conflicts of Interest Policy

Mrs Ellis-Fenwick advised that the ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services.

In order to ensure, and be able to evidence, that these decisions secure the best possible services for the population it serves, the Board must demonstrate accountability to relevant stakeholders (particularly the public), and probity and transparency in the decision-making process. A key element of this assurance involves management of conflicts of interest with respect to any decisions made.

As required by the Health and Social Care Act 2012, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

The Standards of Business Conduct and Conflicts of Interest policy has been developed in accordance with current guidance issued by NHS England, although this was expected to be updated in the coming months.

ICB policies

Mr Burnett added that as part of the transition process to an ICB, the CCG has been carrying out a review of key policies to ensure these are updated and reflective of any recent changes in legislation.

The ICB Board is required to approve any policies which are referred to directly in its Constitution; hence presentation of the Standards of Business Conduct and Conflicts of Interest Policy.

All other key policies, such as those related to Governance, Clinical, Safeguarding, Information Governance, Quality and Human Resources have been/or are in the process of being reviewed. Those that have already been approved will be made available on the ICB website when it is launched on the 1st July 2022.

Those policies which are still being reviewed will go through the relevant internal approval process and will then be uploaded to the ICB website.

The ICB Board is asked to agree to the approach taken in relation to other key ICB policies.

The ICB Board considered the document. Mr Fahy advised that as a general point of guidance, it was good practice for members of the Board or any Committee to raise any potential areas of conflict with the associated Chair in advance of the meeting, so that the item can be dealt with smoothly, which was noted.

Mrs Ellis-Fenwick advised that a specific section on conflicts of interest and how they are managed had been included in the Committee Terms of Reference to strengthen the process.

Professor Sir Jonathan Van-Tam advised that he could not see any reference in the policy to the expiration of a conflict of interest and indeed whether it was relevant, and suggested this could be picked up with NHSE, which was noted for action by Mrs Ellis-Fenwick.

Action: Mrs Ellis-Fenwick

The ICB Board agreed to:

- **Approve the Standards of Business Conduct and Conflicts of Interest Policy.**
- **Approve the approach taken in relation to other key ICB policies.**

22/08 SPECIFIC LEAD ROLES ON THE BOARD

Sir Andrew Cash advised that there were two roles on the ICB which required specific individuals to be identified which were:

- Conflicts of Interest Guardian
- Freedom to Speak Up Guardian

Mrs Julie Pomeroy had agreed to be the Conflicts of Interest Guardian for a short period in the absence of Mr Pete Moore.

Mr Martin Fahy had agreed to be the Freedom to Speak Up Guardian.

The ICB Board was asked to support those appointments.

The ICB Board agreed to:

- **Approve the appointments of the two individuals identified.**

22/09 INTEGRATED CARE PARTNERSHIP

Mr Turner advised that as referred to earlier in the meeting the establishment of the Integrated Care Partnership (ICP) is one of the two statutory components of an ICS along with the ICB.

The ICB is a statutory authority whereas the ICP is a statutory joint Committee of the ICS.

In terms of the legal process, the ICB has a duty under the new Act to jointly establish the ICP as a statutory joint committee with all Upper Tier Local Authorities within the footprint of the ICS.

It is recommended that the NHS Lincolnshire ICB Board approve:

- The formal establishment by the ICB of the Lincolnshire Integrated Care Partnership as a joint committee with Lincolnshire County Council as per by section 26 of the Health and Care Act 2022.
- The appointment of Sir Andrew Cash, interim ICB Chair, and John Turner, ICB Chief Executive as the ICB representative on the joint committee.
- Note that the membership of the Lincolnshire Health and Wellbeing Board will essentially be the same as the ICP.

The ICB Board considered the paper. Mrs Pomeroy sought clarification on whether there was any conflict of interest between the ICP and the Health and Wellbeing Board or whether they were completely aligned. Mr Turner advised that he had previously talked about simplicity in Lincolnshire with there currently being only one Upper Tier Authority which has a duty to have a Health and Wellbeing Board. Lincolnshire is only of only three areas in the country that has the same set-up.

By way of an example in North and North East Lincolnshire there are six Upper Tier Authorities, each of whom are required to have a Health and Wellbeing Board. As such their ICP has to be an umbrella across all of those and therefore their membership is quite varied across their patch.

Numerous conversations have taken place as part of the various Health and Wellbeing Board meetings in Lincolnshire over the past year with a view to making this as smooth and sensible as possible.

In summary the membership of the Lincolnshire ICP and Health and Wellbeing Board will be entirely consistent. The University of Lincoln and the Local Enterprise Partnership (LEP) will also be members going forward.

Meetings will be held on the same day in the same venue on a quarterly basis having a shared conversation about the health and wellbeing of the Lincolnshire population.

Councillor Woolley concurred with Mr Turner's comments, adding that is about making sure we get it right for Lincolnshire and the co-terminosity which is in place in Lincolnshire is a real positive.

Professor Sir Jonathan Van-Tam advised that he was content with the explanation about the relationship between the ICB, Health and Wellbeing Board and the ICP and did not have any particular issues. However, it was important to ensure the details of how to deal with any potential conflicts was clearly set out – in short a pathway for resolution.

Mr Burnett advised that the Terms of Reference for the ICP would capture that aspect in relation to conflicts of interest.

Mr Gaunt referred to the Integrated Care Strategy and sought clarification on the expectations around when this needs to be developed by. Mr Turner advised that the Strategy needs to be in place by December 2022, but there is already one in place which is the current Health and Wellbeing Strategy which a number of individuals at the meeting have previously worked on together, so no material changes were proposed to that between now and December. During the next calendar year there will be a comprehensive review of all key documents to update and enhance what is already in place.

The Board agreed to:

- **Approve the formal establishment by the ICB of the Lincolnshire Integrated Care Partnership as a joint committee with Lincolnshire County Council as inserted by section 26 of the Health and Care Act 2022.**
- **Approve the appointment of Sir Andrew Cash, interim ICB Chair, and John Turner, ICB Chief Executive as the ICB representative on the joint committee.**
- **Note that the membership of the Lincolnshire Health and Wellbeing Board will essentially be the same as the ICP.**

22/10

AGREEMENTS

Mrs Williamson advised that the paper presented had been prepared to provide the ICB with information on the delegation of Primary Medical Services to ICBs on the 1st July 2022 and an overview of the operating model for the delegation functions including Pharmacy, Optometry and Dental Services (PODs) and the approach for the delegation of complaints functions to ICBs.

Within the paper was information which detailed the work and progress that has been undertaken in respect of the delegation of those services and then transition of PODs from April 2023.

In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHS England to ICBs upon delegation. However, in all cases NHS E/I remains accountable to the Secretary of State for the services, which means that NHSE/I will have oversight, set standards and service specifications for the services.

To ensure that any transition is safe, effective and benefits are maximised, NHSE/I and ICB Designate Chief Executives have agreed a phased transition to our future state through 2022 to 2024.

The ICB Board were recommended to note the Delegation of Services from NHS England to Integrated Care Boards on 1st July 2022 and approval for the Delegated Agreement to be signed by the ICB Chief Executive.

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

- **Note the Delegation of Services from NHS England to Integrated Care Boards on 1st July 2022.**
- **Approve the Delegated Agreement to be signed by the ICB Chief Executive.**

22/11 SCHEDULE OF PROPOSED BOARD MEETINGS AND COMMITTEE MEETINGS

Sir Andrew Cash referred to the schedule of proposed Board and Committee meetings as included in the pack of papers.

The next meeting is scheduled to take place on Tuesday, 26th July. There will be the public session and then a Development Session immediately afterwards.

There will be six formal business meetings and six Development Sessions each year. Dates for 2023 were currently being worked through and would be circulated to the ICB Board Members once finalised.

It was hoped to move the meetings around the county if possible, but this would need to be worked through in terms of suitability and digital access.

The Board agreed to:

- **Note the schedule of Board meetings for 2022.**

22/12 DATE AND TIME OF THE NEXT MEETING

Sir Andrew Cash summarised the discussions that had taken place during the meeting and then thanked everyone for their attendance and drew the meeting to a close.

The next meeting of the ICB Board will take place on Tuesday, 26th July 2022 at 9.30 am at Bridge House, Sleaford.

Chair Signature

Date

Not Delivered
In Progress
On Track to Deliver
Delivered

ACTION LOG - PUBLIC

Date of Meeting:	Tuesday, 26 th July 2022
Agenda Item:	1 (iv)
Reporting Officer:	Sir Andrew Cash, Interim ICB Chair

Date of Meeting	Minute Number	Item	Action	Lead	Due Date	Progress
01/01/22	22/02	Declarations of Interest	To circulate the Declaration of Interest Form to all ICB Board Members for completion and return by Monday, 11 th July 2022.	Ms Bates/All	11 TH July 2022	Delivered but there are still some forms outstanding.
01/07/22	22/03	Introductory Comments	Equality of access and outcomes in comparison to other areas – update/further information to be provided as part of wider public health and population health management information – to a future ICB Board Development Session.	Mr Turner/ Professor Ward	July 2022	Delivered. Presentation to be provided on 26 th July 2022.

Date of Meeting	Minute Number	Item	Action	Lead	Due Date	Progress
01/07/22	22/07	Standards of Business Conduct and Conflicts of Interest Policy	To check whether there is an expiration time period for conflicts of interest.	Mrs Ellis-Fenwick	July 2022	Delivered. Update to be provided at the Board meeting on the 26 th July 2022.

To: ICB Chairs

NHS England
Skipton House
80 London Road
London
SE1 6LH

9 June 2022

Dear Colleague

Introductory message to ICB Chairs from Richard Meddings

I wanted to write to you ahead of 1 July, and Integrated Care Systems being placed on a statutory footing, to properly introduce myself, and to thank you and your teams for the work you are doing.

ICs are already transforming health and care services, making them more joined up and patient centred. The shift to system working offers a huge opportunity to address the deep challenges that the NHS confronts as the Covid response moves into the next phase – one where we focus not just on recovery, but on reform for the future.

As ICB Chairs, you will play a valuable and active role in forging the relationships across and beyond the health service which will provide the foundation for meaningful improvements to be made for your communities over the coming months and years. And as the agenda-setters for the NHS in your respective areas, you are also able to provide leadership and supportive challenge to improve care where you can see and hear from staff and patients it is needed most.

I chaired my first NHS England Board meeting last month, at which I set out my personal areas of focus that will shape the Board's agenda over the coming months.

As Amanda Pritchard set out in her recent [letter to the system](#), we are not setting any additional expectations or priorities on local systems beyond those already set out in the 2022/23 priorities and operational planning guidance, the Delivery plan for tackling the COVID-19 backlog of elective care, and supporting guidance. However, I wanted to share my immediate areas of interest with you directly, as I am sure many of these will be shared by you and your Boards alongside other areas that are particularly relevant to your system.

Clearly there are many other very important, indeed essential, areas where we must maintain momentum, including mental health, community services, children and young people, maternity services and health inequalities, and our collective focus on these areas has not waned. But as I look at the immediate months ahead there are seven areas which are, in my mind, central to success; they are:

1. achieving a marked improvement in the number of patients awaiting treatment and in the length of time people are waiting;
2. improving urgent and emergency care performance and ambulance response times;

3. improving access to primary care;
4. shoring up our workforce, with a focus on both the immediate needs of the service but also the longer-term planning, looking out 15 years, which we have now commenced and where we are drawing on a wide range of external expertise to help us;
5. reviewing our capacity, covering the real time assessment of the number of beds, scanners and workforce gaps, but also dynamically whereby changes (for instance in working practices or in the application of technology) could increase our capacity without needing to add more physical resource;
6. merging the five organisations NHSE, NHSI, NHS Digital, NHS X and HEE by end March 2023, and seizing the organisational effectiveness opportunities that can arise from any such merger, and;
7. supporting the successful establishment and development of ICSs.

The last point is why I am so keen to establish a direct link with you all, and to do everything in my power to support you to succeed. As part of this I would be keen to hear your perspectives on how NHS England can best help you in your role. I will shortly be establishing a regular rhythm of engagement to enable me to hear directly from you, through visits to meet with you and your partners and regular meetings for us to share our insights and experiences. In the meantime, please do share any thoughts or comments with me directly.

In the coming months and years, it is clear to me, the NHS cannot simply do more of the same and expect a different outcome. Instead we need to harness the agility, innovation and 'can do' spirit that marked the NHS's response to the pandemic as we address its impacts. One powerful example of this is the support your organisations have given to Claire Fuller's work setting out a vision for the future of primary care.

In the short time I have been in post, I have had the opportunity to meet with a number of you and have sensed a depth of commitment and ambition which gives me confidence not just in the transformational potential of the ICS and the impact you can individually make at system level in your roles, but also in the contribution you can collectively make as a key part of the new leadership community for the NHS in England.

I look forward to working directly with you and to hearing your views as, together, we work to fulfil the trust placed in us to improve health and care across the country.

Yours sincerely



Richard Meddings

NHS England Chair

Sent via email

John Turner
Lincolnshire CCG AO

NHS England and NHS Improvement
- **Midlands**
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30th June 2022

Dear John

Re: CCG Annual Assessment 2021-22

I write to you in connection to the CCG Annual Assessment process for 2021-22. As you will be aware NHS England has a legal responsibility to review CCGs' performance on an annual basis which historically has been carried out under the auspices of the CCG Improvement and Assessment Framework and, more recently, the NHS Oversight Framework. In 2020-21 the annual assessment was in the form of a self-assessment.

As a result of the continued impact of Covid-19 a simplified approach for 2021-22 has been agreed which involves NHS England undertaking a review against twelve Nationally determined Key Lines of Enquiry (KLOE). The assessment used the CCGs Annual report as one of the main source documents along with the consideration of the views of Health and Wellbeing Boards (HWB).

You will find enclosed in appendix 1 the completed assessment of Lincolnshire CCG for 2021-22. Please could you ensure that this is shared within your organisation and included in the CCGs legacy documents in light of the establishment of Integrated Care Boards from the 1st July 2022.

If you have any queries or wish to discuss further, please do not hesitate to contact.

Yours sincerely,



Oliver Newbould

Director of Strategic Transformation – Central Midlands

NHS England and NHS Improvement

Appendix 1 Self-Assessment template - Key Lines of Enquiry

CCG Annual Assurance 2021-22

Region	Midlands
CCG Name	Lincolnshire
ICS	Lincolnshire
Completed by (name and job title)	Adrian Perks, Assistant Director of Strategic Transformation

Assessment overview:

Theme 1	Quality of care, access and outcomes
<p>1. How has the CCG contributed to ensuring delivery of health services in the priority areas set out in the <i>2021/22 Operational Planning Guidance</i>?</p>	
<p>Evidence: CCG annual report / SOF dashboard</p> <p>The 21/22 operational planning priorities were:</p> <ul style="list-style-type: none"> A. Supporting the health and wellbeing of staff and taking action on recruitment and retention B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19 C. Building 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 D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay F. Working collaboratively across systems to deliver on these priorities <p>The CCG has acted as a proactive and competent lead for system-level working to address priority areas set out in the 2021/22 Operational Planning Guidance.</p> <p>In response to these, the CCG has worked well together to model and plan against the guidance.</p> <p>The ability of the system and its constituent organisations to work together in the event of incidents should be commended, especially in the context of both Urgent & Emergency Care and Covid Vaccination programme.</p> <p>The local success of the Covid Vaccination Programme was celebrated as an example of how the system worked collaboratively to tackle health inequalities and improve population health. Vaccination rates are amongst some of the best regionally and nationally.</p>	

The work on health inequalities has been excellent and outlined later in this report, but the CCG has been key in the organisation and development of collaborative working and innovative solutions and actions in primary care to support acute and vice versa.

UEC pressures has seen significant challenge over the last year and there remains a huge amount to be done to resolve handover delays, flow and capacity in the department, however, there has been strong work in learning from covid and implementing innovative schemes to improve flow and reduce conveyance to ED by working together as a system, led by the CCG.

The system presented as a positive and proactive team with clearly aligned aspirations that will improve the health & well-being of the population of Lincolnshire.

2. How has the CCG monitored oversight of quality and patient experience?

Evidence: CCG annual report / SOF dashboard

The CCG has undertaken significant work over the last year to bring together the functions required to deliver effective oversight of quality and patient experience. This work has included the development of a Quality & Performance Strategy and strengthened clinical leadership and integrated clinical/managerial structures

The CCG Constitution clearly states their guiding principles regarding public involvement and is available to view on their website

The Patient and Public Involvement Non-Executive Director is a key member of the Board, Quality and Patient Experience Committee (QPEC) and champions engagement and equalities at many levels of the organisation

The Non-Executive Director for Public and Patient Involvement offers advice and Legal Duty for Involvement

The CCG aims to continuously improve challenge to the CCG from a patient perspective to influence commissioning decisions. The engagement function is part of the CCG's Nursing and Quality Team and is led by the Director of Nursing and Quality, which ensures that patients and the public are at the heart of CCG decision making

Reports on engagement and outcomes of this are reported to QPEC and Primary Care Commissioning Committee (PCCC) if it is regarding a GP surgery

Updates from the Non-Executive Director and escalation of engagement feedback if required are reported into their Board meetings. important to us that the public sees how their feedback has helped to shape local services and how much we value all feedback and engagement. This is regularly published for members of the public to read

This is set out in their Communication and Engagement Strategy and values are outlined in their constitution

Monthly reports to CCG Committees share an overview of current patient experience and engagement activity

The CCG have provided considered leadership in taking this forward within the emerging national guidance. The developing structures recognise the importance of both local measurement and monitoring and the need for benchmarking data

Clinical quality and oversight arrangements that have been implemented are very strong

The focus on multi-agency work, including Safeguarding, is excellent

3. How has the CCG supported the system to respond to emergency demands and manage winter pressures?

Evidence: CCG annual report / SOF dashboard

The CCG has provided clear system leadership in relation to responding to emergency demands and managing winter pressures

Collectively, the system responds extremely well in the event of a crisis, although sometimes they work less collaboratively on more chronic issues

They have led an Acute Services Review looking at four key pathways; Orthopaedics (elective and non-elective), Urgent & Emergency Care, Acute Medicine and Stroke Services and, through an extensive consultation process, developed a plan which better responds to emergency demands and winter pressures

Most recently this has been ratified and will be passed to the ICB for implementation

There are clear plans in place that capture the contribution of all partner agencies

Performance is reviewed and escalations are always handled in a collaborative way, led by the CCG

The CCG continued to committed officers to attend all LRF cell meetings, TCG and SCGs and daily system GOLD calls took place throughout the first and second wave response and during winter.

Daily system calls (7 days) took place to manage system pressures with additional calls taking place in the event of increased demand and escalation

A winter cell (UEC and Flow) was established to focus primarily on discharges and system bed capacity. The CCG Urgent Care Team led by the CCG continued to monitor and address daily demand through understanding of system pressures, actions, risks and mitigations to support de-escalation producing OPEL reports and liaising directly with the NHSEI UEC team to share intelligence, actions and provide assurance

The ability to respond to the demands and pressures experienced across the system is hindered by known workforce pressures in all constituent parts of the system

Theme 2

Preventing ill-health and reducing inequalities

4. How has the CCG supported actions to address inequalities in NHS provision and outcomes?

Evidence: CCG annual report / SOF dashboard/ Planning Guidance

Addressing Health inequalities is one of Lincolnshire's key system priorities. A system Health Inequalities Programme has been established to take forward this work

Improvement has outlined approach to support the reduction of health inequalities at both national and system level – see below infographic.

The approach – 'Core20PLUS5' defines a target population cohort and identifies '5' focus clinical areas for accelerated improvement. This

approach has been embedded within the Health Inequalities and Prevention Programme

The CCG Chief Executive and the Director of Public Health are jointly leading the plan to put addressing Health Inequalities in the centre of the programme for the developing ICS.

Achievements so far:

- Established system Health Inequalities Programme Board with multi-agency representation, this includes Public Health, Healthwatch Lincs, District Councils
- Developed governance and Health Inequalities Framework, priorities and 2021/22 work plan
- Secured HEPP funding to take forward a multi- agency project focused on the coastal area of Mablethorpe, using behavioural science research to understand and reduce the barriers for people accessing Diabetes Prevention support) and participating in HEPP leadership development programme
- In Lincolnshire, all NHS organisations have identified a named executive board-level lead for tackling health inequalities and a Health Inequalities Executive Leads network has been established across the Lincolnshire system
- Collective leadership focus - NHS Boards have developed five-year Action Plans to increase the diversity of senior leaders
- Participating in the Health Equalities Partnership Programme training and leadership support offer
- Health Inequalities training (Placed based approaches for reducing Health Inequalities) provided to senior staff and programme leads by Professor Chris Bentley

Plans for strengthening leadership and accountability and embedding a system approach to health inequalities:

- Identification of PCN Health Equality Champions - Developing a brief for the role of PCN Health Equality Champions to support PCNs and the PCN Clinical Director Alliance with identifying named leads for each PCN.
- Strengthen accountability to local population including data reporting - The Health Inequalities Programme will work with partners to develop system guidance for inclusion of key HI metrics for internal and public performance reports and implement any national/ regional tools recommended
- Develop as part of ICS – support NHS organisations to serve as ‘anchor institutions’
- Development of differential/ allocative resourcing to address inequalities as part of planning for 2021/22
- Build on Health Inequalities Training provided in 2019 to senior staff and programme leads by Professor Chris Bentley, providing a series of training opportunities on Health Inequalities. This will include continuation of attendance on training made available by the Health Equity Partnership Programme
- The Health Inequalities Programme will work with partners to develop system guidance for inclusion of key HI metrics for internal and public performance reports and implement any national/ regional tools recommended
- Health Inequalities tools tested and fully operational and embedded in the system
- Adoption and implementation of Health Inequalities Impact assessment – HEAT
- Establishing a Health Inequalities Community of Practice, programme Launch and programme of regular HI conferences
- Establish HI Partnership Board

The ICS identified the following key actions for during 2021/21 to develop both inpatient smoking cessation services and a specialist antenatal smoking cessation service to establish:

- Lincolnshire LTP Tobacco Dependency Steering Group
- The prioritisation process for identifying roll out based on areas of greatest prevalence/need based on local data
- A project team and develop plans for inpatient smoking cessations services
- A project team and develop plans for commissioning and implementation of a smoking cessation service within specialist mental health services and learning disability services

The ICS had the benefit of close collaboration and involvement of Lincolnshire's Director of Public Health who leads the system Population Health Management function and whose team support and steer the Health Inequalities planning. Lincolnshire's Public Health division already commission the wider 'One You Lincolnshire' stop smoking service and provide resource & capacity to quickly develop & commission this expansion of stop smoking services in Lincolnshire

The ICS provided system leadership in setting the following targets to address health inequalities with regard to cardiovascular disease:

- Atrial fibrillation (AF) – develop a proof of concept model, manual pulse check in long term condition reviews
- Cardiac rehabilitation - review workforce model and capacity, and develop a trajectory
- Heart failure (HF) - work with ULHT and LCHS to agree the pathway
- Familial hypercholesterolemia (FC) - establish this service, to ensure patients are identified
- Hypertension - work with public health, to reduce the management burden on GPs

The CCG has taken a proactive approach to addressing health inequalities and improving outcomes through adopting an inclusive, collaborative approach with partners, e.g., the local success of the Covid Vaccination Programme was celebrated as an example of how you have worked collaboratively to tackle health inequalities and improve population health. Vaccination rates are amongst some of the best regionally and nationally

The CCG via a system approach that enabled escalation and, as importantly, de-escalation, preserving actions and capacity until needed.

Whilst the pandemic was particularly challenging the system worked well together to both protect the public as far as possible both in hospital and in the community and services associated

There are surge plans in place which are being reviewed and the CCG support learning events following major events, bank holidays and on the back of the pandemic.

Winter pressures and Bank Holiday planning has been in place and support provided from a variety of regional and national teams. There remains challenge in the acute providers in flow and handover delays, with equal difficulty in discharge

The CCG have been working closely with providers and LA teams to work through robust processes, however, due to volumes and capacity issues, this has remained a challenged area over the last year

The CCG are positive in their emergency response and leading and facilitating system meetings across partners.

Excellent work was done to improve the uptake of annual health checks for people with severe mental health problems, learning disabilities and autism with Primary Care and the specialist provider working collaboratively

5. Does the CCG have effective systems and processes for monitoring, analysing and acting on a range of information about quality, performance and finance, from a variety of sources, including patient feedback, analyses of access to services and experiences of service users, so that it can identify early warnings of a failing service?

Evidence: CCG Annual report/ Planning Guidance/ Records of engagement/ Governance & reporting structures

The CCG has been working in shadow form as one CCG and towards ICS for many months

As part of this work the CCG has worked to develop a series of workstreams which are clinically led and have representation from Chairs where appropriate to ensure robust oversight and challenge, in addition to ensuring there is both a clinical view and strategic/leadership view which can be triangulated based on a variety of metrics and measures

These are presented and discussed, and outcomes determined through actions and escalation processes, demonstrating the commitment to triangulating and ensuring processes for performance monitoring and oversight is robust and sees early warnings from multiple angles

There is an effective performance support call, focusing on delivery against planned activity and trajectories to understand dips and trends for the constitutional mandated priorities

All partners including CCGs and NHSEI contribute to discussions to address performance and quality concerns. There is also an interface with the CCG and NHSEI quality team to discuss quality risks and development of system quality governance arrangements

The Quality and Patient Experience Committee (QPEC) has been chaired by the Non-Executive with responsibility for Patient and Public Involvement

The Quality and Patient Experience Committee conducts its role in several ways including scrutinising the clinical effectiveness of commissioned health care providers both in and out of the county

This work involves cross-checking multiple sources of information that the CCG receives, such as complaints data, patient experience feedback, performance data, incidents, infection rates and staffing levels

The Committee can make recommendations and oversee corrective actions and provides assurance to the CCG Board that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CCG does

The CCG has robust financial systems that are tested by internal audit. The system has weekly CFO meetings where performance, risk and opportunities are shared, discussed and escalated as necessary

The Internal Auditors review the effectiveness of systems and processes, providing the Audit Committees and the Governing Bodies with the assurance

The Finance and Performance Committee is chaired by one of the CCG Non-Executive Directors

The Committee was established to provide assurance to the Board that the financial strategy, financial policies and Quality, Innovation, Prevention, Productivity (QIPP) plans effectively support the organisational strategy

The CCG has led an Acute Services Review as the reconfiguration of acute hospital services forms a key part of the Lincolnshire health and care system's transformation plans, including in the most recent articulation through the Lincolnshire's NHS Long Term Plan 2019-24 (which is the local response to the NHS Long Term Plan). This considered Orthopaedics (elective and non-elective), Urgent & Emergency Care, Acute Medicine and Stroke Services

The Lincolnshire plan, developed by the CCG, responds to Lincolnshire's specific strengths, challenges and requirements and clarifies a shared future ambition for health services in Lincolnshire so it can work to make these a reality

Following the CCG-led analysis of population needs, citizen feedback and performance benchmarking eleven priority areas were identified where the health and care system can make the biggest impact in terms of improving the quality and efficiency of care in Lincolnshire

Monitoring, analysis and acting on information about quality, performance and finance is not restricted to CCGs, the governance arrangements established across system partners through the ICS enables a wider system approach

In addition, Local Authorities also support in monitoring performance and quality for instance through regular performance reports to Health Overview and Scrutiny Committee. It is fair to say quality and performance oversight is iterative in this system and developing really effectively under CCG oversight

6. How has the CCG taken account of lessons from managing COVID-19, in a way that locks in beneficial changes and explicitly tackles fundamental challenges, including support for staff, and action on inequalities and prevention?

Evidence: CCG annual report / SOF dashboard

The CCG provided a clear leadership role in the management of the Covid pandemic and associated vaccination programme, with dedicated senior officers assigned to this priority

Throughout the Covid Vaccination Programme colleagues across Lincolnshire worked collaboratively with statutory and third sector partners to develop innovative offers to increase vaccine uptake

Their strategic yet highly practical approach to engagement and involvement with all cohorts has consistently yielded great results.

Merit should be given to the creative work done to address health inequalities and under-served populations

Throughout, system colleagues kept the regional Covid Vaccination Programme Team fully apprised of what had worked well (and not so well) and were happy to share their learning & experience with other systems across the Midlands

This detail was also shared through the regional Team with National colleagues, so this success could be both celebrated and replicated.

The positive, can-do approach adopted by the team was refreshing and offered valued support to struggling systems across the geography of the Midlands and beyond

There was effective engagement with the Midlands regional Covid Vaccination Programme Team, with local experience shared with peers both regionally and nationally

During regional Quality Assurance visits, staff working on this programme consistently reported feeling supported in Vaccination Centres, Hospital Hubs and Primary Care services

Theme 3	People
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7. How can the CCG evidence that it has supported the health and wellbeing of its workforce?
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Evidence: SOF dashboard / Staff survey

The health and wellbeing of staff has been supported through system wide support as evidenced by the system People Plan interventions and they have been able to access all national support offers

One of the key principles of the system is to ensure it is people-centred and focuses on the delivery of the ten objectives of the People Framework

8. How has the CCG contributed to the delivery of the priorities for the NHS workforce set out in the <i>NHS People Plan</i> and <i>2021/22 Operational Planning Guidance</i> , and the implementation of <i>Our NHS People Promise</i> ?

Evidence: 21/22 Planning Guidance / SOF dashboard

The CCG as an employer in the system have supported the work to deliver the people plan and the work of the system people board

During 2021/22 the workforce cell progressed into the 'People Team' as a strategic leaders group reporting to the People Board

Senior people leaders within the People Team provided strategic oversight for the four pillars of the 2021/22 People Plan in addition to their roles in provider organisations

Further engagement with wider system partners e.g., Lincolnshire Care Association (LinCa), Primary Care and the Voluntary sector has progressed well

Theme 4	Leadership
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9. Has the CCG demonstrated effective system leadership and progressed partnership working, underpinned by governance arrangements and information-sharing processes, including evidence of multi-professional leadership?
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Evidence: CCG annual report / Health & Well-being survey / Governance statement return

The CCG has in place robust governance structures and reporting processes to ensure full consideration and monitoring of commissioned services.

The Board has a number of formally constituted Committees in order to discharge its duties effectively and is compliant with statutory responsibilities and functions.

The Quality and Patient Experience Committee (QPEC) is chaired by the Non-Executive with responsibility for Patient and Public Involvement. It triangulates numerous sources of information such as complaints, patient experience feedback, incidents and performance to scrutinise the clinical effectiveness of provider organisations and identify emerging trends or issues. QPEC can make recommendations and oversee corrective actions and provides assurance to the CCG Board that commissioned services are being delivered in a high quality and safe manner. During the year the Committee has considered, for example BAME update Better Births update and Annual Report, Equality and Diversity updates Healthwatch updates, Patient, Public, Involvement and Engagement updates, Provider escalation reports, Quality Performance reports and SEND reports.

The Primary Care Commissioning Committee (PCCC) is chaired by another Non-Executive Director and provides assurance to the CCG over the management of primary care contracts. During the last year the Committee has considered, for example, Quality, Patient Experience and Effectiveness updates including Health Professional updates, complaints updates and results of patient and public consultations such as Lakeside Practice, Stamford, Stackyard Public Consultation and Engagement Report/Stackyard Transfer and Closure of the Woolsthorpe Branch.

The CCG also has four Locality Clinical Committees whose key purpose is to provide the CCG Executive and the Board, with advice in order that it is informed by the CCG members within the locality. This recognises the importance of local knowledge and its application in allowing the CCG to discharge its functions successfully. The Locality Committees also provide a conduit for the Board to communicate effectively with practice representatives and the membership of the CCG and feed in patient, clinical and performance feedback.

The system Quality Surveillance Group ensures a shared understanding across system partners of the quality risks within the system and that appropriate actions have been enacted to address any concerns. The main purpose of this forum is to ensure that quality improvement support is given from system partners as needed, and assurance to all the organisation Quality Leads that required improvement actions are being addressed at pace.

The CCG has led an Acute Services Review as the reconfiguration of acute hospital services forms a key part of the Lincolnshire health and care system's transformation plans, including in the most recent articulation through the Lincolnshire's NHS Long Term Plan 2019-24 (which is the local response to the NHS Long Term Plan). This considered Orthopaedics (elective and non-elective), Urgent & Emergency Care, Acute Medicine and Stroke Services

The Lincolnshire plan, developed by the CCG, responds to Lincolnshire's specific strengths, challenges and requirements and clarifies a shared future ambition for health services in Lincolnshire so it can work to make these a reality

Following the CCG-led analysis of population needs, citizen feedback and performance benchmarking eleven priority areas were identified where the health and care system can make the biggest impact in terms of improving the quality and efficiency of care in Lincolnshire

Theme 5 Finance and Use of Resources

10. Evidence that the CCG has delivered its break-even target in-year and contributed to the reduction of system deficits.

Evidence: CCG annual report / End of year accounts

The CCG reported a £2.4m deficit against a £4.9m deficit plan

The underspend of £2.5m is mainly related to prior year benefits in Continuing Healthcare and primary care and delayed investment, mainly in primary care and mental health

Collectively the system was successful in the delivery of their Capital plan and improved performance

The transition of ULHT from SOF 4 to SOF 3 reflects the significant quality improvements and improved financial governance and control that the Trust and CCG have delivered. However, it is recognised that sustained improvement is dependent on both continued progress within the Trust and on significant developments in system working

The Lincolnshire system remains in SOF4 and continues to work towards a target RSP transition date of the third quarter 2022/23 following at least two full quarters of demonstrable progress against agreed service and financial milestones

A System Improvement Director was appointed in July 2021 and led a system diagnostic and development of an improvement programme that is currently entering its delivery phase

System working is generally considered to be good

In addition, a system Strategic Delivery Plan has been developed which describes a new operating model of care that will be implemented over the next three years

This includes a fully integrated health and care system delivered through a population health-based model of care built around General Practice and 14 integrated PCN/Neighbourhoods

To promote efficiency of service provision the CCG has invested £0.5 million in a Digital First Primary Care Education programme and delivering training and support to the workforce in basic IT skills, enhanced n365 training, digital leadership, group consultations and online consultation Total Triage training. The CCG worked with colleagues across the system to support and deliver telehealth, personalisation and social prescribing, improved records, integrated care and linked data

11. Evidence that the CCG has delivered the Mental Health Investment Standard.

Evidence: CCG annual report / End of year accounts

The system has hit their MHIS target in relation to Mental Health spend

Theme 6 Involve and consult with the public

12. How does the CCG identify and engage with deprived communities, ethnic minority communities, inclusion health populations and people with disabilities (people with learning disabilities, autism or both, people experiencing mental ill-health and people experiencing frailty) and the full diversity of the local population?



Evidence: CCG annual report / Records of engagement (CCG websites) / Governance & reporting structures

Throughout the Covid Vaccination Programme colleagues across Lincolnshire worked collaboratively with statutory and third sector partners to develop innovative offers to increase vaccine uptake.

Their strategic yet highly practical approach to engagement and involvement with all cohorts has consistently yielded great results.

Merit should be given to the creative work done to address health inequalities and under-served populations

Throughout, system colleagues kept the regional Covid Vaccination Programme Team fully apprised of what had worked well (and not so well) and were happy to share their learning & experience with other systems across the Midlands.

This detail was also shared through the regional Team with National colleagues, so this success could be both celebrated and replicated.

Excellent work was done to improve the uptake of annual health checks for people with severe mental health problems, learning disabilities and autism with Primary Care and the specialist provider working collaboratively

The CCG uses data from the Health and Social Care Information Centre (HSCIC) and the Joint Strategic Needs Assessment (JSNA), produced by Public Health, which gives all organisations in Lincolnshire information about health needs of the population. This helps us to target engagement with communities and populations experiencing the greatest need or barriers and make commissioning decisions based on local population health needs

The new county-wide Citizen's Panel provides the opportunity to gather feedback from a representative group of the population as well as involve those not typically engaged with currently. The panel includes individuals who choose to be involved through online engagement such as surveys and online focus groups. The CCG invite panellists' to be involved in specific projects such as carers or people with disabilities and give an opportunity for them to get involved, including those in full-time employment and living in rural locations.

The CCG strongly supports the use of social media as a positive communication channel to provide members of the public, GP practices and other stakeholders with information about what they do and the services they commission. This is a great opportunity for them to listen and have conversations with a wide and diverse range of people, especially with hard-to-reach groups.

The CCH has developed a programme of Involvement Champions, inviting individuals to apply who are keen to increase their involvement and particularly targeting those individuals who are seldom heard and from diverse communities. With support they will be able to promote and support engagement activities and, building up trust and openness with their peers and communities, reach out to those not able or unwilling to engage directly

The CCG worked closely with their acute, community and mental health provider organisations and County/District Councils to share and promote involvement opportunities to all audiences, members and patient groups, extending reach and engagement. They developed a comprehensive database with details of local communities, support groups and contacts for all protected characteristics and more such as homeless charities, food banks, sheltered housing, over 60s walking groups, youth cabinets, newspapers for the blind etc.

In the response to Covid-19 and to increase the up-take of the Covid-19 vaccination amongst all inclusion groups and communities, the CCG established a dedicated Inclusion

and Health Inequalities Team. The team worked to ensure vaccination equity for the following priority groups (age including children and younger people, Black and Asian Minority Ethnic communities, gender, clinically extremely vulnerable, carers, faith/religious groups, learning disabilities, autism, physical health, dementia, mental illness, sensory impairment, homeless and rough sleepers, traveller communities, transient populations, unregistered populations, prisons and areas of deprivation) and targeted communication and engagement activities to reach out to these groups. Some examples of this work have been to ensure that their communication materials are translated into different languages, targeted engagement events with translation services where there is lower up-take across Eastern European communities, taking pop-up vaccination clinics into workplaces, churches, nomad centres, YMCA, co-production with trusted community leaders, Eastern European vaccination days, the production of patient experience videos reaching out to diverse communities and working with deaf, blind and learning disability service users gathering feedback to inform service delivery.

Work with the communications and engagement teams has enabled accessible methods to be considered and embedded in health activities/campaigns to notify and advise diverse communities of e.g., Covid-19/vaccinations and other key health priorities to tackle health inequalities. Regular update reports have been shared with the Equality Forum as well as regular bulletins circulated to CCG's workforce to keep them updated with EIHR developments

The CCG submission articulates information that demonstrates a broad approach to engagement and recognition of the diversity of the communities and hard to reach groups. The effectiveness of working across partner agencies within Lincolnshire has been key to understanding the local population needs and developing effective ways to engage.

Public Meeting of NHS Lincolnshire Integrated Care Board

Date: 26th July 2022

Location: Bridge House, Sleaford

Agenda Number:	4 (i)
Title of Report:	High Level Report: Lincolnshire Health Inequalities Approach
Purpose:	Sandra Williamson Director for Health Inequalities, Prevention and Regional Collaboration
Appendices:	Appendix 1 – Health Inequalities 21-22 Year End Report

1. Key Points for Discussion:	<p>The attached summary report details the progress update on Health Inequalities for 2021/22 and an overview of the approach for 2022/23.</p> <p>Nationally, NHS England and Improvement has outlined the approach to support the reduction of health inequalities at both national and system levels – ‘Core20PLUS5’. The approach defines a target population cohort – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.</p> <p>This approach has been embedded within our Health Inequalities and Prevention Programme.</p>
2. Recommendations	<p>The ICB Board are recommended to note the high-level briefing report and endorse Lincolnshire Health Inequalities approach for 2022/23. At a future development session of the ICB we would like to take the opportunity for more in-depth session and detail briefing.</p>
3. Executive Summary	<p>The purpose of the report is to provide:</p> <ul style="list-style-type: none"> • an overview of the progress that has been made during 2021/22 on delivery of our Lincolnshire ICS plans to <i>tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire.</i> • Key highlights of the Lincolnshire approach and how ‘Core20PLUS5’ and Health Inequalities will continue to be embedded in all our ICS system work for 2022/23 <p>Background</p> <p>In Lincolnshire, over the last 18-24 months the ICB Chief Executive (formerly the Lincolnshire Clinical Commissioning Group Chief Executive) and the Director of Public Health co-sponsor the development of the Lincolnshire ICS Health Inequalities programme to put reducing Health Inequalities at the centre of the key priorities for the ICS.</p>

This is led and delivered by Director of Health Inequalities, Prevention and Regional Collaboration and Public Health Consultant, working collaboratively ICB colleagues, system programme leads, Primary Care Networks (PCNs), NHS Provider Trusts and partners across our Integrated Care System (ICS).

The Covid 19 pandemic has shone a harsh light on the inequalities experienced disproportionately by some groups. With our shared ambition we have increased our collaborative working which has strengthened our ability to drive impactful action to reducing inequalities, focusing on understanding the inequalities in how our services are used, and then changing how they are delivered and prioritised, with practical actions for providers and clinicians.

Strong collaboratives have been formed amongst NHS organisations, Primary Care, Health and Wellbeing Boards, Local Authority Public Health, Social Care and children's services, voluntary sector organisations. Working collectively to address agreed key priorities, and work at a local level to better understand community needs and deliver services which address the causes of inequalities.

System leaders are aware of how the Inverse Care Law operates in this large, rural county, and are looking to build on work on Population Health Management to ensure an innovative and effective approach to helping those who need the most help.

A Lincolnshire Framework for Action has been developed to support this and will be integral to the design and delivery of services going forward and will be part of a long-term programme, embedding the principle that action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

We have a Lincolnshire Health Inequalities Programme Board and Health Inequalities Improvement network in place - bringing together stakeholders from across Lincolnshire's health and care system to lead on this important programme of work. We are currently exploring how a shared and joint governance oversight of our work to tackle Health Inequalities will be developed, as a key element of this collective endeavor for the ICS, ICB, ICP and our Provider Colleagues.

2021/22 Year End Report

The attached 2021/22 Year End Report (Appendix 1) provides details of progress against the National Five Strategic Priorities and 'Core20PLUS5' as well as our local priorities and in meeting Lincolnshire ICS objectives.

The first Health Inequalities workshop was held on the 19 May 2022. 89 people attended the event which was held virtually. Attendees came from a range of organisations across the Lincolnshire system including County and District Councils, Provider Trusts and CCG. Feedback from attendees has been really positive.

The Health Inequalities Community of Practice (CoP) was formerly launched at the workshop. The CoP provides access to a range of useful information and guidance on Health Inequalities, including Tools and data as well as a discussion forum.

A new Lincolnshire Health Inequalities Dashboard was launched in April 2022, developed by the Health Inequalities Programme in conjunction with colleagues from the Arden & GEM Commissioning Support Unit (CSU) Advanced Analytics Team.

The dashboard, which is available via the GEMIMA platform, is the first stage of work providing access to key Health Inequalities metrics at Primary Care Network (PCN) level.

Lincolnshire approach - Health Inequalities and Prevention Programme Overview 2022/23

The vision of the Health Inequalities programme is:

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

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

We will tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire to achieve our ambition - a year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire.

We will achieve this through action to address and use our resources (people, time, and money):

- **Access to effective Treatment, Care and Support** – to improve the provision of and access to healthcare and the types of interventions planned for all – for example ensuring health literacy is supportive; ensuring there are health inequalities impacts for all commissioned services. Providing exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes.
- **Prevention** - to reduce the causes, such as improving health lifestyles – we will work with Public Health colleagues to ensure the NHS maximises its contribution to prevention through embedding preventative approaches into pathways which focus on smoking, healthy diet, reducing harmful alcohol use and increasing physical activity. This will include targeted programmes which promote healthy ageing, and which support people known to be at high risk of developing long term physical and mental health conditions
- **Wider determinants** - to improve ‘the causes of the causes’ – we will work with partners as part of the Lincolnshire Anchor Institution partnership development to ensure the work of the ICS delivers wider social impact e.g., increase access to good work, improving skills, housing and the provision and quality of green space and other public spaces

Addressing health inequalities requires the actions of multiple organisations working together to co-design services which are responsive to the local community. This may include partnering with organisations within the health care systems, such as general practices and community services, other public bodies, such as local authorities, voluntary sector organisations and communities themselves. Taking a whole system approach to target intervention and/ or actions for the 20% most deprived areas in Lincolnshire and identified inclusion health groups – would involve actions at 3 levels:

Strategic Approach	Tactical Approach	Operational Approach
How do we address the causes – the wider determinants of health inequalities?	How do we plan our service delivery and commissioning across Lincolnshire to help address, rather than exacerbate, inequalities?	How can we change what we do in frontline services to ensure people from coastal, rural, and deprived communities can access them?
How do we support wider determinants, pathways and commissioning between NHS and other services e.g. the right home environment is essential to health and wellbeing, and the condition and availability of good housing can have a significant impact on improving health	How do we support investment in evidence-based prevention services where we know this will improve outcomes and will focus this investment in the 20% most deprived areas in Lincolnshire and with inclusion health groups?	How can we develop tailored based interventions based on identified ‘plus’ population cohorts built on the analysis of ‘Core20PLUS5’?

A summary of the **2022/23 Health Inequalities Programme Plan** is detailed below outlining key areas of focus for the Programme this year. Feedback from NHSEI on this year’s plan submission has been very positive. The plan has been reviewed in the light of the recent report from the NHS Race & Health Observatory Report - Ethnic Inequalities in Healthcare: A Rapid Evidence Review to ensure that recommendations are incorporated within it.

Workstreams include:

Embedding a system approach to health inequalities:

- Implementing Health Inequalities tools such as the Health Equity Assessment Template (HEAT) and embedding within ICS governance and project management processes, within Lincolnshire NHS organisations and ICB system transformation programmes.
- Providing a regular programme of Health Inequalities Training and Development – priority for 2022/23 HEAT. HEAT training package to be provided to all NHS staff and training delivered by end of September 2022
- Continued development of the Health Inequalities Community of Practice, building and supporting a network of Health Inequalities Champions within system programmes, ICB, NHS Trusts and PCNs
- Planned programme of Health Inequalities workshops and annual conference planned to take place in Q3/Q4
- Development of differential/allocative resourcing to address Health Inequalities by embedding within service redesign and transformation the principle of targeting resources according to need i.e. groups experiencing health inequalities
- Development of ICS Health Inequalities Strategy by September 2022: agreeing key priorities and including Channel Strategy/Approach to ensure equitable access and mitigate against digital exclusion

Prevention:

- We will continue to develop through our population health management approach to ensure that people are identified and supported to manage their condition at the earliest possible stage, with a greater focus on services (e.g., practices, NHS providers) working in the most deprived areas for all service and quality improvement plans.

- Implement NHS Long Term Plan Tobacco Dependency Services (Acute inpatients, Mental Health and Learning Disabilities services, smoke-free pregnancy pathway) during 2022/23. On target for phased implementation during Q2 for Maternity and Mental Health and Q3 for the Acute inpatient pathway.
- Establish Prevention Oversight Group with key partners to incorporate Weight Management, Alcohol, Tuberculosis as part of the delivery of the NHS Long Term Plan.
- Addressing the barriers to diabetes prevention in Mablethorpe as identified through the HEPP (Health Equity Pilot Project) which is a multi-agency project. Implementation of the solutions identified to overcome these barriers includes recruitment of health and wellbeing coach working within Marisco Practice (One You Lincolnshire are engaged to support this) and redesign and issuing of new communication materials using behavioural sciences taught in our project. On target for completion by September 2022.
- Work in partnership with all NHS organisations, Local Authority, Primary Care, and wider partners to establish CVD Prevention and Respiratory programme as part of the 2 clinical priority areas identified within the national 'Core20PLUS5'. Blood pressure identification and optimisation is a key priority for 2022/23 and target ambition to achieve 74% (of patients identified receiving intervention) to prevent heart attacks and strokes. This is supported by the Public Health Team and Know Your Numbers increasing public awareness and promoting the wide range of services available for people to support them manage their blood pressure.
- Vaccinations: The Lincolnshire Covid 19 vaccination has taken various approaches over the last 19 months to ensure that health inclusion is at the core of the service that we provide. Working with our partners including Primary Care and Community Pharmacies to provide ease of access for patients, targeting low uptake areas/population groups and engagement with communities as part of the Health Inclusion Strategy. Adopting the learning from our Covid vaccination work to develop our continued health inclusion focus with tailored/ targeted solutions to address inequalities in uptake of Covid, Flu and Pneumonia vaccines for 2022/23.
- Childhood Immunisations: Local Authority work underway to research and develop an action plan to address inequalities in uptake of childhood immunisations. On target for completion by October 2022.
- Childhood Obesity: Lincolnshire County Council is piloting a Child and Family Weight Management Service over two years from September 2022. This service is designed using a progressive universalism model in order to ensure both a universal offer and targeted action to address health inequalities in childhood obesity and overweight. This represents a significant investment of Public Health Ringfenced Grant monies over 2 years.

Intelligence, data, and analytics:

- Continued focus on supporting programmes with access to Health Inequalities data; further develop system Health Inequalities key measures to assess how well services are performing in the 20% most deprived areas of Lincolnshire and with the most vulnerable groups to ensure that provision/ and or resources reaches out and meets the needs of all people in the community, those facing disadvantages.
- Working with the Population Health Management Programme and the Lincolnshire network of analysts supported by the Public Health team and Arden & Gem CSU on the ongoing development of system KPIs and dashboards which will support internal and public performance reports to support our ICS, ICB, ICP and our Provider Colleagues.
- Maintaining the focus on improving data collection such as ethnicity data across all NHS Providers and Primary Care and the needs of inclusion health groups and intersectionality – captured as part of standard reporting.

Support to Programmes and Change Initiatives:

- The Health Inequalities Improvement Team will provide support with undertaking HEAT reviews for service change/ quality improvement opportunities, identifying the people who currently have the poorest outcomes (access, experience, outcomes)

	<p>and optimising opportunities to reduce the Health Inequalities gap and mitigating against any potential adverse impacts.</p> <ul style="list-style-type: none"> • Primary Care Networks (PCNs) play a vital role in reducing health inequalities. PCNs are supporting patients daily through a proactive approach to identify and support those patients at the risk of worsening health. Each PCN has put into place a health inequalities improvement intervention for identified patient groups who have poorer health outcomes – on target for completion by end of Q2. • Work in partnership with programmes, NHS Trusts, Primary Care, and key partners in the ongoing review of current access arrangements for all services (current and new) to ensure that services are delivered or commissioned in ways which optimises access for people from disadvantaged groups. This includes considering geography, transport, buildings, health literacy and digital inclusion. • Support an approach with Clinical Care Directorate for the development of care and disease pathway improvements that focusses on the 5 Clinical Priorities identified in the national ‘Core20PLUS5’ on bringing together key clinicians and professionals across primary, community and secondary care underpinned by a population health management approach and targeted intervention to support the 20% most deprived and inclusion groups.
4.	Management of Conflicts of Interest
	Not applicable
5.	Risk and Assurance
	Risk Register management and oversight through the Health Inequalities Programme
5.	Financial/Resource Implications
	Not applicable
6.	Legal, Policy and Regulatory Requirements
	<p>ICSs will need to comply with duties to reduce inequalities between patients in both their ability to access services, and the outcomes achieved (health and social care bill sections 14Z35 and 14Z2).</p> <p>ICSs will have duties to promote integration across health services, health-related services and social care services where it would reduce inequalities in outcomes and access for patients (under section 13N of the NHS Act 2006).</p>
7.	Health Inequalities implications
	Not applicable
8.	Equality and Diversity implications
	Not applicable
9.	Patient and Public Involvement (including Communications and Engagement)
	Not applicable
11.	Author(s)
	Not applicable
12.	Sponsoring Director/Partner Member/Non-Executive Director
	Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration Sandra.williamson6@nhs.net

Appendix 1

Health Inequalities Programme

2021/22 - Year End Lincolnshire CCG/ ICS Report



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1. What are Health Inequalities?

Health inequalities are avoidable, unfair, and systematic differences in health between different groups of people.

But the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status.

Health inequalities can therefore involve differences in:

- **health** status, for example, life expectancy and prevalence of health conditions
- **access** to care, for example, availability of treatments
- **quality and experience** of care, for example, levels of patient satisfaction
- **behavioural** (lifestyle) risks to health, for example, smoking rates, alcohol consumption, diet, physical activity
- **wider determinants** of health, for example, access and opportunities in relation to jobs, housing, education and welfare services

People experience different combinations of these factors, which has implications for the health inequalities that they are likely to experience

(Source: Kingsfund)



Those at high risk include:

- Socio economic factors e.g., income, availability of work
- Protected equity characteristic: e.g., BAME; religion; disability; LGBT+
- Socially excluded e.g., homeless; Gypsy/Roma; veterans
- Geography: e.g., rural, coastal

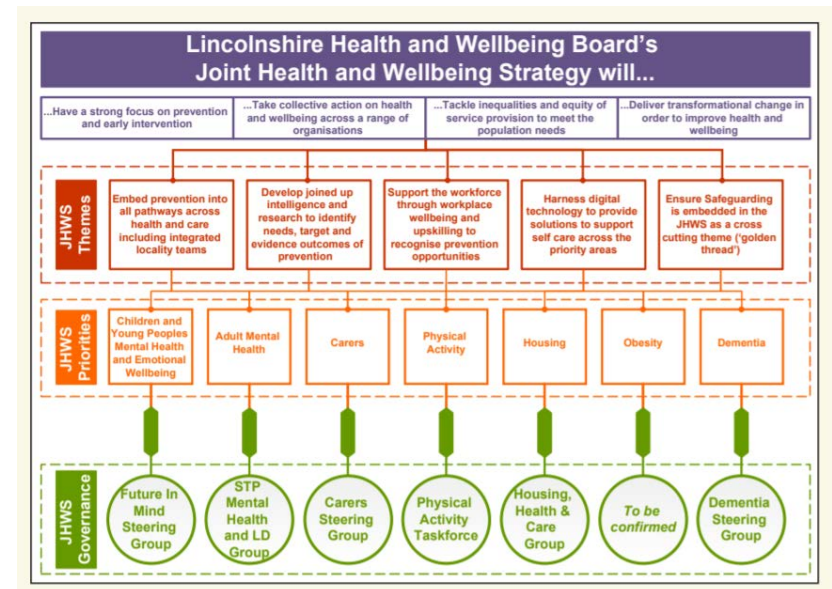
2. What is the Local Picture?

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

In more recent times the gap is widening. It has been ten years since the publication of The Marmot Review. Over the last decade health inequalities have widened overall and the amount of time people spend in poor health has increased. Increases in life expectancy have slowed since 2010 with the slowdown greatest in more deprived areas of the country.¹

The challenge to respond to health inequalities and meet our legal duty has therefore never been greater. COVID 19 has also had a significant impact.

In Lincolnshire our shared Joint Health and Wellbeing Strategy² 2018 aims to: have a strong focus on prevention and early intervention; ensure a focus on issues and needs which will require partnership and collective action across a range of organisations to deliver; deliver transformational change through shifting the health and care system towards preventing rather than treating ill health and disability; focus on tackling inequalities and equitable provision of services that support and promote health and wellbeing.



¹ [Report: HEALTH EQUITY IN ENGLAND: THE MARMOT REVIEW 10 YEARS ON](https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on) the following evidence was published: <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on>

² <https://www.lincolnshire.gov.uk/downloads/file/2613/joint-health-and-wellbeing-strategy-for-lincolnshire-2018-pdf>

3. Lincolnshire ICS – Deprivation and Health Inequalities

The map below shows distinct pockets of deprivation along the east coast. East Lindsey has high levels of deprivation, with **resort towns such as Skegness and Mablethorpe among the 10% most deprived localities in England**. Boston and South Holland also have high levels of deprivation.

Lincolnshire’s towns and urban areas contain **pockets of both deprivation (comparable to the eastern coastal areas) and affluence**, this includes western settlements such as Lincoln and Gainsborough.

Health is one of the components from the IMD, which measures risk of premature death and quality of life via physical health metrics.

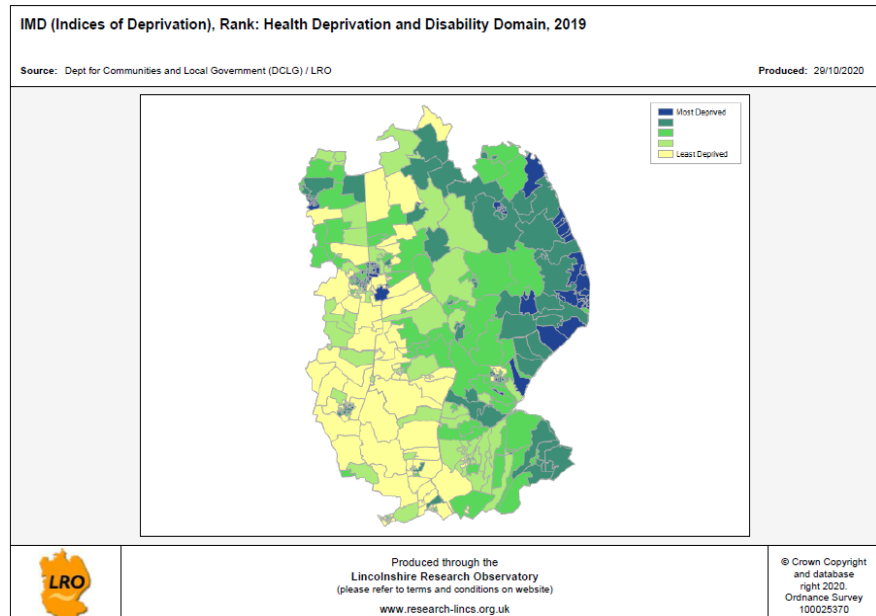
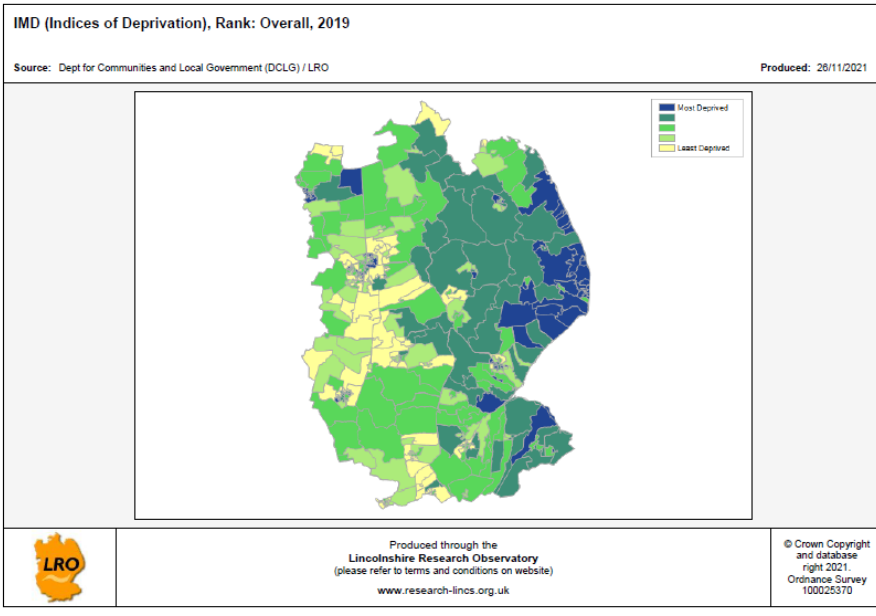
The map below shows that there are **disparities in health deprivation**. This mirrors the map of overall deprivation on the left. It shows that high performing areas, in dark green, are concentrated in west Lincolnshire, while localities on the east coast have high levels of health deprivation. There are also concentrations of poor health outcomes in Lincoln.

The maps of the 2019 **Indices of Multiple Deprivation** shows the variation across Lincolnshire - gaps between different areas of the county as well as different groups within the population.

Key messages:

* Darker shading – higher proportion live in most deprived

* Many health and healthcare usage indicators are worse in areas with higher deprivation



Access to Services

Due to the rural and coastal nature of Lincolnshire, the county faces specific challenges around deprivation, homelessness, an increasingly frail and elderly population, as well as an increasing migrant population.

As a rural and coastal county, Lincolnshire faces a series of interlinked challenges, including sparsity, poor transport and digital infrastructure compared to urban counterparts, contributing to social isolation. People have to travel further to access services and many communities have limited or no mobile phone and broadband coverage.

The Chief Medical Officer's Annual Report in 2021 outlines evidence of a significant health service deficit in coastal areas in the UK, in terms of lower recorded service standards; poorer performance against cancer indicators and higher emergency admissions.





The report highlights those coastal areas that are also sparse – such as Lincolnshire – also struggle to reach the critical mass needed to sustain services

Coastal Health

- 83% of the population on the coast live in areas within the 20% of England's most deprived
- Over 30% of population living with lifelong limiting conditions on the East coast
- Over 30% of registered population over 65 (compared to 18% in England)
- High levels of temporary residences (the coastal strip home to more than 200 caravan sites and c25000 static caravans)

Life expectancy is a key measure of a population's health status. Figures for Lincolnshire as a whole compare well with the national figure, both being 79.5³ for males and 83.0 compared with 83.1 for females⁴. However, the difference in both life expectancy and healthy life expectancy between different areas within Lincolnshire is stark and demonstrates the level of health inequalities that people face within our County.

The following table shows the figures for the highest and lowest areas in Lincolnshire: Source: Office for National Statistics (ONS) - * Life expectancy at birth for males/females, 2017--2019 and **Healthy life expectancy for males/females, 2017-2019

Life Expectancy				Healthy Life Expectancy			
	Most deprived quintile	Least deprived quintile	Absolute Gap		Most deprived quintile	Least deprived quintile	Absolute Gap
	74.1	83.5	-9.4		52.3	70.7	-18.4
	78.7	86.4	-7.7		51.4	71.2	-19.8

³ Office for National Statistics (ONS) , Life expectancy at birth for males, 2013-2017

⁴ Office for National Statistics (ONS) , Life expectancy at birth for females, 2013-2017

4. Programme Overview

Vision:

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

Aim:

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

Ambition:

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

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

This is led and delivered by Health Inequalities SRO, Health Inequalities Programme Lead and Team, working collaboratively with Public Health colleagues, system programme leads, PCNs, Trusts and partners across our ICS to:

- Ensure everyone has opportunity to improve health and wellbeing
- Level-up health and care provision to ensure our communities in highest deprivation and need get the resources needed to minimise inequalities including ability to develop local bespoke solutions to start to surface unmet need
- Facilitate organisations to join on PCN footprints as a key partner in the community and offer joined up/ co-ordinated care where people receive most of their health and care services in the community and recognise the key role locally for the voluntary sector in supporting particularly excluded groups
- Ensure all plans and policies put forward take account of Health Equity assessment through adoption of the 'Health Equity Assessment tool (HEAT) and supporting clinical services/ colleagues in recognising the importance of wider determinants on health
- Embed greater focus on prevention within the NHS, working with local partners, to help prevent or lessen impact of illness. This will be important in improving health equity.
- Embed a population health management approach in using data, insight and best evidence to take action to reduce health inequalities and evaluate impact

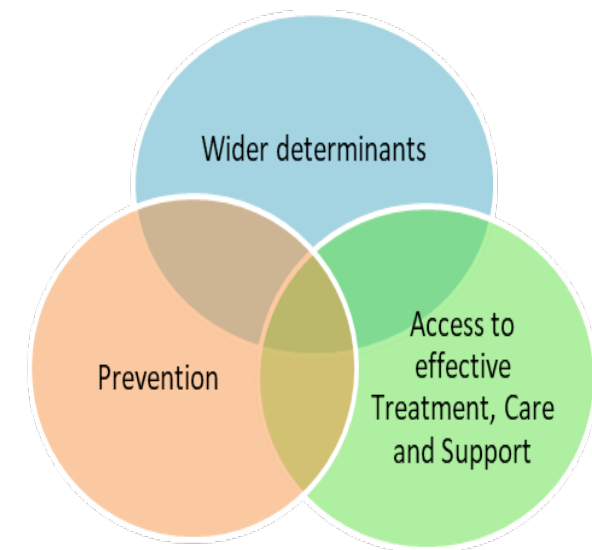
- Improve understanding of our local population and local health needs, through using the joint strategic needs assessments (JSNAs) and the collation of additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.
- Work in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we serve to improve health and healthcare for the local population.
- Ensure we seek the views of patients, carers and the public through greater emphasis on co-production and co-design with people with lived experience is embedded in service redesign by embedding personalisation within our approach

We will tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire to achieve our ambition - a year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire. The Lincolnshire Health Inequalities programme focuses at 3 levels and will take a place-based approach which requires collaboration and partnership working to improve population health and tackle health inequalities:

We will achieve this through action to address:

Access to Healthcare – to ensure exceptional healthcare for all through equitable access, excellent experience, and optimal outcomes.

- **Prevention** - to reduce the causes, such as improving health lifestyles – embedding focus on smoking, healthy diet, reducing harmful alcohol use and increasing physical activity
- **Wider determinants** - to improve ‘the causes of the causes’ working with partners as part of the Lincolnshire Anchor Institution partnership development to increase access to good work, improving skills, housing and the provision and quality of green space and other public spaces



Reducing health inequalities and improving health equity is everyone's business and will be a “golden thread” through all our work and at all levels.

Nationally, NHS England and Improvement has outlined the approach to support the reduction of health inequalities at both national and system levels – delivered through Five Strategic Priorities and ‘Core20PLUS5’.

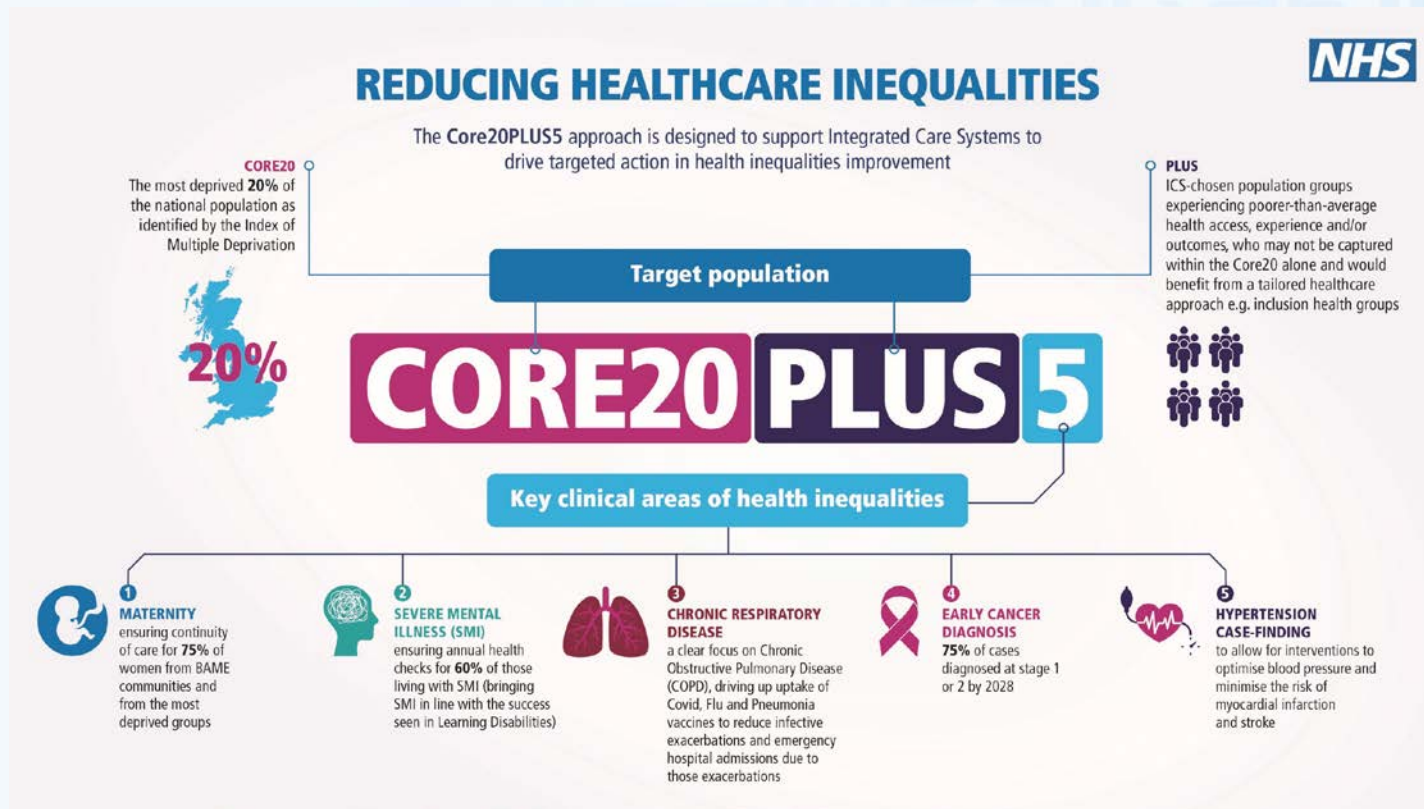
The approach – ‘**Core20PLUS5**’ defines a target population cohort (20% most deprived and ethnic minority communities and ICS locally determined population groups) who experience poorer-than-average health access, experience, and/ or outcomes who would benefit from a tailored health care approach and identifies ‘5’ focus clinical areas for accelerated improvement. This approach has been embedded within our Health Inequalities and Prevention Programme

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

- Priority 1 - Restore NHS services inclusively - By understanding waiting lists, DNAs, cancellations (all broken down by ethnicity and IMD quintiles), waiting well
- Priority 2 - Mitigate against digital exclusion - Engage virtual consultations across boundaries, use of remote tech, digital literacy, supply data packages
- Priority 3 - Ensure datasets are completed and timely -Prioritising improved quality of clinical data; attention to ethnicity variation in access to health, improving IMD at all touchpoints in the system and shared
- Priority 4 - Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes - Through vaccinations, AHCs, CVD prevention, COPD identification and management
- Priority 5 - Strengthen leadership and accountability

5. Health Inequalities Programme Update

5.1 CORE20Plus5



Target Population - Core 20Plus. Within Lincolnshire, we have identified our Core 20Plus population as:

- The 20% most deprived communities as identified by the Index of Multiple Deprivation (IMD) – this equates to c120,000 people, 15% of Lincolnshire population
- Plus - Ethnic minorities (c101,000 people, 13% of Lincolnshire), the largest ethnic minorities group being “any other white background” (8.2%) - a significant proportion of this group are people from an Eastern European background
- Plus - ICS locally determined population groups (evidence and insight based)



Locally determined population groups who experience poorer-than-average health access, experience, and/ or outcomes and may not be captured within the CORE20 alone include temporary residents, traveller communities, homeless people, rural and coastal communities, farming and military families.

Although local data is often limited and information on service uptake and outcomes can be difficult to segment in relation to these groups of our population, insights, and intelligence to date from service providers and system programmes have shown these to be key groups within Lincolnshire for whom health inequalities in access, experience and outcomes can be significant.

Inclusion Health: Defining Lincolnshire 'Plus' population groups - examples



Farming &
Rural



Temporary
Residents /
Travellers



Military
Families



Eastern
European
Communities



Homeless

Mental Health Transformation Programme and Neighbourhood Teams working together with Partners have identified the significant challenges people from our homeless communities' experience in accessing and engaging with Health Services - the **Holistic Health for the Homeless Team**, which has been established within the City of Lincoln, is enabling mental health and health services to engage more effectively with and provide tailored support for this population group.

The rurality and coastal nature of Lincolnshire, provides additional challenges for communities living and working in those areas, where public transport links are extremely limited and distance to access health services is greater than in non-rural areas of the County. Issues that have been highlighted include integration, isolation, employment, and housing; all of which contribute to people experiencing poor mental health and other associated health problems. Local discussions in Mental Health Services and transformation have been identified that a large challenge with supporting the communities is being able to connect with them, establishing trusted relationships that enables people to identify what is available and feel safe to access help.

Our Covid19 vaccination work has included tailored approaches to support uptake of specific health inclusion groups e.g. Homeless, Travellers Community and people with Eastern European ethnicity population groups, where analysis shows uptake is lower than average. Lincolnshire's Health Inclusion Strategy for Covid vaccinations, targets low uptake in areas of greatest deprivation and ethnic groups with lower uptake than the whole population (and uses our learning to date as well as data dashboards to monitor progress and tailor responses to increase uptake. Flu vaccination uptake rates mirror those of Covid 19 vaccinations, being lower in most deprived areas and "white other" groups (particularly those from an Eastern European background).

Military families are another key group in Lincolnshire who can experience poorer access, experience, and outcomes – the Maternity and Neonatal Programme, working in Collaboration with the Maternity Voice Partnership, have been awarded funding for 2 years to pilot a new service to support Military Families.

5.2 Progress against NHSEI Five Strategic Priorities in 2021/22

Priority	2021/22 Progress	Performance
<p>Priority 1: Restoring NHS services inclusively</p>	<p>Our Weekly system performance tracker includes elective admissions and first outpatients' reports, with activity broken down by ethnicity and deprivation. We have completed analytics "deep dives" on First Outpatient appointments (breakdown of recovery and DNAs by ethnicity, deprivation, specialism) and Waiting List Recovery (by ethnicity, deprivation, age, PCN area, specialism). Results have been presented at the Planned Care, Cancer and Diagnostic System Boards. We have also completed initial analysis of elective waiting lists times by deprivation/ethnicity.</p> <p>As well as producing the weekly Cancer dashboard, a Health Inequalities data analysis drill-down has been completed for Cancer First Outpatients – waiting times and Did Not Attends (DNAs) focussing on type of appointment offered (virtual versus face to face) – analysis by age, deprivation, and geography.</p> <p>We can monitor screening uptake (Breast, Bowel and Cervical) which is now integrated within our Cancer Dashboard to provide an understanding of areas of low uptake, variation and working with the Primary Care Networks (PCNs) to develop improvement plans for 2022/23.</p> <p>Implementation of Personalised Follow up Pathways (Cancer) and Living with Cancer (LWC) interventions to reduce variance in experience and ensure equity for patients in all communities in Lincolnshire. Utilising data and insight from across system to inform future service delivery models.</p>	<p>Restoration of Outpatient access – 82.2% restoration in our most deprived communities compared to 95.5% in our least deprived communities. Higher restoration seen for our White Irish (137%), Any Other Black background (129%) and White and Black Caribbean (124%), however numbers are low with 890, 195 and 304 attendances respectively in 2019/20. This is compared to our White British (87%) and Any other White Background (92%).</p> <p>Restoration elective admissions – Fairly Equitable restoration in 2021/22 at ~91% for all communities, ranging from 89.6% to 93.6% across deprivation deciles with the most deprived at 91.6% and the least deprived 92.1%.</p> <p>Restoration of emergency admissions – a faster restoration for our least deprived communities at 92.6% compared to 88.9% in our most deprived communities. Overall recovery is 92.4%</p> <p>2 weeks wait - those living in the 10% most deprived areas with an average wait time of 3.89 weeks compared to the next higher wait for decile 3 (30% most deprived) at 3.26 and 3.0 in the least deprived areas. (local analysis).</p>

	<p>The mental health transformation programme utilises local data and is working towards a population health management approach. To enable engage most effectively with and provide for these population groups examples include:</p> <ul style="list-style-type: none"> ○ embedded Holistic Health for the Homeless Team within the City of Lincoln. This is a systemic team which works as part of the wider Integrated Place -based Teams to provide support for our homeless cohort. The learning from this work is helping us to expand the work in other areas such as Boston. ○ Integrated Place -based Teams to embed specialist older adult provision in areas of highest need. ○ Working with Public Health colleagues, the Improving Access to Psychological Therapies (IAPT) service is undertaking service to review to position greater resources into areas of high deprivation, such as around the East Coast area, to reduce the need for travel and improve service uptake 	
<p>Priority 2: Mitigating against 'digital exclusion'</p>	<p>Analysis of First Outpatient appointments access channel take up (digital, face to face and telephone channels)</p> <p>Examples within the Cancer programme include video/ text pilot to support cervical screening in deprived areas has concluded and is being taken up by PCNs as business as usual. Working closely with the East Midlands Cancer alliance to support expanding the programme for 2022/23.</p>	<p>Virtual/face to face outpatient appointments – No significant difference between our most and least deprived communities; 34.7% (43.7% in 2020/21 and 30.1% in 2021/22) of appointments have been delivered virtually since March 2020, across all deprivation quintiles. This is not the case when we consider a patient's ethnicity and in particular patients with 'any other white background' where access to virtual outpatient appointments reduces to 26.6% (<i>Local Analysis from SUS</i>).</p>

	<p>Our Living with Cancer Programme support offers are offered as digital, educational (eg. leaflets, flash cards etc) and face to face options. Personalised follow up pathways are person centred and patients are given a choice in how they access follow up appointments and interventions which support self-management.</p> <p>Within Mental Health, kiosks have been sited in some key areas with links to the vitrucares platform e.g. Lincolnshire university. Supporting communities who experience digital poverty by installing digital kiosks and loan of tablets. Sim cards and tablets have been purchased as part of the community transformation programme. Research is also being undertaken with Lincoln university and the rural network around digital exclusion and the Mental Health Transformation programme will be using learning from this to develop plans for 2022/23</p>	<p>In Lincolnshire the cervical screening text message project has increased uptake of those who had previously not responded to 3 invitation letters by 8%. The project saw the Cancer Team working with pilot GP practices to create a video personal to the practice that explained what would happen to patients when they attended for their screening at their practice. These videos were then sent to eligible patients who had previously not responded to 3 invitation letters.</p>
<p>Priority 3: Ensuring datasets are complete and timely:</p>	<p>Health Inequalities Analysis and Intelligence Workstream Group established. We have undertaken several data analysis deep dives during 2021/22 and will continue this work in 2022/23, which will include, but not exclusive, focus on Cancer and Planned Care.</p> <p>We continue to monitor performance on ethnicity recording and work to improve data collection on ethnicity. Performance on ethnicity recording for our three Lincolnshire trusts and other key providers is monitored and reported on our weekly system performance tracker.</p> <p>Data sharing with GP practices is being established as part of the ongoing implementation of a Population Health Management approach in Lincolnshire.</p>	<p>Emergency care dataset – 87.2% ethnicity coding completeness compared to 85.7% nationally (<i>at 2021/22 Q2, national HI dashboard</i>)</p> <p>Outpatients dataset – 83.2% completeness compared to 79.5% nationally (<i>at 2020/21 Q4, national HI dashboard</i>)</p> <p>Inpatient spells – 85.8% completeness compared to 86.7% nationally (<i>at 2021/22 Q2, national HI dashboard</i>)</p> <p>Mental Health Trust (LPFT) - Ethnicity data has a compliance level of 98% from IAPT and 93% from Rio (via MHSDDS submission – DQMI Score) This is well above national average. The Trust's Integrated Performance Report is currently being revamped.</p> <p>Community Trust (LCHS) has continued to work to improve the data quality, collection and use of data on ethnicity. This includes regular</p>

	<p>This allows data to be extracted from practices, pseudonymised, and joined with other record level data required to understand and respond to population health and allowing us to understand and address equity and health inequality of outcomes for groups of individuals according to their geography, characteristics, or circumstances, this also allows us to understand where information recording and reporting improvements can be made at source. During 2021/22 data flows have been established with practices accounting for around half of the registered population of the ICS, with the remaining practices being brought into the Population Health Management programme during 2022/23</p> <p>Development of the first phase of the Lincolnshire Health Inequalities Dashboard to support CORE20Plus 5 has now completed and available from April 2022. This will provide data at County, locality and PCN level and will identify any disparities across a range of indicators using the slope index, split by deprivation and ethnicity.</p>	<p>reporting active use of data to drive decisions in the organisation. The Trust is exploring using other data sources that enhance the quality and completeness of data - key to this is working with the patient system supplier to draw down data from the core system supplier that is input by other clinicians.</p> <p>Primary Care - Mandatory ethnicity reporting is not currently in place within Lincolnshire; however, we will work with PCNs to implement this in 2022/23, aligning with DES requirements on General Practice and our work within our PHM Programme to create shared data sets.</p>
<p>Priority 4: Accelerating preventative programmes</p>	<p>Significant work has been undertaken to date to increase vaccination uptake in rural and high deprivation areas. This has included specific activities including language translation (culturally competent) and pop-up vaccination sites.</p> <p>Tobacco Prevention – established Tobacco Dependency Steering group to coordinate the development of the delivery plans for the Tobacco dependency treatment service in acute settings (acute and mental health) and maternity services (smoke free pathway) for implementation during 2022/23. Recruitment underway.</p>	<p>Flu vaccination – As of January 2022 overall vaccination rate at 67.11%. However, at 55.67% our most deprived communities are 19% points behind our least deprived communities where vaccination rates are 74.75%. For equity, an additional 16k patients in deprived communities need to be vaccinated. This is most notable for patients with ‘any other white background’ where uptake is 35.51%; For equity with ‘British’ patients (uptake 70.86%), an additional 10k patients would need vaccinating. (<i>January 2022 -regional Flu reporting</i>)</p> <p>COVID vaccination – 50% of patients with ‘another white background’; 67% of ‘mixed White and Black Caribbean’ and 62% of ‘Black or Black British Caribbean’ in our most deprived communities are vaccinated compared to ~65%, 79% and 82% respectively in our least deprived. (<i>Feb 22, age 12+, national HI dashboard</i>).</p>

	<p>The COVID vaccination programme has developed a Health Inclusion Strategy for Covid vaccinations, which targets low uptake in areas of greatest deprivation and ethnic groups with lower uptake than the whole population (Significantly lower vaccination uptake by ‘White Other’ ethnicity, particularly Eastern European communities) and uses our learning to date as well as data dashboards to monitor progress and tailor responses to increase uptake. This approach is expected to be roll out for other vaccination uptake e.g. Flu</p> <p>Flu vaccination uptake rates mirror those of Covid 19 vaccinations, being lower in most deprived areas and “white other” groups (particularly those from an Eastern European background).</p> <p>Memorandum of Understanding (MOU) has been agreed with all practices to support the recovery and restoration of Primary Care and improvement of care for patients with long-term conditions, for example which might include Diabetes, COPD, and Atrial Fibrillation, Heart Failure, and blood pressure monitoring. The requirement includes targeted support to address health inequalities to ensure equity in access also and increase patient engagement through personalised care.</p>	<p>LD health checks – 79.3% of our patients with learning disabilities received an annual health check in Q4 of 21/22. This equates to 259 fewer health check compared to the previous year. The CCG will be asking practices to prioritise these patients during Q1 22/23.</p> <p>There is some variation across practices in terms of delivery this year compared to last year, also data indicating health plan completion rates is becoming available and variation is being picked up with practices (e.g., to understand low health plan completion and where there are high decline rates).</p> <p>Achieved the national target (75%) for March.</p> <p><i>(local reporting)</i></p>
<p>Priority 5: Strengthening leadership and accountability</p>	<p>Lincolnshire has named SRO/Executive Leads for Health Inequalities at system, CCG board and Trust boards as well as a CCG Board Non-Exec lead and PCN Alliance Health Inequalities Lead. The system has also established a Health Inequalities Programme Team.</p>	<p>ICBs, once established, and trust board performance packs are therefore expected to be disaggregated by deprivation and ethnicity.</p>

Health Inequalities programme governance in place, including Health Inequalities improvement network meeting regularly and Health Inequalities Analytics and Intelligence Workstream Group established to work with the PHM programme.

The Lincolnshire CCG board and executives receives regular updates on performance relating to Health Inequalities. Work commenced on revising ICS Board Performance Pack to be disaggregated by deprivation and ethnicity. We are working with Lincolnshire's three Trusts to develop an integrated and consistent approach to performance monitoring /reporting on key Health Inequalities data including ethnicity and deprivation. Our HI Analytics and Intelligence Workstream Group will oversee and support this work.

We are rolling out the use of the Health Equity Assessment Template (HEAT) and used to support the review of operational plans for 2022/23 and will be embedding this within ICS project management and governance arrangements in 2022/23 and providing a programme of training and support.

We have established a Health Inequalities Community of practice which provides a range of resources and support to colleagues on Health Inequalities and the local picture.

5.3 Progress against NHSEI Five Clinical Priorities in 2021/22

5 Clinical Areas	2021/22 Progress	Performance
Hypertension Case Finding	As part of the roll out of the National blood pressure monitoring @home project - 85 practices across	Hypertension prevalence from QOF in Lincolnshire for 2020/21 is 16.97%, compared to national prevalence of 14%, local information suggests this will rise to over 17.2% in 21/22. The

	<p>Lincolnshire have received blood pressure units, (over 3,000 units) during Q3 21/22. An evaluation of this work is due to take place during 2022/23.</p> <p>A key area of focus for the Lincolnshire system led by the Public Health team - Know Your Numbers. Taking forward this system priority area will include taking several approaches and key projects identified under 3 areas: Making Every Contact Count, increasing public awareness and promoting the wide range of services available for people to support them manage their blood pressure.</p> <p>The Health Inequalities Programme will take a lead role in oversight of the implementation of the CVD prevention action plan and continue to build on the Core20PLUS5 approach introduced in 2021/22 to support tackling health inequalities and supporting PCN delivery plans.</p> <p>The Midlands Strategy unit completed review of inequalities in access to planned hospital care for Lincolnshire and included Heart Failure pathway – findings indicated that patients living in the least deprived areas are more likely to have a pacemaker fitted. Deep dive to be planned in 2022/23 to investigate further.</p>	<p>highest prevalence is 22.9% in coastal towns (First Coastal PCN 22.9%). (QOF as at 2020/21, Chief Medical Officer's Annual Report 2021 'Health in Coastal Communities' and local reporting)</p> <p>Current performance is below pre-pandemic levels:</p> <ul style="list-style-type: none"> a) 52% of patients (aged 79 years or under) with blood pressure treated to target in 2020/21, compared to 74% in 2019/20. From local information this rises to 67% at March 2022. b) 65% of patients (aged 80 years or over) with blood pressure treated to target from QOF in 2020/21, compared to 86% in 2019/20. From local information this rises to 80% at March 2022. <p>(QOF as of December 2021 and Local reporting)</p>
<p>Early Cancer diagnosis</p>	<p>Our Early Diagnosis and Screening Programme leads on this work, with its plans to increase the number of Stage 1 and 2 cancers in Lincolnshire. Work aligns with the National Cancer Programme and the expected impact from various programmes of work to improve early diagnosis. Following improvement work</p>	<p>The aspiration is that 75% of cases diagnosed at stage 1 or 2 by 2028. In 2018, the % of stage 1 and 2 diagnoses ranged from 49% in South Lincolnshire to 57% in South West Lincolnshire; compared to 55% nationally.</p> <p>Nationally, in 2018, 58% of Cancers were diagnosed at Stage 1 or 2 for patients in the least deprived communities in the country. For</p>

	<p>around staging data, we are now at a point where there is confidence in staging data to be able to benchmark and monitor future improvement work for 2022/23.</p> <p>Late cancer presentations are a key focus of our early cancer diagnosis work and will be driven by geographical variation, and specific tumour sites to introduce interventions to seek to reduce the late presentations. Analysis has shown no inequalities due to gender / ethnicity however initial information indicates that there may be inequalities due to age, this requires further investigation and will be actioned in 22/23.</p> <p>The NHS Galleri trial (running in Lincolnshire 4th April to 29th May 2022) is expected to have a significant impact in improving early staging of cancer. We are embedding Health inequalities within this work.</p> <p>The Cancer Alliance will continue to collaborate with NHSEI S7a Public Health Commissioners with regards to population screening and screening uptake, with particular focus on cervical screening and support lower uptake performance across Primary Care settings.</p>	<p>those in the most deprived communities, this reduced to 49%. (CCG data not available unfortunately) (<i>cancerdata.nhs.uk</i>)</p>
COPD/respiratory	<p>Programme paused in 2021/22 (will be restarted in 2022/23)</p> <p>We will use the learning from our Covid vaccination work to develop our 22/23 plans for Flu to ensure inclusive uptake, including a specific focus on increase uptake of Covid, Flu & Pneumonia vaccines (Core 20+5) for people with Chronic Respiratory</p>	<p>COPD prevalence in Lincolnshire is 2.3% compared to national prevalence of 1.9%, this increases to 4.5% in coastal towns (First Coastal PCN 4.66%). Locally available information suggests there is little change at March 2022.</p> <p>Flu and c-19 vaccination uptake for COPD/ Asthma patients are not available at this granular detail for the CCG and will be further progress during 2022/23 to support data/ performance monitoring.</p>

	<p>Disease (COPD). We will use data dashboards to monitor uptake and implement tailored solutions to populations with lower uptake.</p> <p>The Midlands Strategy unit completed review of inequalities in access to planned hospital care for Lincolnshire and included COPD pathway – findings indicated that patients from more deprived areas are less likely to be offered pulmonary rehab or prescribed steroid inhalers. Deep dive to be planned in 2022/23 to investigate further.</p>	<p><i>(QOF 18/19, Chief Medical Officer’s Annual Report 2021 ‘Health in Coastal Communities’ and QOF 2020/21 Lincolnshire CCG)</i></p> <p>Spirometry paused due to c-19 will be a focus for 2022/23 to ensure equity in access across Lincolnshire</p>
<p>Maternity (Continuity of Carer)</p>	<p>As part of the development of Lincolnshire Maternity and Neonatal Programme we have Continuity of Carer (CofC) teams in place in Gainsborough, Sleaford and a team in the Wolds area (covering Horncastle, Woodhall Spa, Bardney, Market Rasen and surrounding villages). These teams are covering the whole pathway (antenatal, delivery and post-natal). The next Continuity team will be in Skegness and women are being booked onto the pathway, but further recruitment is needed before intrapartum care can be provided. Skegness is a coastal area with one of the highest deprivation levels within the country.</p>	<p>The aim is to ensure continuity of care for 35% of women from Black, Asian and minority ethnic communities and from the most deprived groups.</p> <p>Black and Asian women in Lincolnshire are 1.3 times more likely to require a maternal C-section and 1.2 times more likely to suffer from maternal post-partum haemorrhage than White women. (sus, 2021/22)</p>
<p>Severe Mental Illness (SMI Health Checks)</p>	<p>Ensuring annual health checks for 60% of those living with Serious Mental illness (SMI) bringing SMI in line with the success seen in learning disabilities is a key priority for Lincolnshire. A SMI Health Delivery group established to drive forward – through:</p>	<p>45.6% of our patients with a serious mental illness (SMI) received all six physical health check in Q4 provisional 21/22. Performance is somewhat short of the 60% standard.</p> <p><i>(local reporting)</i></p>

- Promoting the importance of health checks to the public, patients, and the wider Lincolnshire system
- Working with GP practices and PCNs to improve access and consistent delivery of SMI health checks
- Sharing data between secondary and primary care to ensure all eligible patients are included in SMI registers and all health checks are recorded in clinical systems
- Lincolnshire Partnership Foundation Trust (LPFT) community clinics to offer health checks to people known to them with SMI

(SMI health check published statistics. As at December 2021 national reporting 1495 people to achieve full health check to meet the national target.)

Public Meeting of NHS Lincolnshire Integrated Care Board

Date: 26th July 2022

Location: Bridge House, Sleaford

Agenda Number:	5 (i)
Title of Report:	Integrated Quality & Performance Report – July 2022
Report Author:	Tim Fowler, Associate Director of Contracting and Performance
Appendices:	Integrated Quality and Performance Report

1. Key Points for Discussion:
<p>The report is presented for discussion and feedback. The approach has been to incorporate targets presented in the Quality Performance report, into a single Integrated Quality & Performance Report for the ICB.</p> <p>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.</p>
2. Recommendations
<p>The Board is asked to note this report and consider the actions underway.</p>
3. Executive Summary
<p>Overview</p> <p>The July integrated performance report incorporating constitutional standards, quality and safety measures and elective recovery activity, presents CCG and system performance updated to June where available. The focus areas continue to be urgent care pathways, cancer, elective treatment backlog, long waiters and mental health. Key actions are detailed within the report.</p> <p>Urgent & Emergency Care</p> <ul style="list-style-type: none"> The number of people waiting more than 12 hours in A&E increased to 692, from 680 in May. <p>Ambulance response times increased to 9 minutes 46 seconds for Category One incidents (7 minute standard) and 1 hour 11 minutes and 51 seconds for Category Two incidents (18 minute standard)</p>

- 2hr handover delays have increased at both Lincoln and Pilgrim

Cancer

- In June, 416 patients were over 62 days improving from 508 in May
- The number of patients waiting 104 days or more also reduced in June to 148, from 154 in May
- 60.5% of patients were told their cancer diagnosis outcome within 28 days in May, compared to 56.6% in April

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals has increased by 2020 to 105,487 in May
- 104 week breaches continue to reduce, as performance improved to 0.05%, remaining better than the national average of 0.12%

Mental Health

- The total waiting list size for Lincolnshire patients at all hospitals has increased by 2020 to 105,487 in May
- 104 week breaches continue to reduce, as performance improved to 0.05%, remaining better than the national average of 0.12%

Primary Care

- Lakeside CQC report was published on the 1st June with an overall requires improvement rating. The Practice remains in Special Measures for a further six months to ensure the improvements still required are made.

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 Quality & Performance Report (Board)

July 2022



Lincolnshire
Integrated Care Board



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System Delivery Overview Update

Urgent & Emergency Care

All Urgent and Emergency care services are continuing to operate under significant pressure and that is particularly noticeable in Emergency Departments and Ambulance Trusts. This is due to a combination of demand, workforce pressures and lack of discharges from hospital where patients no longer need to reside and increasingly now additional pressures due to rising Covid numbers and heatwave. Coronavirus infections remain high, but we have seen a slight decrease in hospital inpatients in the last few days 92 as at 19/7/22 and have outbreaks across a wide range of settings.

Integrated Discharge Hub

Lincoln County Hospital and Pilgrim Hospital, Boston recently opened their Integrated Discharge Hubs. The Integrated Discharge Hub brings together staff from ULHT, Lincolnshire County Council Adult Social Care, Lincolnshire Community Health Services and Libertas Reablement Service to triage referrals and ensure the most appropriate discharge Pathway is put in place for patients, to ensure safe and timely discharges from the acute hospital. The Integrated Discharge Hub is also joined virtually by partners from Age UK, St Barnabas, Palliative Care, Continuing Healthcare and Neighbourhood Teams.

The mission of the Integrated Discharge Hub is not only to facilitate timely discharge once acute consultant led care has been completed, but to promote and maximise independence and wellbeing through a strengths-based and person centred approach, in turn improving patients quality of life and reducing the potential of further hospital admissions.

The Integrated Discharge Hub commenced on the 28th June and is already seeing positive results and improved communication between organisations. With phase one well under way, the next steps are being considered to expand and create an acute and community hub.

System Delivery Overview Update

Planned Care

The system Elective Activity Coordination Hub has a robust waiting list management process in place and is tracking all patients over 78 weeks to ensure patients are treated at the earliest opportunity and we meet the pledge to have zero waits by end of March 2023. ULHT had no patients waiting over 104 weeks by the national target of the end of June for capacity reasons, 1 patient has chosen to be treated in August. At neighbouring providers there were a small number with a longer trajectory agreed with respective regions the majority of those with a confirmed date with a mix of complexity, capacity and choice.

United Lincolnshire Hospitals Trust has supported United Leicester Hospitals (UHL) with mutual aid for long waiting patients in Leicestershire and those patients in the main will be treated in July unless they have chosen a later date.

Additional independent sector capacity is being sought where there are challenges in particular specialties the system benchmarks very well regionally for elective care and the plan for this year is to use every opportunity to deliver more activity than pre pandemic to reduce waiting times for the population but clearly the impact of Covid does impact capacity so maximising the use of sites that are less affected by acute demand within the county and with independent providers.

Cancer

The backlog for cancer patients has shown an improvement for both 62 and 104 days from the peak last month. Levels of urgent referrals and referrals seen are above regional and national average and the proportion of urgent referrals waiting over 62 days is now below regional but higher than national average. As previously outlined work is being undertaken with the cancer alliance to support short- and long-term solutions to colorectal as it is the largest backlog from Covid to recover. Patients continue to be monitored via multiple mechanisms and are clinically prioritised as previously reported at trust and system level.

System Delivery Overview Update

Emergency Preparedness, Resilience & Response (EPPR)

There have been no declared incidents since the last report. On 18th July, a level 4 heat health alert was issued by central government. There was no associated formal EPPR response although the ICB participated in regional and local coordination groups and led a command approach in the system. At the time of writing this is ongoing and learning from the heatwave response will contribute to future adverse weather plans.

The ICB participated within Exercise Agnew IV. This was facilitated by the local resilience forum and tested fallback communications. The exercise was successful and identified elements for further development.

The recently revised incident response plan (IRP) was tested in a command post and communications cascade exercise. This involved system wide health & social care partners along with regional colleagues in NHSE and UKHSA. The exercise tested the ability to notify all partners in the case of a major incident and subsequently convene a coordinating group.

Learning Disabilities

Delivery over April and May is 238 Health Checks, 78 ahead of 21/22 but 15 behind 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.

Executive Summary

Overview

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



Urgent & Emergency Care

- The number of people waiting more than 12 hours in A&E increased to 692, from 680 in May
- Ambulance response times increased to 9 minutes 46 seconds for Category One incidents (7 minute standard) and 1 hour 11 minutes and 51 seconds for Category Two incidents (18 minute standard)
- 2hr handover delays have increased at both Lincoln and Pilgrim



Cancer

- In June, 416 patients were over 62 days improving from 508 in May
- The number of patients waiting 104 days or more also reduced in June to 148, from 154 in May
- 60.5% of patients were told their cancer diagnosis outcome within 28 days in May, compared to 56.6% in April



Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals has increased by 2020 to 105,487 in May
- 104 week breaches continue to reduce, as performance improved to 0.05%, remaining better than the national average of 0.12%



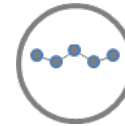
Mental Health

- Performance of early intervention in psychosis (EIP) waiting times is now at 0% seen within 2 weeks, much lower than the 60% standard. The current average wait for the service remains 3 weeks.

Run Charts Key

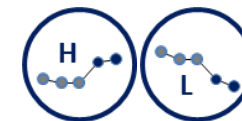
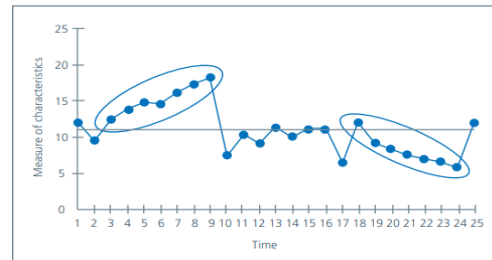
Run charts are displays of time-series data shown in graph form and are very useful tools for improvement work – particularly in terms of how you understand and communicate variation in a process. Being able to analyse and understand current system variation is key to being able to make changes that improve processes and systems.

Extreme Values

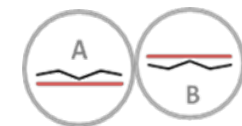
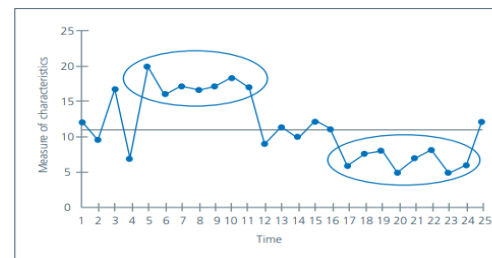


Normal Variation

A Trend
(upward or downward trend)



A Shift
(a run above or below the mean)



Performance Overview

Constitutional Standards







Indicator	Standard	Period	Performance	Midlands	England	Trend		Further Detail
A&E admission, transfer, discharge within 4 hours	95%	Jun-22	72.7%	66.2%	72.1%			-
% Suspected Cancer Referrals First Seen Within 14 Days	93%	May-22	73.4%	80.2%	83.2%			-
Patients receiving treatment for cancer within 62 days of an urgent GP referral	85%	May-22	46.6%	49.9%	61.5%			-
RTT: % of incomplete pathways within 18 weeks	92%	May-22	56.9%	59.9%	63.5%			-
Percentage waiting six weeks or less for a diagnostic test	99%	May-22	62.4%	65.3%	64.8%			-

Urgent Care










Indicator	Standard	Period	Performance	Midlands	England	Trend		Further Detail
A&E attendances- patients waiting over 12 hours (ICB)	0	Jun-22	692	N/A	N/A			Page 16
A&E attendances- time to first clinical assessment within 60 minutes (ULHT)	-	Jun-22	50.8%	35.9%	34.9%			-
Ambulance response times - Mean response time- Category 1 (ICB patients)	00:07:00	Jun-22	00:09:46	00:08:55	00:09:06			-
Ambulance response times - Mean response time- Category 2 (ICB patients)	00:18:00	Jun-22	01:11:51	01:00:35	00:51:38			Page 16
Ambulance handover times - number of handover delays of > 2 hours (Lincoln)	-	Jun-22	223	N/A	N/A			Page 17
Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)	-	Jun-22	123	N/A	N/A			Page 17

Performance Overview

Cancer

Indicator	Standard	Period	Performance	Midlands	England	Trend		Further Detail
Total 62 Day Backlog (ULHT)	-	Jun-22	416	N/A	N/A		↓	 Page 19
Total 104 Day Backlog (ULHT)	-	Jun-22	148	N/A	N/A		↓	 Page 19
Faster diagnosis standard- % of patients told cancer diagnosis outcome within 28 days (ICB)	75.0%	May-22	60.5%	68.2%	70.8%		↑	 -

Planned Care

Indicator	Standard /Plan	Period	Performance	Midlands	England	Trend		Further Detail
Patients waiting over 52 weeks for treatment (% of total ICB waiting list size)	0%	May-22	6.1%	7.3%	5.0%		→	 Page 21
Patients waiting over 104 weeks for treatment (% of total ICB waiting list size)	0%	May-22	0.05%	0.19%	0.12%		↓	 Page 21
Patients waiting over 78 weeks for treatment (ICB)	0	May-22	534	-	-		↓	 -
Total waiting list size (ICB)	-	May-22	105,487	N/A	N/A		↑	 Page 22
Total elective spells (ICB)	10,328	May-22	9,520	N/A	N/A	-	-	 Page 22

Performance Overview

Mental Health

Indicator	Standard	Period	Performance	Midlands	England	Trend	Further Detail
IAPT access - people that enter treatment against the level of need in the general population (ICB)	2.75%	Apr-22	1.79%	N/A	1.58%		-
IAPT recovery rate - people who complete treatment who are moving to recovery (ICB)	50%	Apr-22	50.7%	N/A	50.4%		-
Inappropriate Out of Area Placements(OAPs) in mental health services for adults in non-specialist acute inpatient care per 100,000	0	Apr-22	54.6	119.5	112.6		Page 25
People experiencing first episode psychosis or ARMS that wait two weeks or less to start a NICE recommended package of care (ICB)	60%	May-22	0%	53.8%	68.6%		Page 25
Estimated diagnosis rate for people with dementia (ICB)	66.7%	Jun-22	61.2%	61.1%	62.0%		Page 27
Severe Mental Illness-people with SMI who have received the complete list of physical health checks in the preceding 12 months(ICB)	60%	22/23 Q1	44.7%	41.5%	42.8%		Page 27
Children & Young People (CYP) with MH disorder receiving treatment (one contact) in the reporting period last 12 months	8891	Feb-22	6820	N/A	N/A		Page 28
The number of CYP with an eating disorder (routine) referred with a suspected ED that start treatment within four weeks of referral in the reporting period (rolling 12 months)	95%	21/22 Q4	43.3%	N/A	N/A		Page 28
The number of CYP with ED (urgent) referred with a suspected ED that start treatment within one week of referral in the reporting period (rolling 12 months).	95%	21/22 Q4	88.2%	N/A	N/A		-













Performance Overview

Quality

Indicator	Standard	Period	Performance	Midlands	England	Trend	Further Detail
Never events (ULHT)	0	Jul-22	0	N/A	N/A		-
Never events (NLAG)	0	Jul-22	0	N/A	N/A		-
Never events (NWAFT)	0	Jul-22	0	N/A	N/A		-
Summary Hospital Level Mortality Indicator (SHMI) (ULHT)	1.000	Feb-22	1.0613	1.0423	1.0004		Page 30
Hospital Standardised Mortality Ratio (HSMR) (ULHT)	100.00	May-22	92.60	N/A	N/A		Page 30
Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	1.000	Feb-22	1.0363	1.0423	1.0004		Page 32
Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	1.000	Feb-22	1.1131	1.0423	1.0004		Page 31
MRSA Cases- 12 month rate per 100,000 bed days (ICB)	0	May-22	0.66	0.89	1.27		-
C. Difficile Cases- 12 month rate per 100,000 bed days (ICB)	0	May-22	19.71	24.33	25.79		-
E-Coli Cases- 12 month rate per 100,000 bed days (ICB)	0	May-22	70.68	66.38	67.30		-
Cancelled Operations on the day for non clinical reasons (ULHT)	0.8%	Q4 21/22	25.9%	23.0%	32.7%		-
Number of patients of people with a learning disability receiving inpatient care (ICB)	26	Apr-22	31	-	-		Page 33
Rate per 1000 of people with a learning disability receiving inpatient care (ICB)	0	May-22	51	46	42		Page 33
Cumulative Learning Disability Healthchecks (ICB)	253	May-22	238	N/A	N/A		Page 33
Care Home Quality	-	-	-	-	-	-	Page 35
Safeguarding	-	-	-	-	-	-	Page 36
SEND	-	-	-	-	-	-	Page 36
Serious Incidents Reported (Lincolnshire patients)	-	Jun-22	50	N/A	N/A		Page 37
Ockenden Response	-	-	-	-	-	-	Page 38

Performance Overview

Primary Care

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
Primary Care CQC- number of practices rated as 'Inadequate' by CQC	0	Jul-22	0	N/A	N/A	N/A	N/A	N/A	Page 40
Primary Care CQC- number of practices rated as 'Requires Improvement' by CQC	-	Jul-22	4	N/A	N/A	N/A	N/A	N/A	Page 40
GP Appointments- percentage seen by a GP	-	May-22	35.2%	38.8%	36.5%		↓		Page 41
GP Appointments Mode- percentage seen face to face	-	May-22	68.4%	60.8%	63.8%		↑		Page 41
GP Appointments- time from booking to appointment same day	-	May-22	48.7%	56.0%	46.3%		↑		Page 42
GP Appointments- time from booking to appointment 1-6 days	-	May-22	21.3%	24.9%	21.8%		↓		Page 42
The number of extended access appointments booked excluding did not attends (ICB)	5589	Jun-22	5563	N/A	N/A		↑		Page 43
The percentage of available GP extended access appointments utilised (ICB)	80%	Jun-22	75.0%	N/A	N/A		↑		Page 43

Covid-19 Vaccinations

As at 10th July 2022

COHORT	1	2a	2b	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Total 1 - 9	Total 1 - 12	Total 1 - 18
	Care Homes	80+	HSCW	75-79	70-74 & CEV	65-69	At Risk	60-64	55-59	50-54	40-49	30-39	18-29	13: 12-15 At Risk	12-17 - contacts of immunosuppressed	16-17	12-15	5-11 at risk	5-11			
1st Dose (%)	99%	98%	99%	98%	96%	95%	89%	92%	90%	88%	79%	71%	74%	70%	69%	74%	61%	21%	12%	93%	87%	80%
2nd Dose (%)	98%	97%	98%	97%	96%	95%	86%	91%	89%	86%	78%	67%	69%	51%	50%	58%	43%	5%	1%	92%	85%	76%
% of Booster Vaccines administered to those who received 2nd Dose	97%	98%	89%	98%	95%	97%	86%	95%	92%	90%	83%	71%	63%			28%				93%	87%	
% of 2nd Boosters given to those Eligible	54%	67%		89%																		

Covid-19 Vaccinations

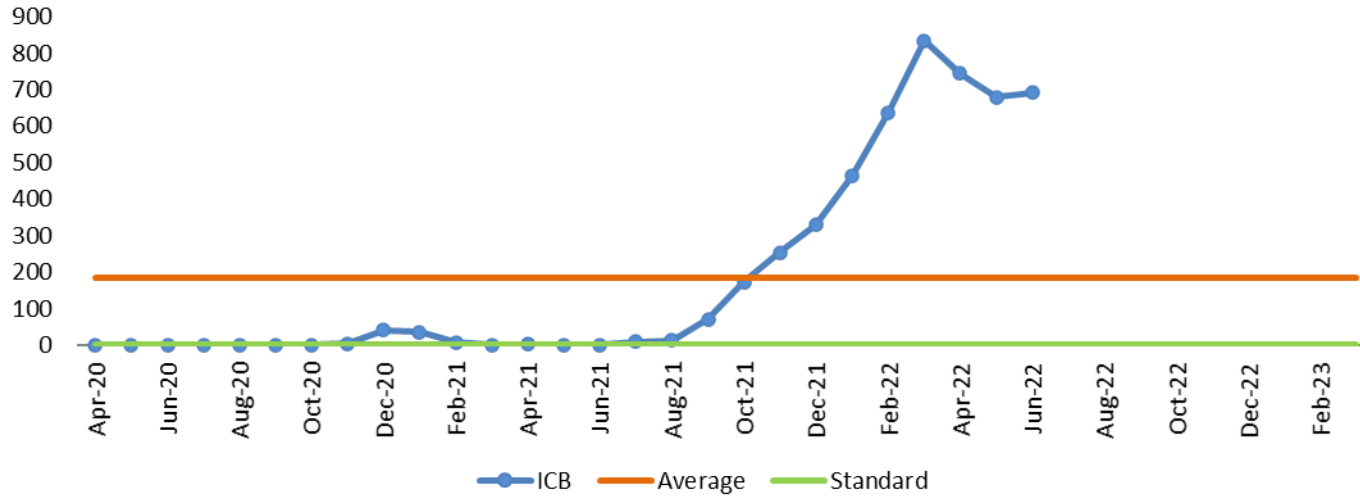
Update

- Spring booster campaign has now ended in line with guidance
- Programme continues with reduced capacity to continue to provide access to of the Ever green offer – that is for patients who haven't had their first vaccine
- Planning is underway for the Autumn booster programme. This will be delivered in partnership by PCNs, the Mass vaccination centres, the Hospital Hub and Community pharmacies. The eligible population criteria has been updated and the team are remodelling the capacity that will be required to facilitate this
- The Autumn booster programme planning will include details of the arrangements to ensure we provide access to local residents affected by health inequalities and also arrangements to increase the capacity to support a surge request
- The team are also reviewing the service delivery arrangements to ensure that these provide value for money and that costs can be contained within the allocation that the system will receive
- The Autumn booster programme is scheduled to commence on 1st September 2022

Urgent Care

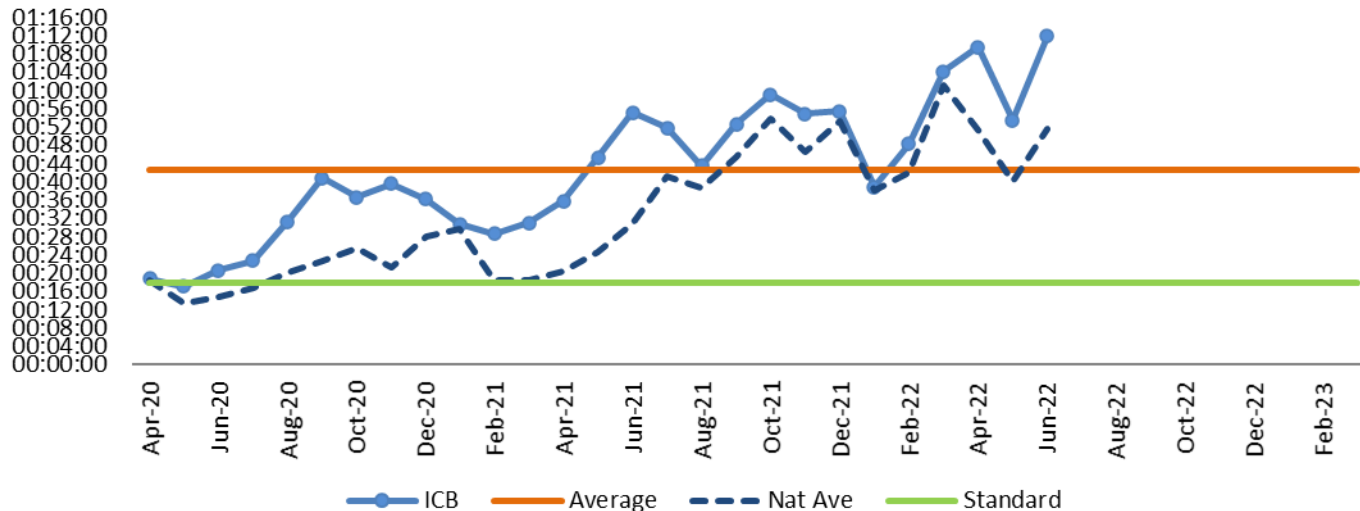
Cause	Actions To Recover
<p>The Lincolnshire system has continued to experience pressure on urgent and emergency care services. Nationally services have experienced unprecedented levels of demand. Covid demand and Covid related absence are also now impacting.</p> <p>The June position was as follows:</p> <ul style="list-style-type: none"> • Demand across T1 & T3 activity has increased in June. • 12 hour decision to admit breaches remain high • The number of patients in hospital for 7/14/21+ days has reduced over the course of the month, however overall LoS is increasing. • Covid bed occupancy has significantly increased since May, with Covid patients being cared for again in ICUs <p>The main risks for the system continue to be staffing levels and the level of demand.</p>	<p>Internal and system wide actions agreed daily on System Resilience Calls. Tactical plan enacted during periods of significant pressure or incident management.</p> <p>The system focus remains on Discharge and Flow with system plan anticipated to impact from the end of Q2. This includes the 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.</p> <p>The system continues to focus on maximising use of alternative pathways, and developing further integration of services to support people at home.</p> <p>Development of the winter plan will commence immediately.</p>

A&E attendances- patients waiting over 12 hours (ULHT)



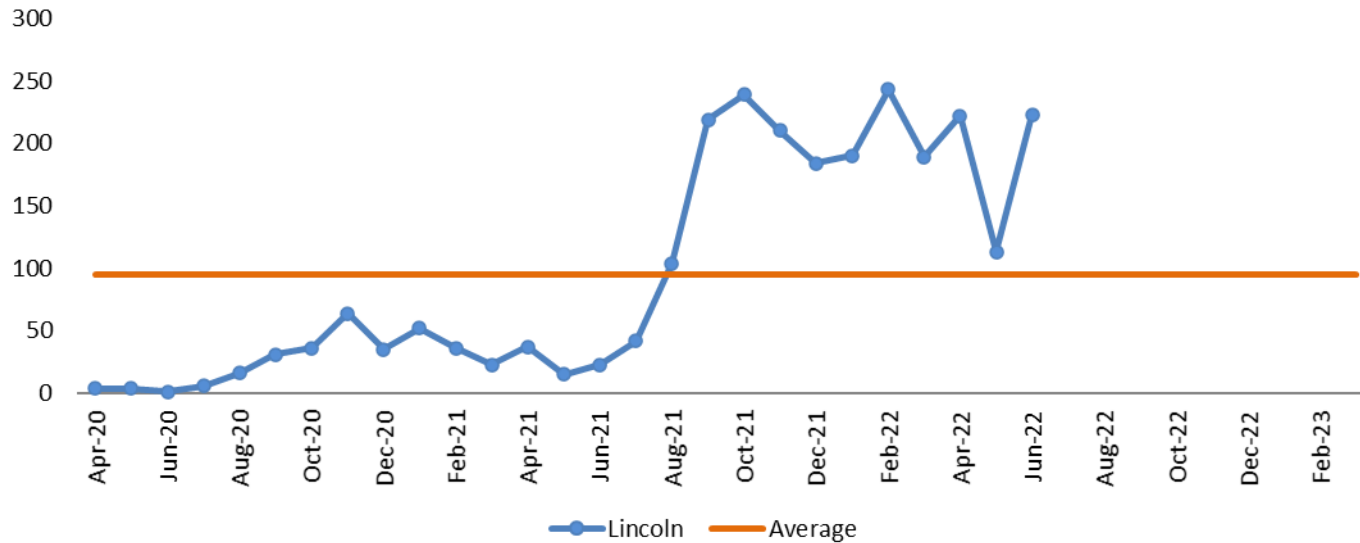
Indicator
A&E attendances- patients waiting over 12 hours (ICB)
Standard
0
Period
Jun-22
ICB
692
England
N/A
Trend

Ambulance response times - Mean response time- Category Two (Lincs)



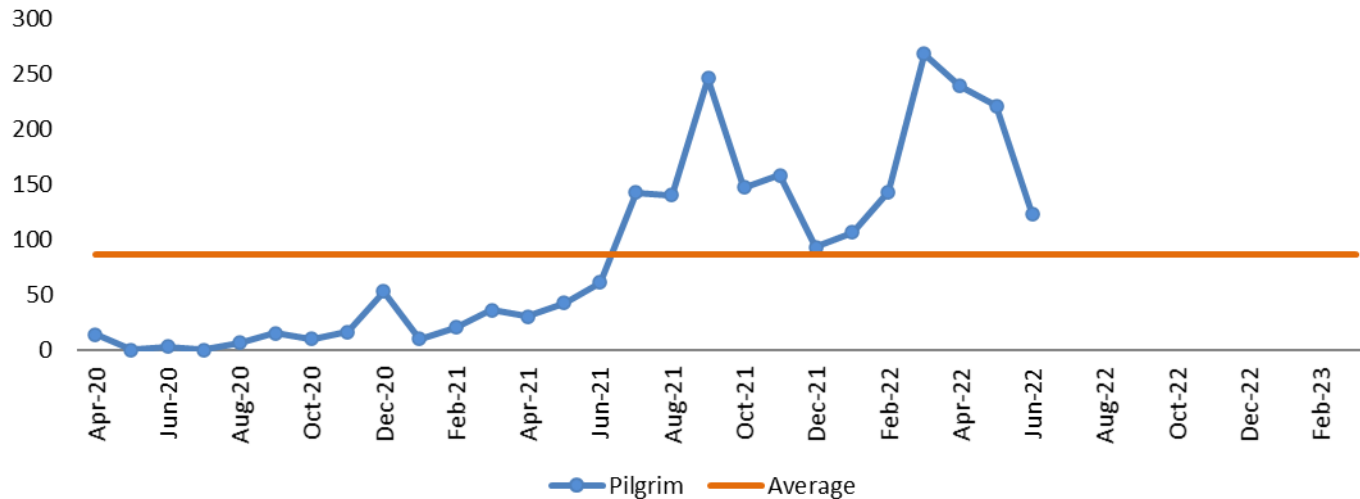
Indicator
Ambulance response times - Mean response time- Category 2 (ICB patients)
Standard
00:18:00
Period
Jun-22
ICB
01:11:51
England
00:51:38
Trend

Ambulance handover times - number of handover delays of > 2 hours (Lincoln)



Indicator
Ambulance handover times - number of handover delays of > 2 hours (Lincoln)
Standard
-
Period
Jun-22
Lincoln
223
England
N/A
Trend

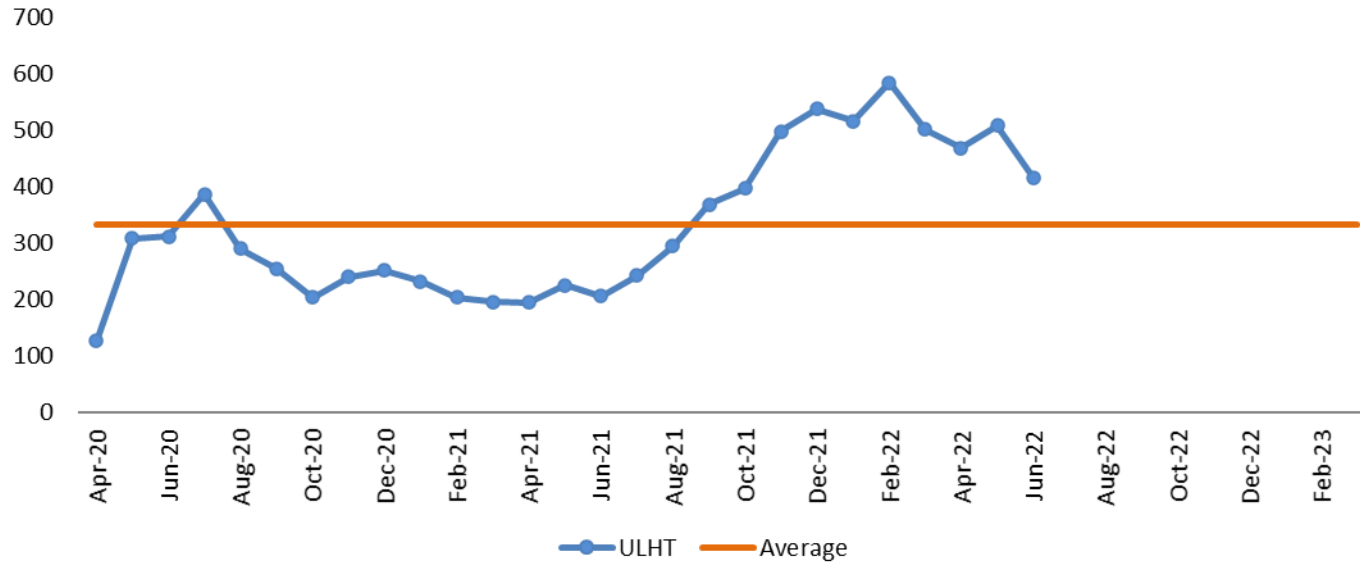
Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)



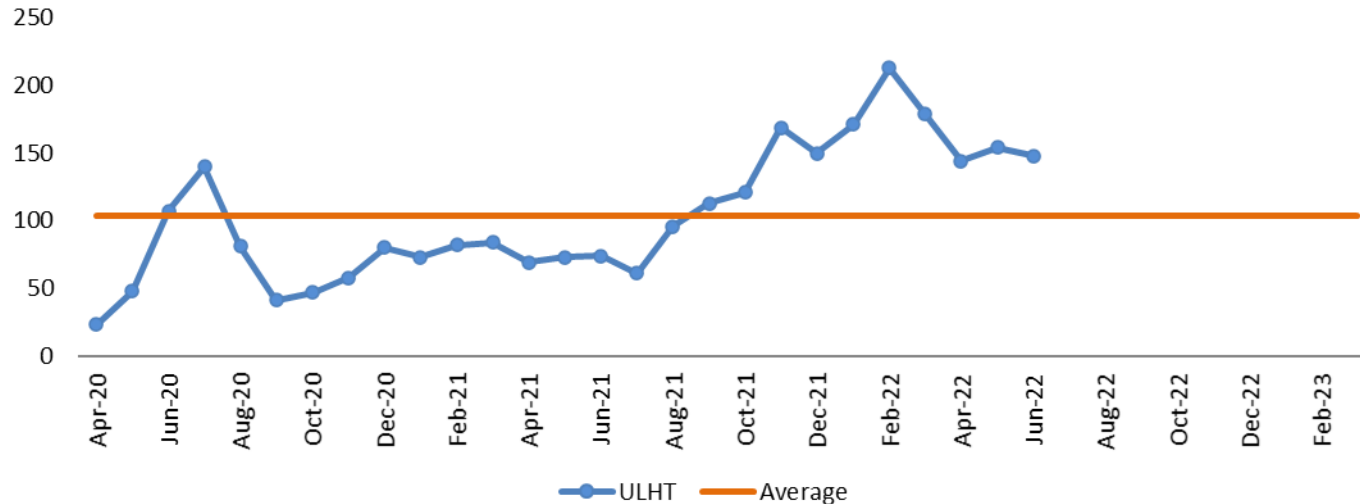
Indicator
Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)
Standard
-
Period
Jun-22
Pilgrim
123
England
N/A
Trend

Cause	Actions To Recover
<ul style="list-style-type: none">• The backlog position is again reducing and is on trajectory at 394 patients are over 62 days,. Colorectal continues to account for the largest part of the backlog 57%, the colorectal backlog is now at 223 patients.• Referral rates remain higher than previous years, they are currently at 115% against baseline, this is the lowest they have been in 5 weeks.• Gynaecology referrals have seen a significant increase over the last 5 weeks. They are averaging at 140-150% compared to baseline.• Upper GI are they only tumour site seeing an increase in the number of patients over 62 days.• We are beginning to see the impact of the 4th wave of COVID with some surgical cancellations requiring HDU beds.	<ul style="list-style-type: none">• A system wide approach has been taken to undertake a deep dive into the issues around the colorectal pathway. The second phase of the colorectal deep dive is well under way and will be presented at the end of July.• The simulation tool for colorectal recovery is almost complete.• The Upper GI team have recruited two new patient navigators to manage the backlog.• Cancer team are working with gynaecology and lung teams to understand the issues they are currently having and to find solutions.

Total 62 Day Backlog (ULHT)



Total 104 Day Backlog (ULHT)



Indicator

Total 62 Day Backlog (ULHT)

Pre-Pandemic Level

81

Period

Jun-22

ULHT

416

England

N/A

Trend



Indicator

Total 104 Day Backlog (ULHT)

Pre-Pandemic Level

22

Period

Jun-22

ULHT

148

England

N/A

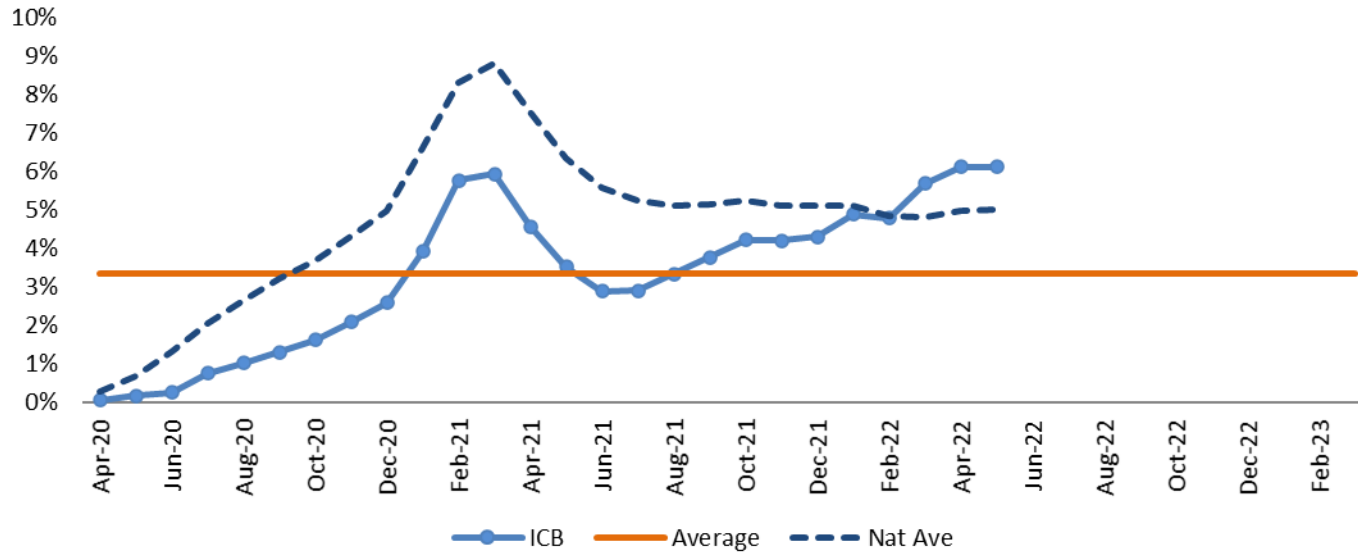
Trend



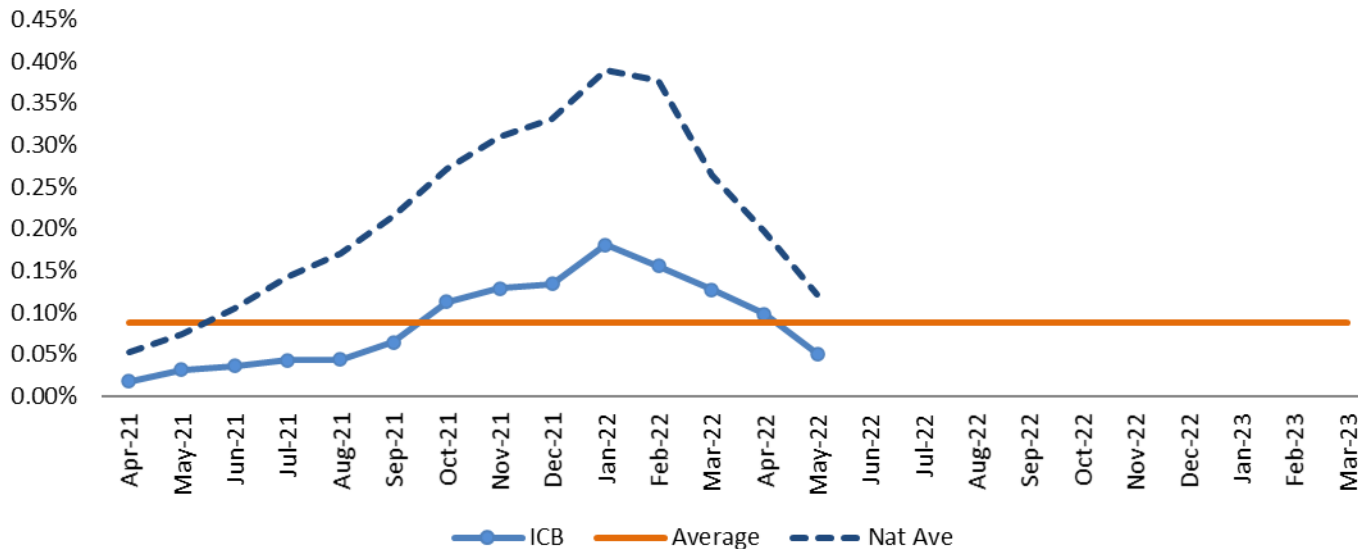
Planned Care & Diagnostics

Cause	Actions To Recover
<ul style="list-style-type: none"> • 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. • Infection Prevention and Control procedures continue to restrict full restoration of pre-covid activity. 	<ul style="list-style-type: none"> • May validated position shows 104 week waiters continuing to reduce but the end of June deadline for eliminating 104 week waits may prove challenging for some Providers; Nottingham and Leicester particularly. Mutual aid is being provided by ULHT to support an out of area Provider with their long waiters in 2 specialties • ULHT Outpatients Recovery & Improvement Group (ORIG) and High Volume Low Complexity (HVLC) are under way with a number of schemes to address productivity and efficiency that will support reduction in waiting list size. • Planning has commenced in preparation to revert to pre-covid IPC procedures which will support increased activity and a reduction in long-waiters • Most diagnostic modalities had restored to greater than pre-COVID capacity. However, the fire at LCH at the end of March continues to impact recovery, particularly CT & MRI, although mitigation plans are in place to minimise the disruption as much as possible. • A business case to expand the provision of services being delivered at the Grantham CDC will be submitted in July and will increase services to include provision of a full range of diagnostic services including pathology, CT, DEXA, MRI and mammography imaging services as well as a variety of other diagnostic tests over the next 3 years. Plans are also being developed for a new CDC in the county, with the business case due for submission in September 2022.

Patients waiting over 52 weeks for treatment (ICB)



Patients waiting over 104 weeks for treatment (ICB)



Indicator

Patients waiting over 52 weeks for treatment
(% of total waiting list size)

Period

May-22

Total 52 Week Breaches

6926

ICB

6.1%

England

5.0%

Trend



Indicator

Patients waiting over 104 weeks for treatment
(% of total waiting list size)

Period

May-22

Total 104+ Breaches

53

ICB

0.05%

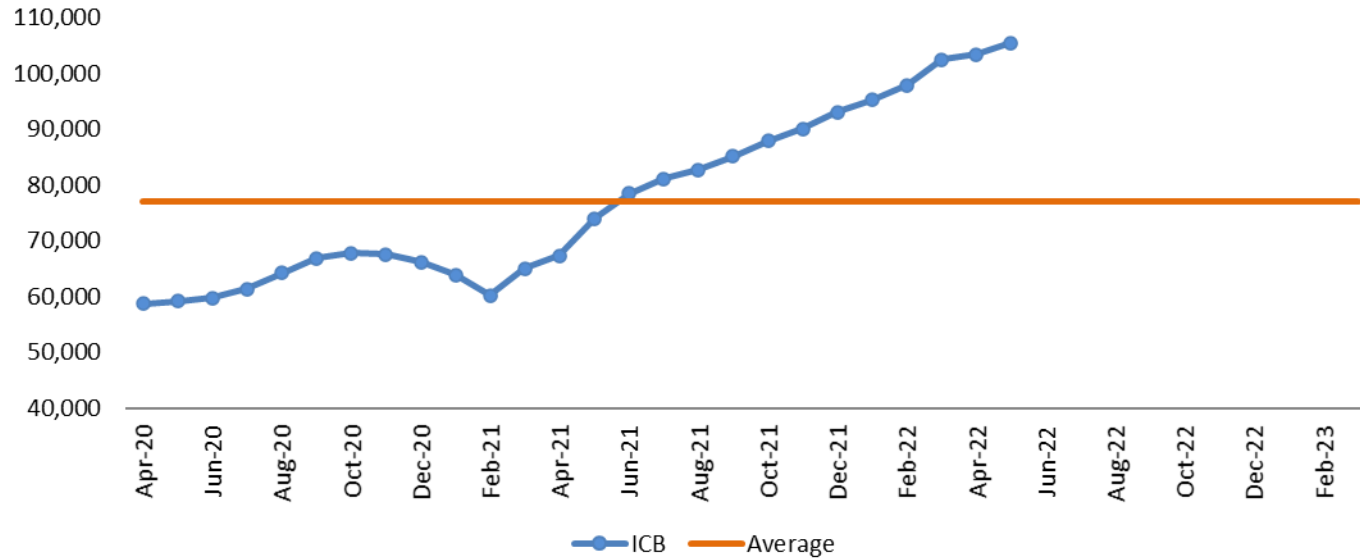
England

0.12%

Trend



Total Waiting List Size (ICB)



Indicator

Total Waiting List Size (ICB)

Period

May-22

ICB

105,487

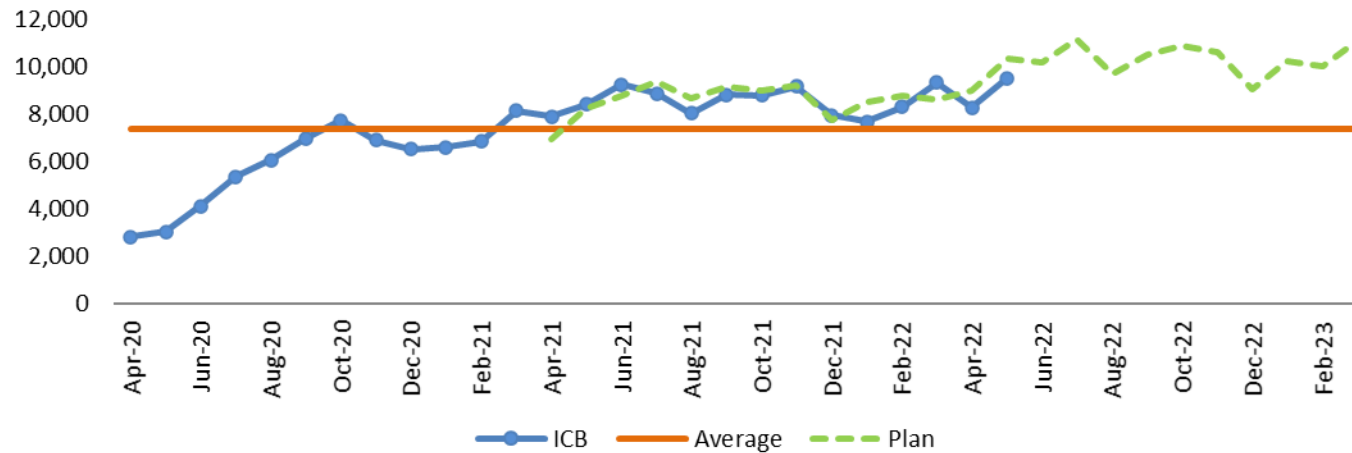
England

N/A

Trend



Total Elective Spells (ICB)



Indicator

Total elective spells

Period

May-22

Plan

10,328












LCCG

9,520

Trend



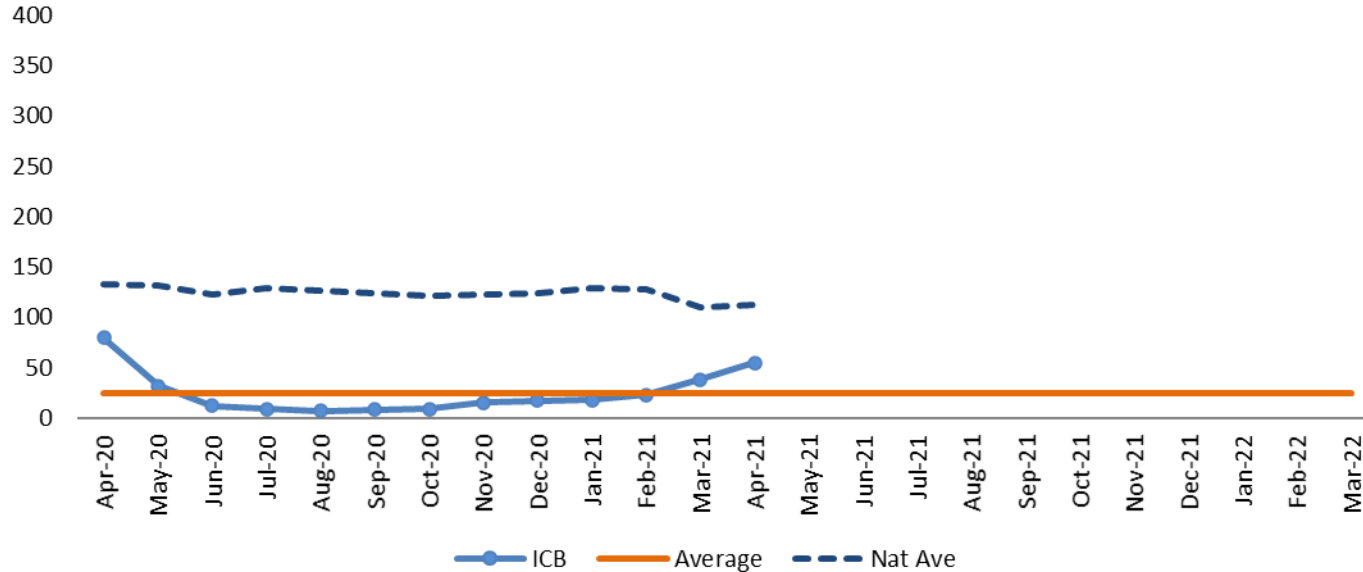
Elective Recovery

Indicator	Period	Plan	LCCG	Trend
First Outpatient Attendances	May-22	27,787	19,859	
F/up outpatient attendances	May-22	38,999	30,339	
Total elective spells	May-22	10,328	9,520	
Total referrals	May-22	20,583	19,743	
Diagnostics- Magnetic Resonance Imaging	May-22	4,506	4,850	
Diagnostics- Computed Tomography	May-22	9,797	10,796	
Diagnostics- Non-Obstetric Ultrasound	May-22	6,520	9,462	
Diagnostics- Colonoscopy	May-22	716	730	
Diagnostics- Flexi Sigmoidoscopy	May-22	410	382	
Diagnostics- Gastroscopy	May-22	728	833	
Diagnostics- Echocardiography	May-22	1,377	1,569	

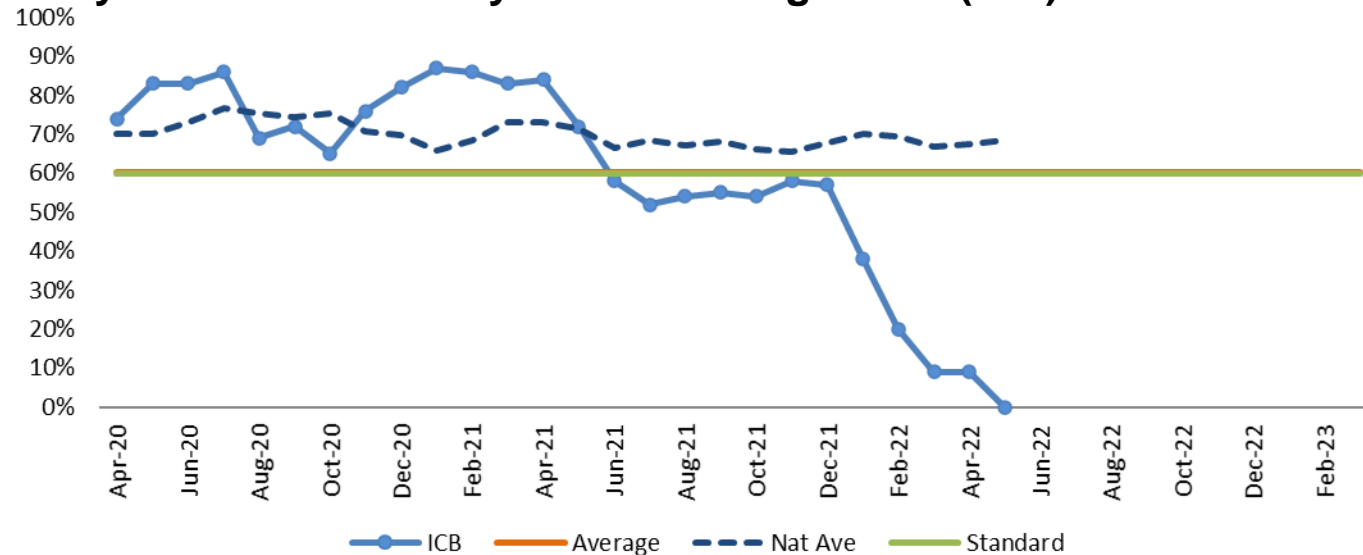
Mental Health

Cause	Actions To Recover
<p>IAPT</p> <ul style="list-style-type: none"> • Demand is increasing • The service continues to have a high number of trainees which impacts on capacity, but will improve the overall capacity eventually. A number of trainees have qualified in March 2022 which is helping improve delivery into 2022/23. Trainees currently work to 60% capacity whilst studying but upon qualification this increases to 100%. <p>Early Intervention in Psychosis waiting times:</p> <ul style="list-style-type: none"> • The service aware of, and is proactively managing the drop in performance as outlined in May’s Integrated Performance Report. • The current wait for the service, although over 2 weeks, is 3 weeks 	<p>IAPT</p> <ul style="list-style-type: none"> • 10 staff started in March/April plus 13 trainees are due to commence in September 2022 • An assurance paper is being prepared for LPFT Sustainability committee in August 2022 which will highlight increased in demand and the ability to keep up and deliver to target. <p>Early Intervention in Psychosis waiting times:</p> <ul style="list-style-type: none"> • The backlog has been addressed with a plan for recovery – improvements expected from July 2022 (current performance being reported is from May 2022) • Demand is outstripping service capacity – Service remodelling is taking place and a business case will follow shortly to expand the team.

Mental Health Out of Area Placements (Lincs)



Early Intervention in Psychosis Waiting Times (ICB)



Indicator
Inappropriate Out of Area Placements in mental health services for adults in non-specialist acute inpatient care per 100,000 (ICB)

Standard
0

Period
Apr-22

Total Out of Area Bed Days
350

ICB
54.6

England
112.6

Trend

Indicator
People experiencing first episode psychosis or ARMS that wait two weeks or less to start a NICE recommended package of

Standard
60%

Period
May-22

Seen < 2 Weeks
0

Total Patients
90

ICB
0.0%

England
68.6%

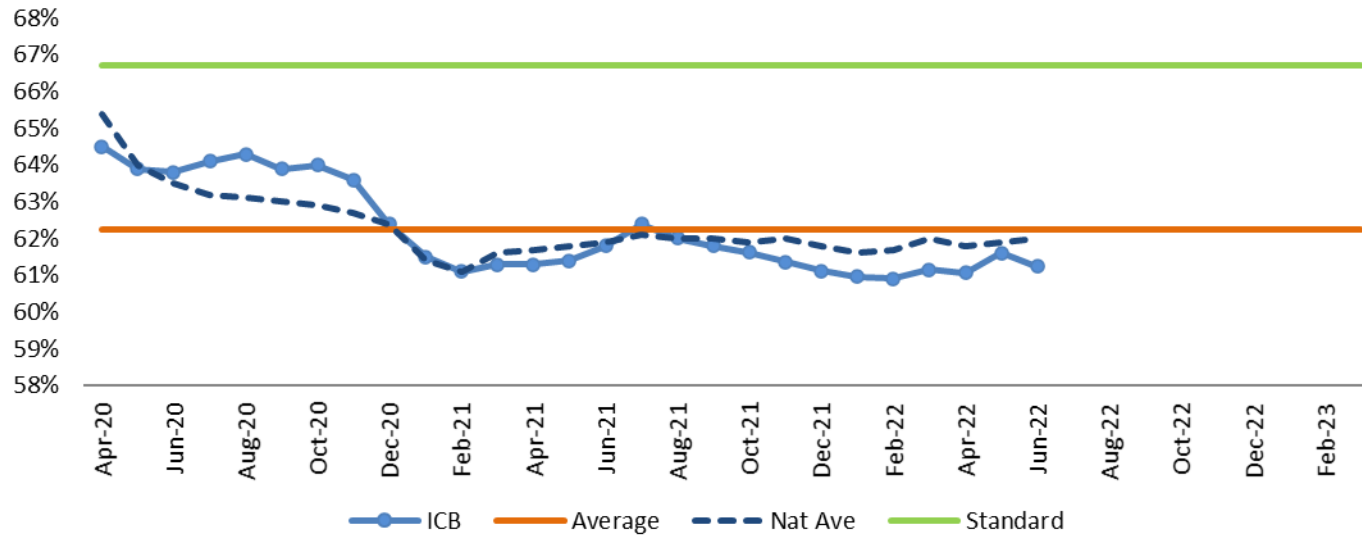
Trend



Mental Health (Community)

Cause	Actions To Recover
<p>SMI Health checks</p> <p>The CCG has promoted the importance of improving SMI health check delivery to GP practices. The re-allocation of new SMI QOF points in December alongside the prioritisation of covid vaccination and urgent on-the-day care has impacted on delivery.</p> <p>The CCG has offered funding support to GP practices to improve delivery through additional capacity. A process for LPFT to inform GP practices of secondary health checks has been implemented, LPFT have also delivered SMI health check clinics to improve access.</p> <p>Local data indicates significantly improved performance by year end in 21/22 with 1,966 health checks completed (45% of SMI register).</p> <p>Lincolnshire ICB Dementia Diagnosis Rate (DDR)</p> <p>National Target is 66.7% Latest data available is June 2022</p>	<ul style="list-style-type: none"> • PCN funding is available to support delivery and improve performance over Q3 and 4. • Some delays in PCN contract completion and plan submission – locality teams are engaging with PCNs to finalise in November. • LPFT have put in place systems to enable sharing of SMI health check data and outcomes with GP practices. Data sharing is planned to go live imminently. This will mean that health checks carried out in secondary care will be coded in clinical systems giving a more complete picture of local delivery. • Promotion of SMI health checks by LPFT community teams is expected to support improved engagement with the offer from GP practices. <p>Dementia Diagnosis Rate (DDR)</p> <p>DDR Recovery plan in train 22/23 –</p> <ul style="list-style-type: none"> • Deep dive of referrals and waiting time data • PCN improvements plans • Digital MAMS pathway expected to improve waits • Seeking to understanding barriers to referral & diagnosis • Appointment of new GP clinical lead – critical to the recovery of DDR

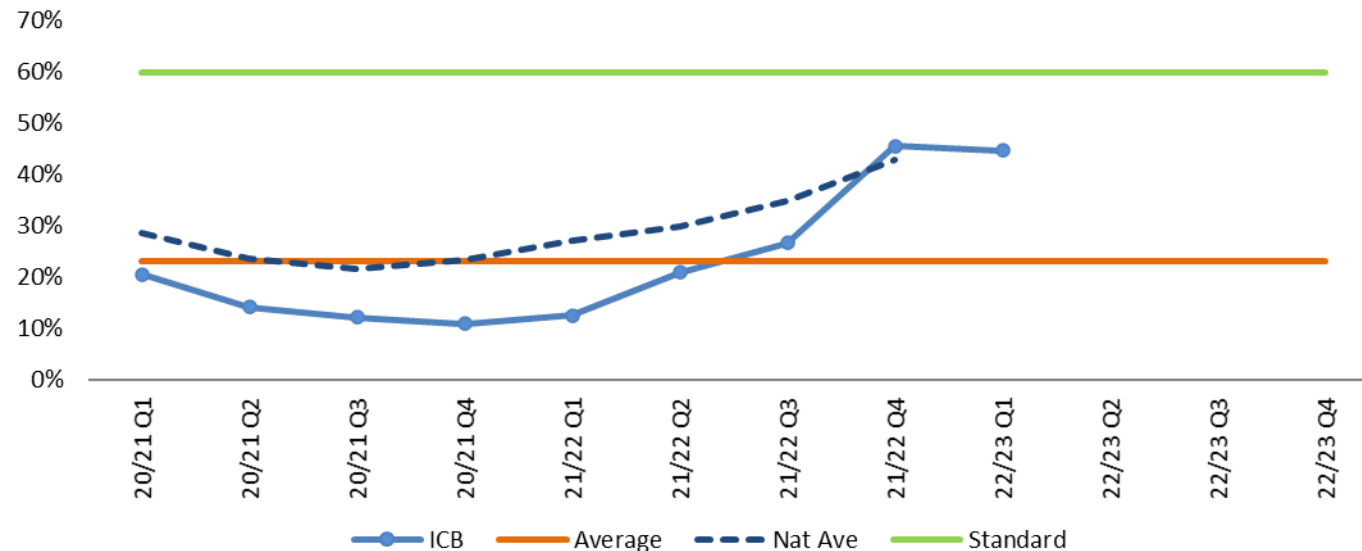
Dementia Diagnosis Rate (ICB)



Indicator
Estimated diagnosis rate for people with dementia
Standard
66.7%
Period
Jun-22
CCG Dementia Register
7,335
Estimated Pts With Dementia
11,976
ICB
61.2%
England
62.0%
Trend



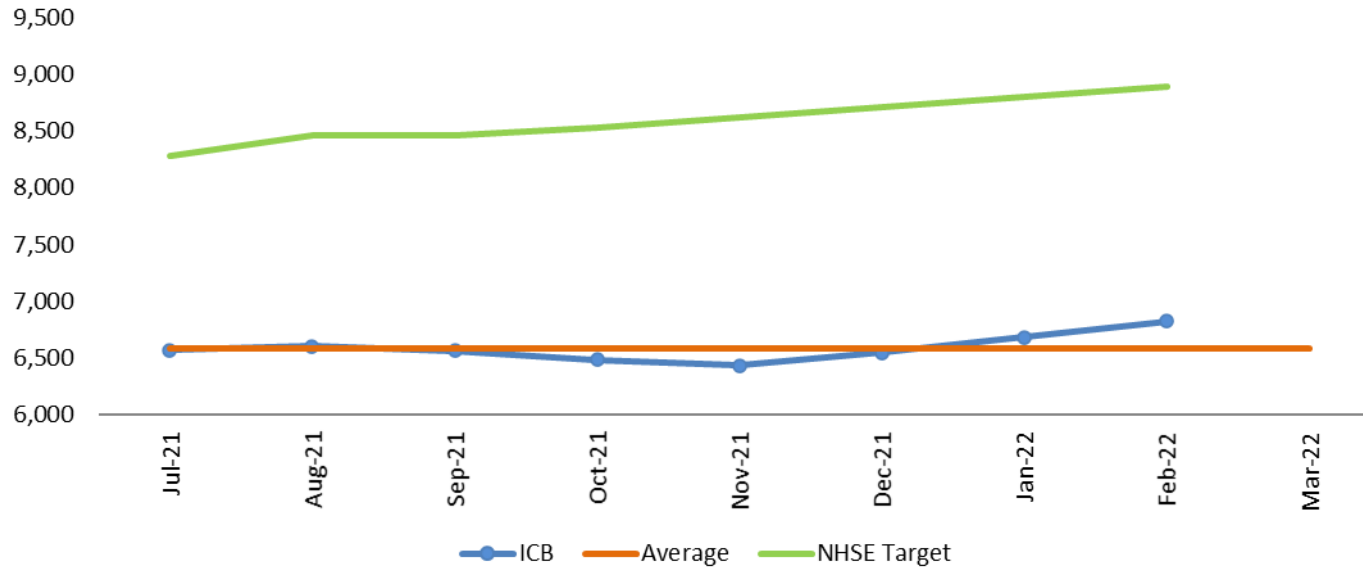
Physical Health Checks for people with Severe Mental Illness (ICB)



Indicator
People with severe mental illness who have received the complete list of physical health checks in the preceding 12
Standard
60%
Period
22/23 Q1
All 6 Checks Complete
1,952
ICB SMI Register
4,364
ICB
44.7%
England
42.8%
Trend



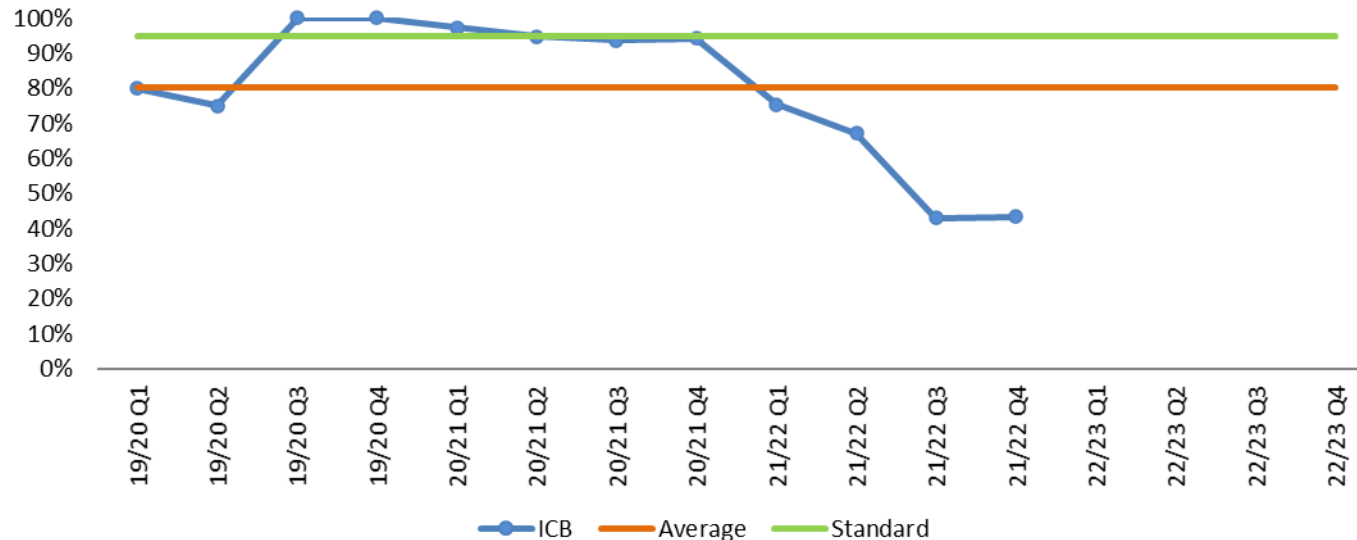
CYP with mental health disorder-one contact (ICB)



Indicator
Children & Young People (CYP) with MH disorder receiving one contact in the reporting period last 12 months
NHSE Target
8891
Period
Feb-22
CYP Receiving One Contact
6,820
ICB (Gap)
2071
Trend



CYP with an eating disorder (routine) starting treatment within four weeks (ICB)



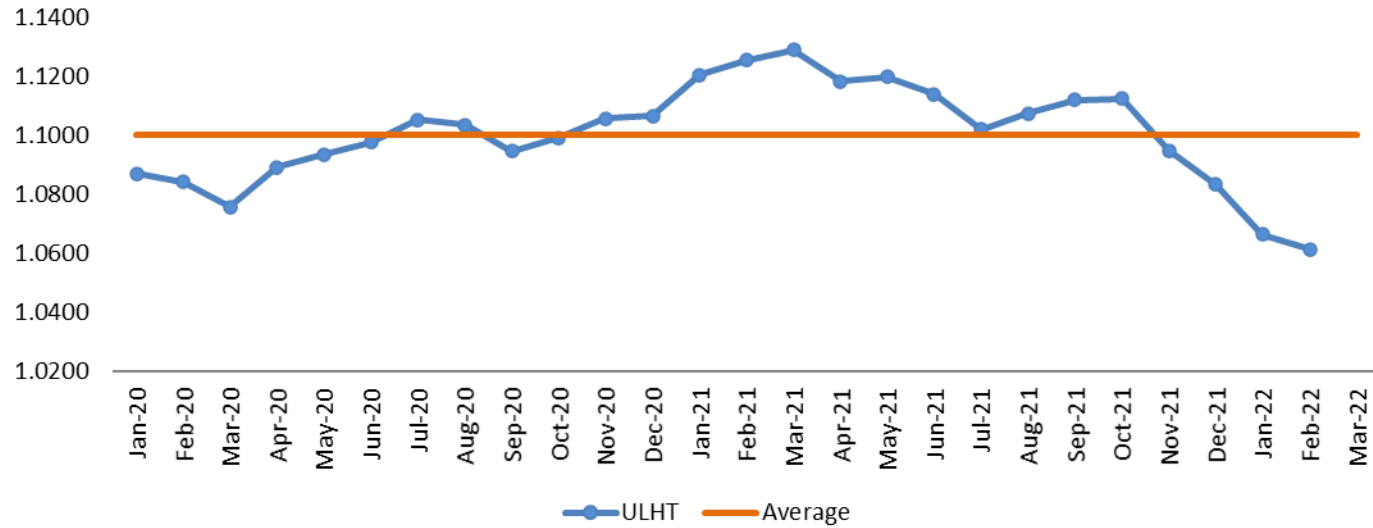
Indicator
The number of CYP with an eating disorder (routine) referred that start treatment within four weeks of referral in the reporting period (rolling 12
Standard
95%
Period
21/22 Q4
Routine Referrals
90
Treated < 4 Weeks
39
ICB
43.3%
Trend



Mortality (ULHT)

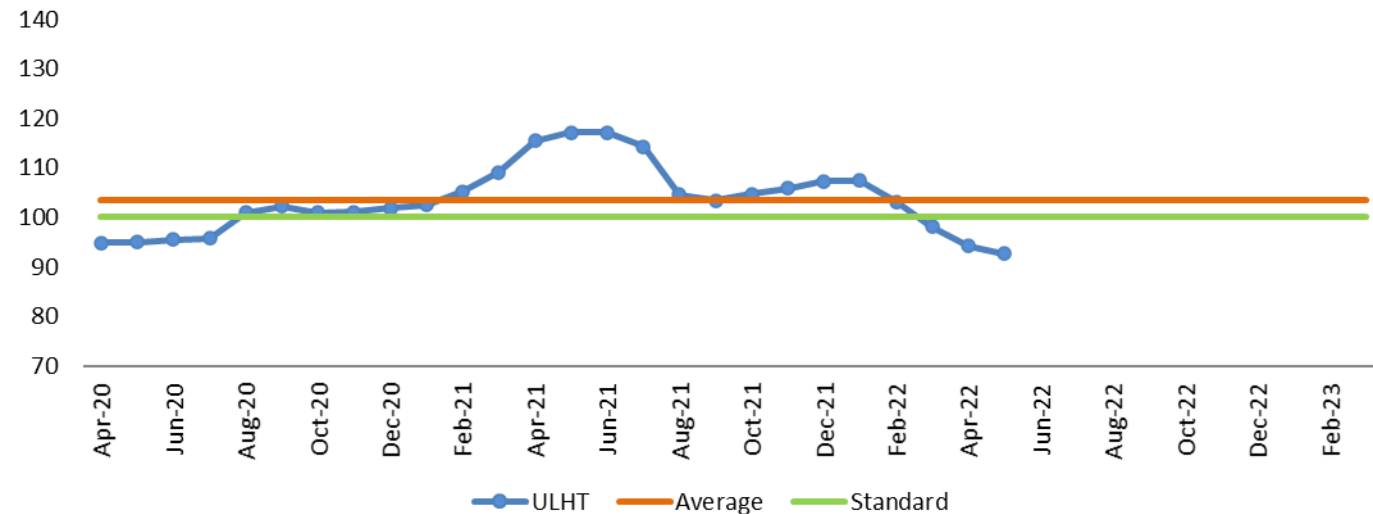
Cause	Actions To Recover
<ul style="list-style-type: none"> ULHT SHMI is 1.062 (March 2021 – Feb 2022); Trust in Band 2 for this time period - so ‘as expected’. SHMI includes both deaths in-hospital and within 30 days of discharge SHMI per site is as below: Lincoln - 1.078 as expected Pilgrim - 1.068 as expected Grantham- 0.791 lower than expected Palliative Care Coding of mortality cases is at 35% compared to 40% national average. 	<p>Aim is for all deaths to be reviewed by the Medical Examiner’s(ME) team and any deaths where issues are identified are escalated for a structured judgement review(SJR) .</p> <ul style="list-style-type: none"> Medical Examiner Officers now working to support the Medical Examiners within the Trust. Any diagnosis group alerting is subject to a case note review. A training program has been completed – ‘capturing care’ workshop. An external triangulation audit of SJRS undertaken with NHSEI through the Better Tomorrow Team. Continued work on ensuring accurate coding, including palliative care coding The Trust are currently working with system partners in rolling out the ME service for community deaths. Collaborative work underway to address ‘within 30 days of discharge’ SHMI rates - OOH SHMI (38%) for the Trust overall. NHSE average (33%).

Summary Hospital Level Mortality Indicator (SHMI) (ULHT)



Indicator
Summary Hospital Level Mortality Indicator (SHMI) (ULHT)
Standard
1.0000
Period
Feb-22
ULHT
1.0613
England
1.0004
Trend

Hospital Standardised Mortality Ratio (HSMR) (ULHT)

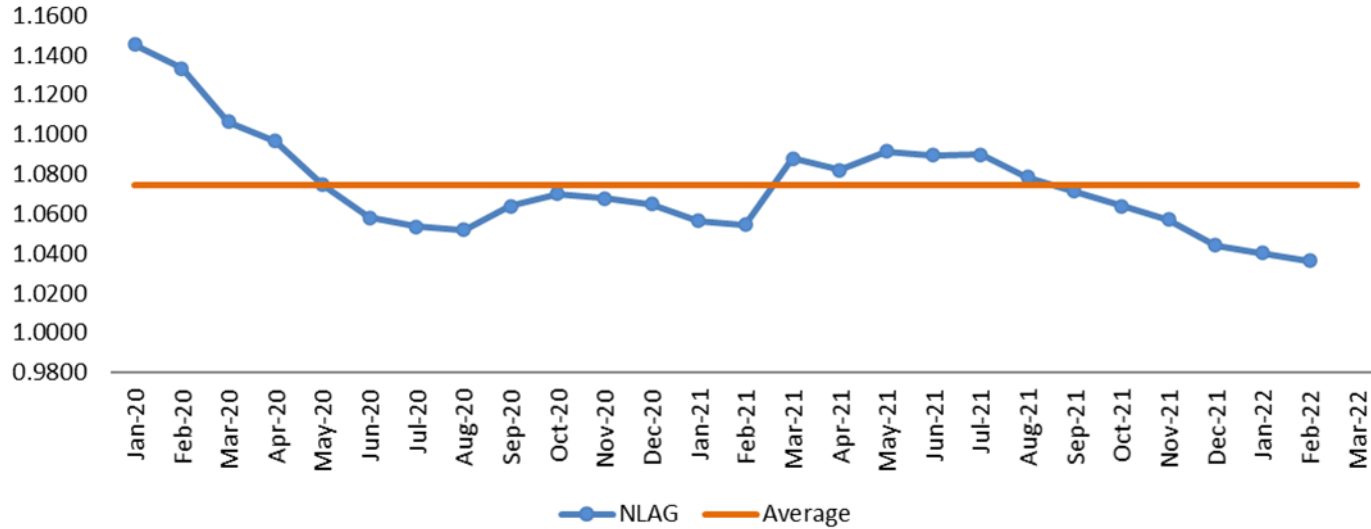


Indicator
Hospital Standardised Mortality Ratio (HSMR) (ULHT)
Standard
100
Period
May-22
ULHT
92.60
England
N/A
Trend

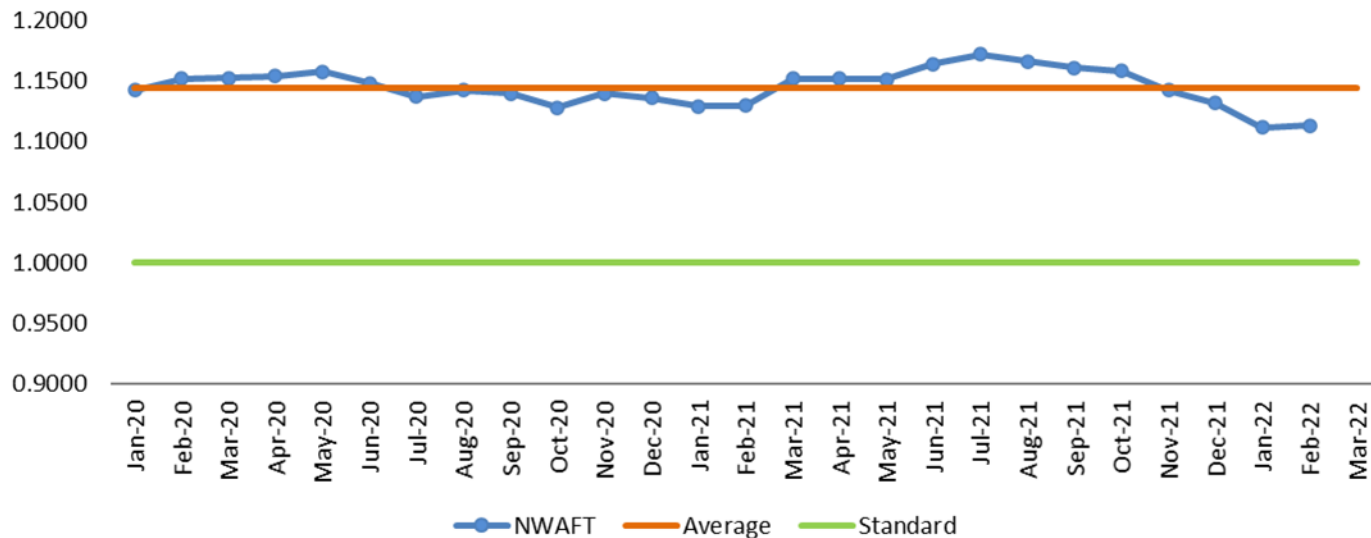
Mortality (NWAFT)

Cause	Actions To Recover
<p>SHMI data (NHS Digital Feb 2021-Jan 2022) Trust wide: 1.1113, as expected range PCH: 1.1860, higher than expected HH: 0.9783 as expected HMSR (April 2021-March 2022) Trust: 101.9, as expected PCH: 111.7, statistically significant HH: 87.6, below expected</p> <p>A deep dive analysis of SHMI data was planned for February 2022 with report shared in June 2022. We remain unclear whether this is a coding, reporting or a quality of care/ patient safety issue.</p>	<ul style="list-style-type: none">• NWAFT have agreed to procure a 3rd party to undertake scrutiny on their Mortality workstream. Awaiting update.• Virtual clinical coding session has been introduced as a pilot with Respiratory consultants at HH. It will be rolled out across the Trust, no date for PCH yet.• QI project has been set up to measure knowledge at PCH and identify 'HSMR Champions' who will share information and knowledge about data quality and coding.• Cambridgeshire and Peterborough ICB and Lincolnshire ICB are working in tandem to support NWAFT.

Summary Hospital Level Mortality Indicator (SHMI) (NLAG)



Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)



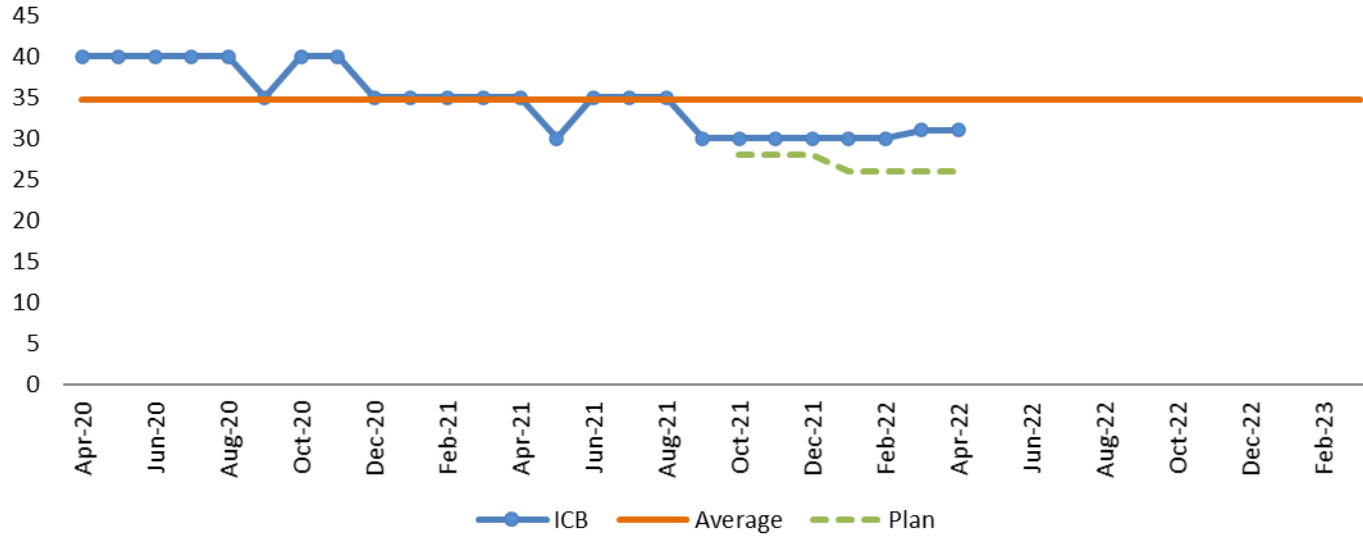
Indicator	
Summary Hospital Level Mortality Indicator (SHMI)	
Standard	
1.0000	
Period	
Feb-22	
Neighbouring Trusts	
ULHT:	1.0613
NLAG:	1.0363
NWAFT:	1.1131
NUH:	1.0197
QEH:	1.0348
England	
1.0004	
Trend	



Learning Disability Inpatients & Annual Healthchecks

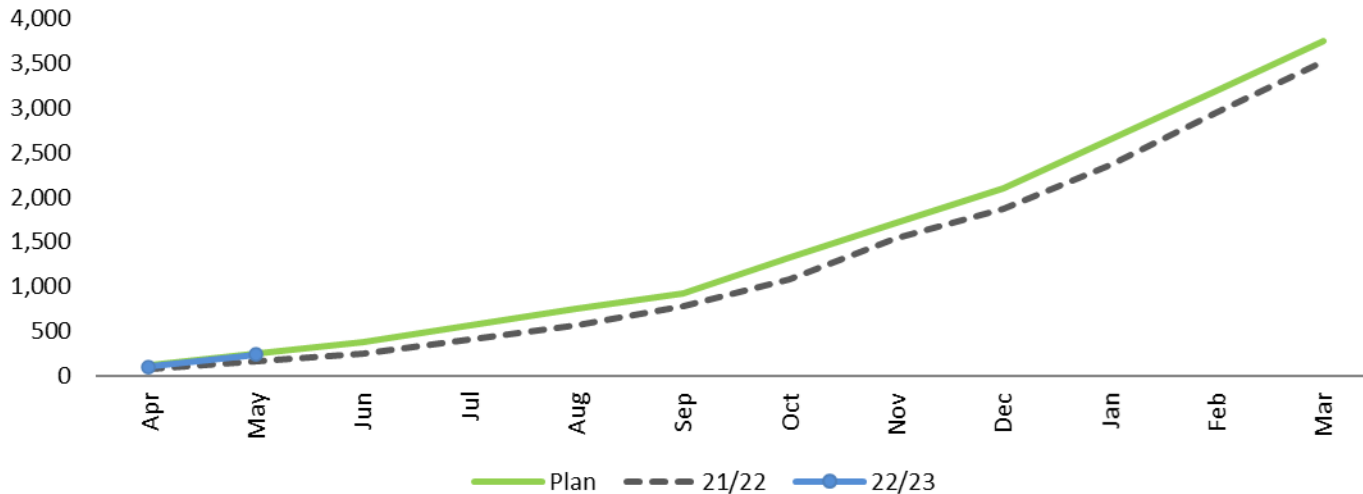
Cause	Actions To Recover
<p>LD Inpatients</p> <ul style="list-style-type: none"> • There are currently 31 LD ICB Inpatients. This current figure is above the 22/23 Q1 target of 26.) <p>LD Annual Healthchecks</p> <ul style="list-style-type: none"> • Delivery over April and May is 238 Health Checks, 78 ahead of 21/22 but 15 behind 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. 	<p>LD Inpatients</p> <ul style="list-style-type: none"> • The issues and recovery actions outlined in the May Integrated Performance Report for learning disability inpatients and annual health checks still hold for June <p>LD Annual Healthchecks</p> <ul style="list-style-type: none"> • 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 but is slower than planned. • Engagement with practices indicates limited capacity to bring scheduled health checks forward in some cases. • A funding bid to NHSE for £20k to support this catch up work has been successful (notification received 13 July).

Number of people with a learning disability receiving inpatient care (ICB)



Indicator
Number of people with a learning disability receiving inpatient care (ICB)
Plan
26
Period
Apr-22
ICB
31
Trend

Learning Disability Annual Healthchecks (ICB)



Indicator
Cumulative Learning Disability Healthchecks (ICB)
Plan
253
Period
May-22
ICB
238
England
N/A
Trend

Care Home Quality

CQC rating	Outstanding	Good	Requires Improvement	Inadequate
June 2022				
No. of Homes: 273				
10 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	193 (remains the same as last month)	52 (remains the same as last month)	2 (remains the same as last month)
CQC rating	Outstanding	Good	Requires Improvement	Inadequate
July 2022				
No. of Homes: 273				
10 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	193 (same as last month)	52 (remains the same as last month)	2 (remains the same as 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: x7 providers

There are 5 Suspensions in place by Health and Lincolnshire County Council:

- Across the East & West localities
- Themes include lack of leadership and governance, whistleblowing issues and lack of engagement

There has been a total of 10 Default Notices by Lincolnshire County Council:

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

July 2022

Safeguarding

Partnership Working

- The Associate Director of Nursing and Quality or Designated Doctor attend Lincolnshire Safeguarding Children Partnership (LSCP) and Lincolnshire Safeguarding Adult Board (LSAB) executive meetings. There is also representation from the safeguarding team at the Lincolnshire Safeguarding Adult Partnership Board and the Domestic Abuse Partnership Strategic group to ensure that any safeguarding issues are identified, addressed and mitigated. The LCCG safeguarding team are actively involved in all sub-groups of the Boards, including statutory safeguarding reviews Child Safeguarding Practice Review (CSPR), Serious Adult Reviews (SAR) and Domestic Homicide Reviews (DHR)). In total the boards have x9 ongoing DHR, x0 SAR: scoping for two potential SAR's and x1 combined CSPR and DHR

Safeguarding Adults / Mental Capacity / Court of Protection

- The draft MCA Code of Practice was published on 17 March 2022, the consultation period was concluded on 14 July 2022. A response has been made by the ICS using the local implementation group as well as by the ICB. The government will now take into account the comments made to determine the final code content and review the timeline for Liberty Protection Safeguards (LPS) to be implemented.

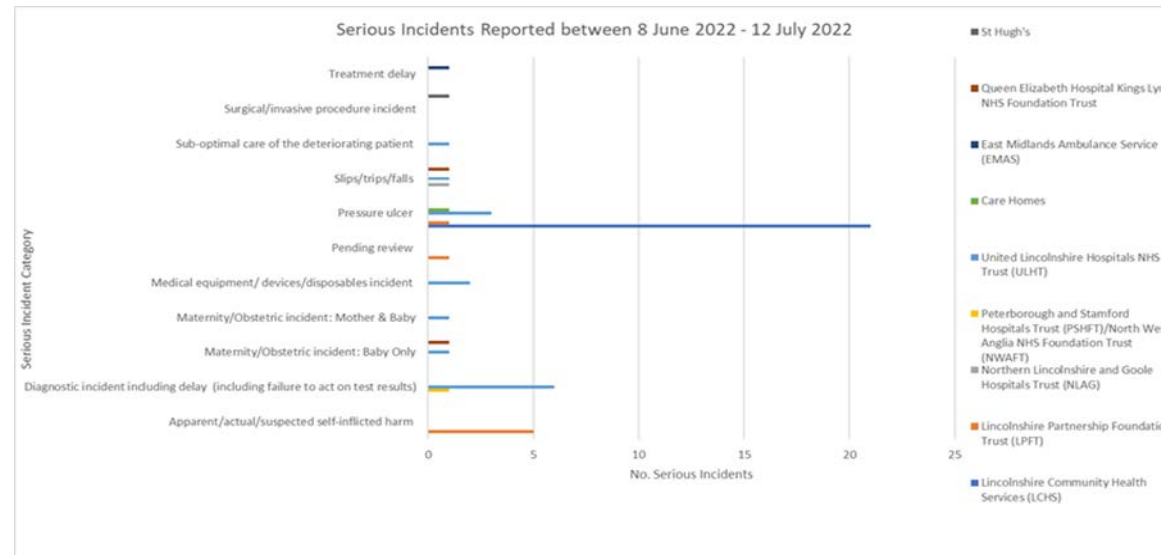
Safeguarding Issues/Risks

- 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 second SEND Clinicians Training Programme relating to the Graduated Approach, SEND and the law has been developed in conjunction with Liaise (the counties SEND Independent Advice Support Service) has been agreed for delivery commencing Autumn 2022 – the three tier programme will be delivered 4x throughout 22/23 and dates will be advertised to allow new colleagues to book as part of their induction on the ICB website
- The online e-learning resource for professionals who work with CYP with SEND called a 'Rough Guide to not putting your foot in it' funded by NHSE and in collaboration with Lincolnshire Young Voices and LA is complete and we launched on July 8th at an online event across the Lincolnshire system Education, Health, NHSE, Social Care, Police and third party organisations. Very positive feedback from right across the system. The launch was covered by the local media and work is being undertaken on how it can be embedded nationally – it currently sits in the [Lincolnshire Safeguarding Children Partnership – Training - Lincolnshire County Council](#)
- The online SPD Education and Training Programme to support CYP with sensory processing difficulties is now live and very well subscribed. We have just added an additional 4 workshops due to demand. We are also developing a business case to explore options for an in house Sensory Therapy service.
- Collaborative development of the Special Schools Programme for CYP with SEND and develop a strategy going forward. A deep dive into CYP who are eligible to move in to a Special setting is underway and we are looking at resourcing the new model with new ways of working has commenced lead by Sharon Herbert ADCO in collaboration with provider leads.

Serious Incidents



Update

- There has been a total of 50 serious incidents reported between 8 June 2022 – 12 July 2022, this represents an increase when compared to the last report (n=35); however, is more in keeping with previous serious incident reporting rates (n=42).
- There has been an increase in the number of serious incidents reported by LCHS, focused on pressure ulcer reporting. A total of (n=21) incidents reported this month, compared to (n=11) last month.
- Consistent with last month, ULHT have reported (n=15) serious incidents. Most of this month's serious incidents reported by the Trust have been categorised as diagnostic incidents (n=6), followed by pressure ulcers (n=3). In addition, there have been (n=2) serious incidents reported in relation to medical equipment and maternity services. Single incidents have been reported in relation to slips/trips/falls and sub optimal care of the deteriorating patient. It is noted that for this month there has been an increase in diagnostic serious incidents reported by the Trust.
- LPFT reported a total of (n=7) serious incidents in the timeframe referenced, this represents an increase when compared to the report last month (n=2). As reported previously, the focus of serious incident reporting for the Trust remains apparent/actual/suspected self-inflicted harm (n=5). In addition, LPFT reported a single slip/trip/fall and a further incident which is pending categorisation (to maintain patient confidentiality no further detail is included within this report).

July 2022

Ockenden Response

Ockenden Insight visit to ULHT, maternity services were inspected by the regional quality team in June. The purpose of the visits was to provide assurance against the 7 immediate and essential actions from the first Ockenden report. The inspection report made reference to the outstanding senior leadership team and the presence of clear executive and NED visibility across maternity services at ULHT. They found many examples of Quality Improvement projects in place including PeriOpt Project; information place mats; updated discharge video in all languages. The visiting team commented on the strong governance methodology being visible across the division with good connections with the corporate team particularly in incident management and robust assurance processes. Staff were able to articulate a positive culture in which they felt confident to challenge decision making and escalate any concerns across both sites. The MVP Chair was recognised for driving an innovative pilot work programme aimed at supporting military families which will inform opportunities for spread of good support practices nationally over time.

Primary Care

Cause	Actions To Recover
<p>Quality</p> <ul style="list-style-type: none"> Lakeside CQC report was published on the 1st June with an overall requires improvement rating. The Practice remains in Special Measures for a further six months to ensure the improvements still required are made. <p>Access</p> <ul style="list-style-type: none"> 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 (more people are seen Face-to-Face but less often by a GP) Ongoing demand pressures and LTC recovery are impacting on patient access times Not affecting the May data set but to note – covid outbreaks and number of staff affected are increasing in frequency in GP practices (currently 21 practices, 70 staff). Enhanced access data completeness is an ongoing issue 	<ul style="list-style-type: none"> CCG senior representatives continue to meet regularly with the Practice Team to receive assurance on continued actions to address concerns and to support. LMC also supporting. ICB Primary Care and Quality teams continue to support practices in improving care quality and patient experience <ul style="list-style-type: none"> Review and monitor access activity Practice support available through Livi system and LMC Lantum available to support practice capacity GPAS monitoring practice pressures and reporting through to OPEL system: managed by the LMC Primary Care team supporting Enhanced Access reporting and following up with PCN

Primary Care

Practices Rated Inadequate: 0

Practices Rated 'Requires Improvement: 4

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		

New Reports

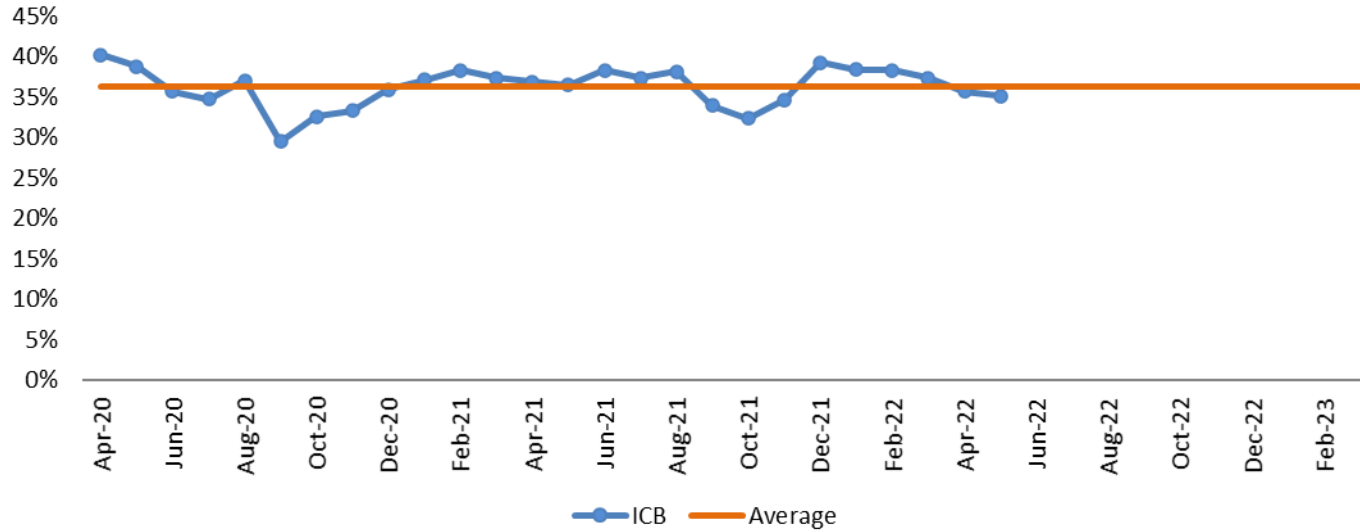
Practice	Publication Date	Locality	Overall Rating	Previous Rating
Lakeside Healthcare	01/06/2022	South	Req Improvement	Inadequate

Actions to recover

Lakeside

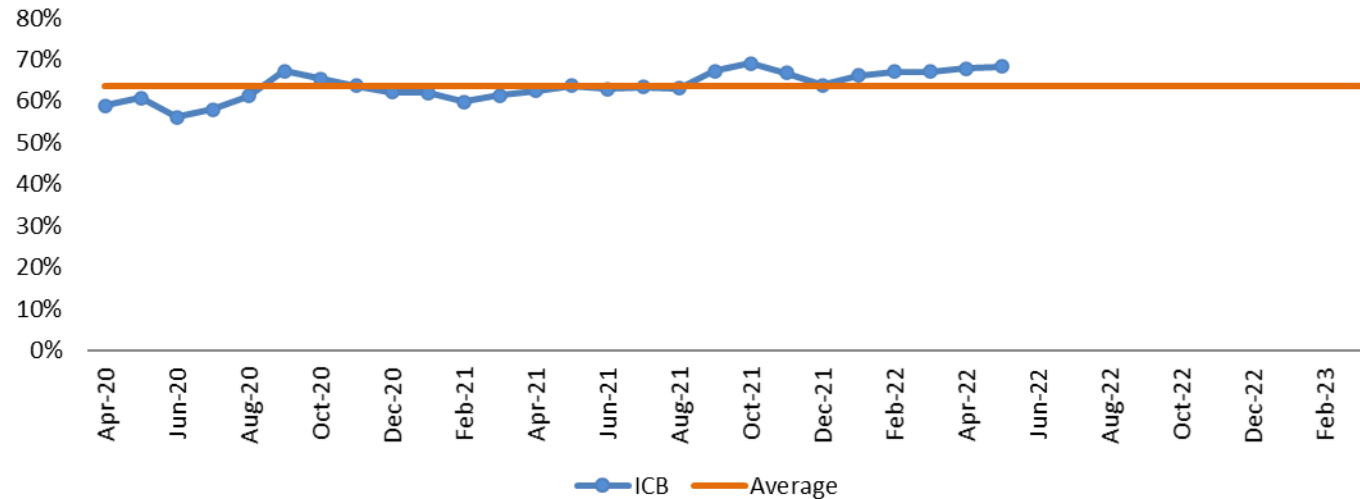
Lakeside received inadequate CQC rating in June 2021. At follow up inspection visit in September 2021 improvements noted, but still areas to address regarding staffing and governance. **Further CQC full inspection in early March 2022 – the CQC report for this inspection was published on the 1st June with an overall requires improvement rating. The Practice remains in Special Measures for a further six months to ensure the improvements still required are made.** CCG senior representatives continue to meet regularly with the Practice Team to receive assurance on continued actions to address concerns and to support. LMC also supporting.

GP Appointments- percentage seen by a GP



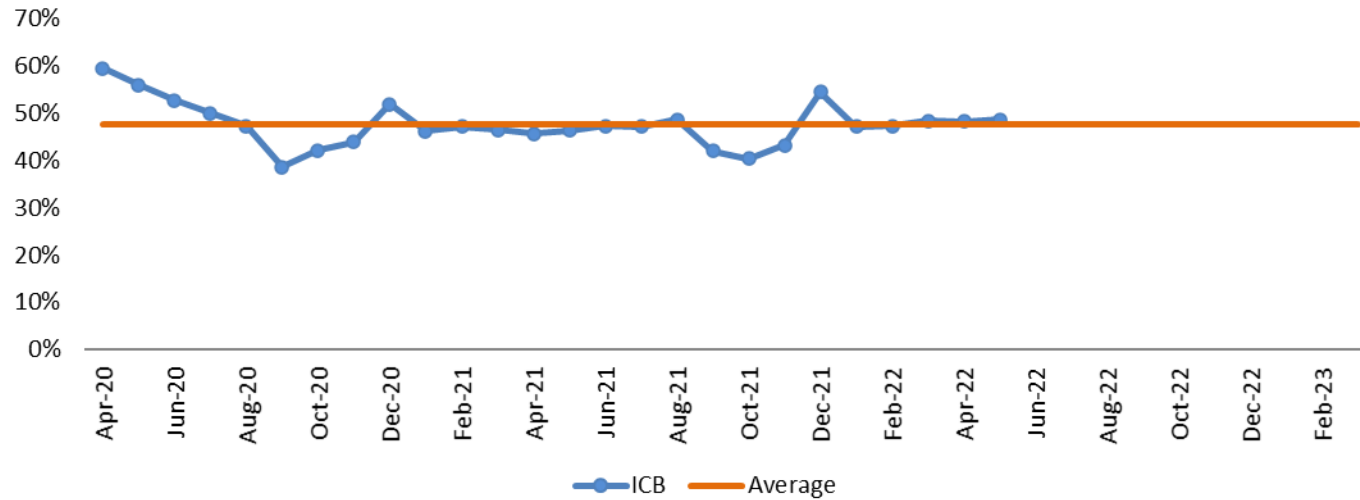
Indicator
GP Appointments- percentage seen by a GP
Period
May-22
20/21
38.8%
21/22
36.5%
22/23
35.2%
Trend

GP Appointments Mode- percentage seen face to face



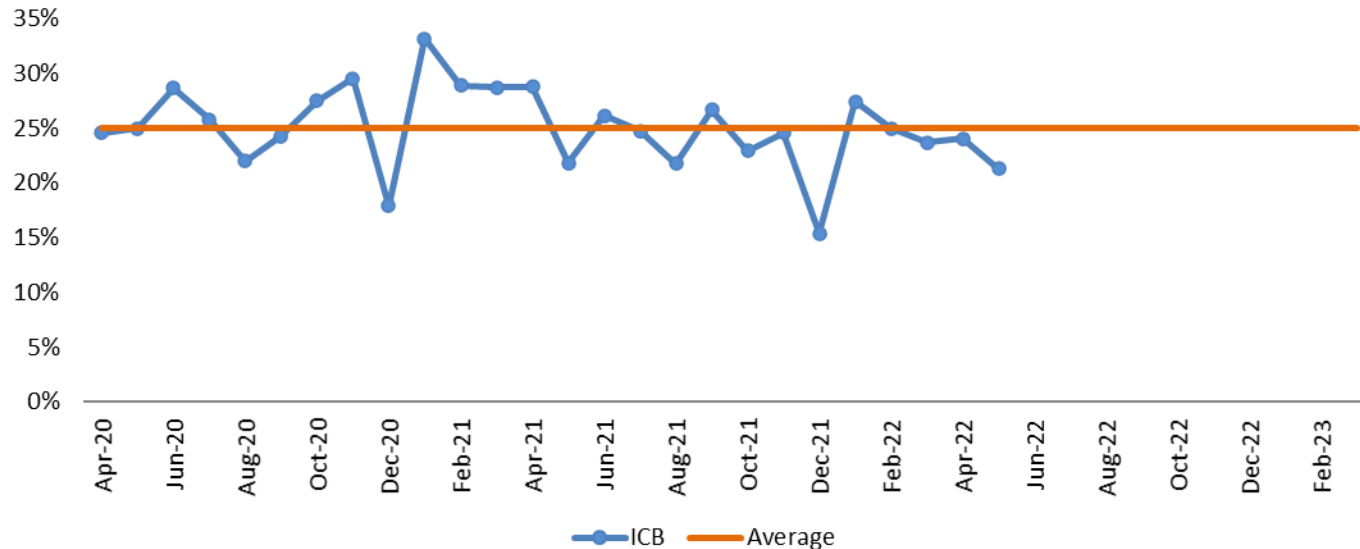
Indicator
GP Appointments Mode- percentage seen face to face
Period
May-22
20/21
60.8%
21/22
63.8%
22/23
68.4%
Trend

GP Appointments- time from booking to appointment (Same Day)



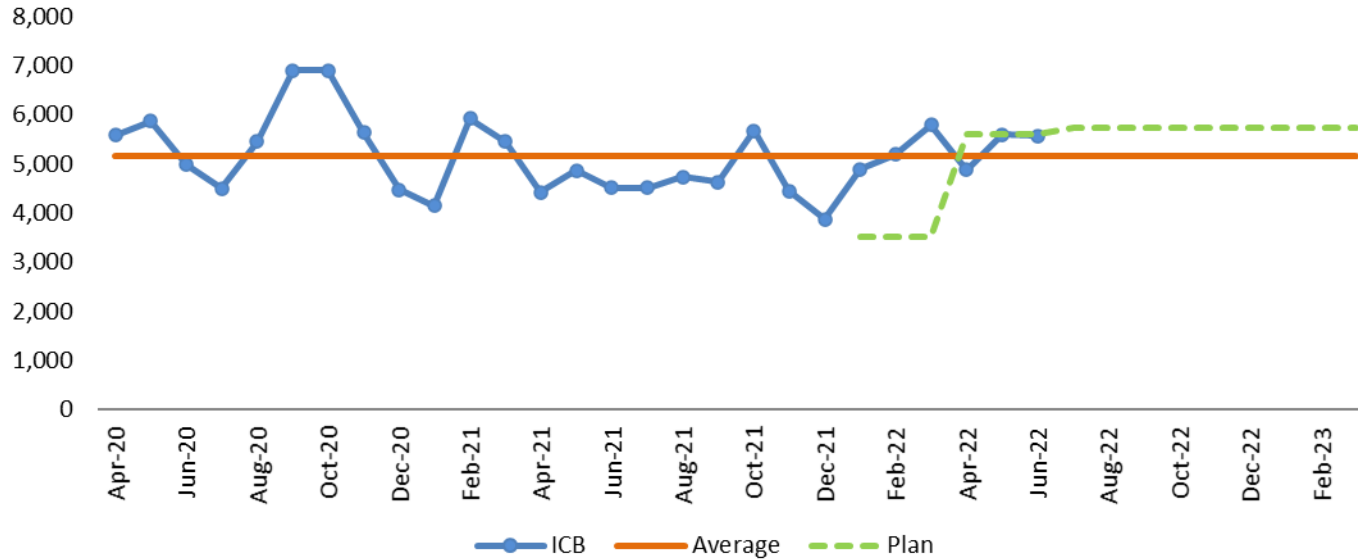
Indicator
GP Appointments- time from booking to appointment (Same Day)
Period
May-22
20/21
56.0%
21/22
46.3%
22/23
48.7%
Trend

GP Appointments- time from booking to appointment (1-6 Days)



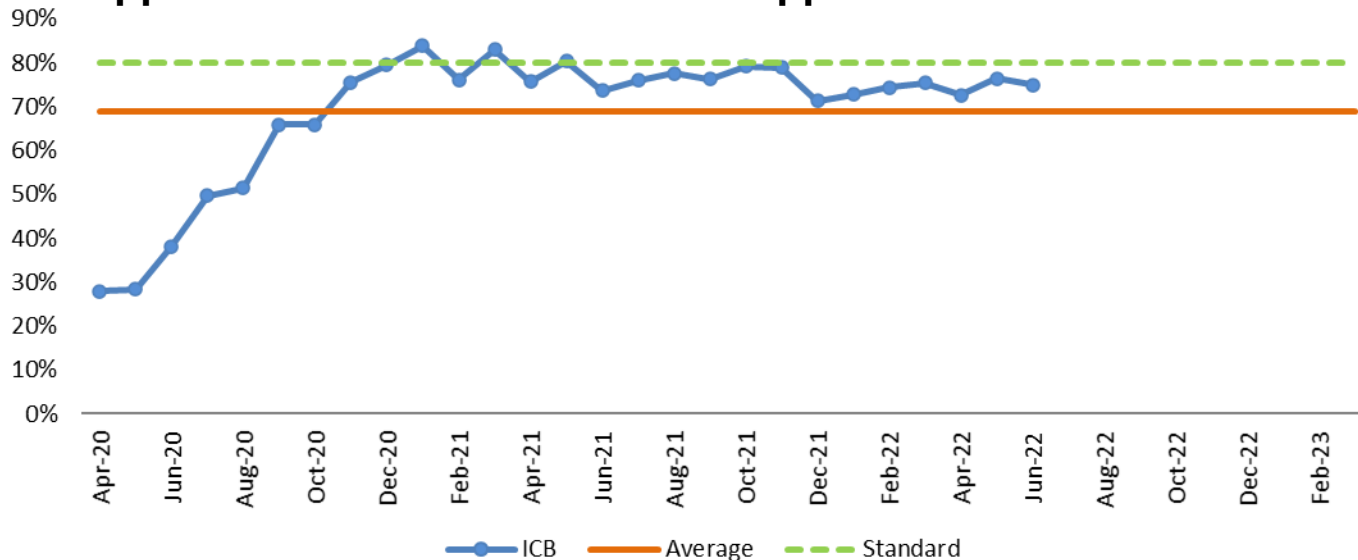
Indicator
GP Appointments- time from booking to appointment (1-6 Days)
Period
May-22
20/21
24.9%
21/22
21.8%
22/23
21.3%
Trend

GP Appointments-Extended Access Appointments Available



Indicator
The number of extended access appointments booked excluding did not attends (ICB)
Period
Jun-22
Plan
5589
22/23
5563
Trend

GP Appointments-Extended Access Appointments Utilisation



Indicator
The percentage of available GP extended access appointments utilised (ICB)
Period
Jun-22
Standard
80.0%
22/23
75.0%
Trend

Public Meeting of NHS Lincolnshire Integrated Care Board

Date: 26 July 2022

Location: Bridge House, Sleaford

Agenda Number:	6 (i)
Title of Report:	Financial Management Report June 2022 (Month 3)
Report Author:	Rebecca McCauley, Senior Finance Business Partner
Appendices:	

1. Key Points for Discussion:	This is a standing report to Board setting out the financial position of the Lincolnshire Healthcare NHS System and the Lincolnshire ICB.
2. Recommendations	The members of the Board are asked to consider and 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.
3. Executive Summary	<p>The report represents the final reported period of the CCG and reports the financial implications of the CCG closing financial position on the newly formed Lincolnshire ICB.</p> <p>The Lincolnshire Integrated Care System planned to deliver a £1.0m surplus position by 30th June 2022 (Month 3). At Month 3 the system reported a £2.1m favourable variance to the plan by delivering £3.1m surplus. This is the position after accounting for an anticipated reimbursement of £2.5m for Outside of Envelope items relating to COVID-19 expenditure incurred (it is expected that this will be reimbursed to the ICB in Month 4).</p> <p>The transition from a CCG to an ICB means that any underspend or overspend is novated between the organisations and so an additional £7.0m allocation will be novated to the ICB in Q2 above planned allocation.</p> <p>The underlying system position for Q1 is a deficit of £3.9m which represents a £4.9m adverse variance to plan.</p> <p>The final system financial plan seeks to deliver a breakeven position for the full year, which is in line with the NHS statutory duty. Delivery of a breakeven position is predicated on £63.8m efficiency schemes which equates to 4.2% of the ICB allocation and of which £19m is either unidentified or has high risk of non-delivery. In total there is £43.4m of identified risk in the plan of which only £4.5m is mitigated.</p> <p>Many of these risks have crystallised in the final month of Q1 with Covid pandemic costs, beds occupancy and high pay costs principal drivers of a £5.2m deficit in ULHT.</p>

Lincolnshire Surplus (+) / Deficit (-)	ICS	Year to Date		
		Planned £m	Actual £m	Variance £m
Lincolnshire CCG		0.0	7.0	7.0
United Lincolnshire Hospitals NHS Trust		0.0	-5.2	-5.2
Lincolnshire Partnership NHS Foundation Trust		1.0	1.2	0.2
Lincolnshire Community Health Services NHS Trust		0.0	0.1	0.1
Total		1.0	3.1	2.1
Adjustment for CCG to Breakeven at 30-Jun-22		0.0	-7.0	-7.0
Adjusted Total		1.0	-3.9	-4.9

Financial Context

Lincolnshire health system (the three NHS providers and the CCG) has agreed a balanced financial position meeting the statutory duty to breakeven against the nationally agreed financial allocation, which reflects the following features:

- A trajectory from legacy system revenue allocations which protected NHS services through unprecedented times, to fair share population-based allocations, with reductions in income (at least in real terms) for every system.
- Inflation cost uplift factor for 2022/23 at 2.8%, including a total indicative pay cost change estimated at 3.0% for 2022/23, and additional allocations to mitigate inflationary pressures on non-pay costs.
- Increased clarity and certainty over capital allocations, with multi-year operational capital allocations, set at ICB level, and greater transparency over the allocation of national capital programmes.
- A general efficiency factor of 1.1% has been set for 2022/23, with additional local waste reduction programmes on top which takes efficiency for most systems in the range from 3.5%-4.0%
- Service development funding (SDF) for nationally supported specific programmes, including funds to support the Ockenden review into maternity services and tackling health inequalities.
- Systems will continue to receive an additional non-recurrent allocation to fund the incremental costs of responding to the COVID-19 pandemic, however this is reduced from 2021/22 levels.
- A return to local ownership for payment flows from a regime which guaranteed income flows during the pandemic period.

The month of June (Month 3 in the NHS calendar) signals the transition from CCG to ICB and therefore has consequences for financial management for both organisations.

The CCG Q1 allocation of £383.0m is supplemented with specific SDF allocations and Covid costs (reimbursed in arrears) and Elective Recovery Fund (ERF); an allocation designed to accelerate the treatment of patients on elective waiting lists. The mechanics of novating resources allocated to one statutory organisation, the CCG, to another, the ICB, brings with it the added complication of finalising statutory financial statements and dealing with any over or underspends in the quarter just ended.

NHS England agreed with ICB Directors of Finance that any variance to plan in the CCG in Q1 would have an equal and opposite effect in the ICB from Q2.

The consequence of a favourable position in the CCG is that the ICB will receive a funding increase. This will bring an additional £7.0m of resources into the ICB financial position.

In addition, a further £2.5m is anticipated to be reimbursed in month 4 to the ICB relating to COVID-19 reimbursable expenditure, when data has been validated.

Revenue Position – Key Points

On 30 June 2022 the Lincolnshire system reported a £3.1m surplus against allocations and income. Against a £1.0m planned year to date surplus this represented a £2.1m favorable variance against plan. This is after the assumed reimbursement of Covid-19 outside of envelope expenditure of £2.5m.

The Lincolnshire CCG/ICB plans to deliver a £3.3m deficit for the full year which is offset in full by a surplus plan of £3.3m at NHS Lincolnshire Partnership NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust plan to deliver break-even positions.

Of the £2.1m favourable variance reported at Month 3, £7.0m was attributable to the CCG of which:

- £4.9m underspend in Primary Care Services because of benefits from prior year (includes prescribing £2.0m)
- £3.7m underspend in Mental Health due to benefits from prior year
- £2.9m underspend relating to Continuing Healthcare Services underspend from prior year benefits and Fully Funded activity lower than previous year.
- £0.9m underspend relates to lower than planned activity for the Acute Independent Sector
- An adverse £2.9m in other programme services relates to under-delivery of efficiency

The £7.0m favourable variance reported by the CCG was offset by £5.2m year-to-date variance reported at ULHT. The majority of the overspend is pay cost related. Principal reasons for the overspend are:

- £1.3m under-delivery of efficiency and waste reduction
- Unplanned costs associated with COVID-19, £0.9m
- A higher than planned level of open beds, £0.5m
- Activity related issues, including the implications of the fire at Lincoln County hospital, £0.7m
- Higher than planned staff costs driven by bank and agency volume and price, £1.8m

Agency and bank account for 21% of ULHT's year to date staff costs. If the agency spend was forecast on a straight-line bases, agency spend would be £51m against a £27m cap.

Risks and Mitigations

The latest submission of the System Financial Plan identifies £43.4m of risk with mitigation of £4.5m. A categorisation of the risk is as follows:

RISK SCHEDULE				
Risk Theme	Nature of Risk/Mitigation	Risk Rating	Impact £	Impact Org
CIP Organisational - Unidentified	Scheme Delivery	High	19.0	All
Provider COVID costs	Costs Continuation	High	13.5	ULHT
Elective Recovery Delivery	Allocation Clawback	Low	0	ICB/ULHT
Non-Elective Activity Recovery	Risks Arrangements on Associate Contracts	Medium	1.3	ICB

Additional Excess Inflation	Additional Costs not in plan	Medium	2.1	Provider
Stranded Costs	Redeployment opportunities	Medium	0.4	LCHS
Associate Contract Disputes	Allocation of ERF	High	7.0	ICB
Recruitment and Slippage Risks	Not Assessed	Medium	TBC	ICB/Providers
Gross Risk			43.3	
Mitigation	ERF Re-basing		(4.5)	
Net Risk			38.8	

Next Steps

The considerable level of identified risk in the system plan will in some case translate into an impact on the financial position within subsequent months without mitigation. This will create an adverse variance to plan and threaten the systems intention to deliver a breakeven position by the 22/23 financial year-end.

The following actions are underway:

1. Implementation of Investment panel and a double-lock (organisational and ICB sign-off) on organisational spend to control system expenditure and conduct a system level review of investments using its principles;
2. An internal audit review of system financial governance will be commissioned in August;
3. Greater focus on pay and non-pay controls to reduce system bank and agency spend, focusing on increased Use of frameworks and price cap compliance
4. Recover and accelerate delivery through the mechanics of the risk and gain share arrangements and with improved transformation plan within the Lincolnshire Health and Care Collaborative (LHCC).

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

Public Meeting of NHS Lincolnshire Integrated Care Board

Date: 26th July 2022

Location: Bridge House, Sleaford

Agenda Number:	7 (i)
Title of Report:	Strategic Partnership Update
Report Author:	To highlight the partnership work that going on to support social and economic investment in Lincolnshire with specific reference to the Towns Funds, Levelling Up and UK Shared Prosperity Funds Jacqui Bunce – Programme Director, Strategic Estates, Planning and Partnerships
Appendices:	Strategic Partnerships Presentation

1.	Key Points for Discussion:
	<ul style="list-style-type: none"> Tackle inequalities in outcomes, experience and access and support broader social and economic development are two of the core purposes of an ICS The attached presentation highlights the Towns Fund projects across Lincolnshire which aim to drive the economic regeneration of towns to deliver long term economic and productivity growth. The CCG/ICB has been an active partner in supporting the development of the bids and business cases. The Towns Fund Boards are moving into the delivery phase and are being asked to widen their remit to include the Districts plans for UK Shared Prosperity Fund
2.	Recommendations
	<ul style="list-style-type: none"> To note the investments and projects within the Towns Funds across Lincolnshire and the UK Shared Prosperity Fund and Levelling Up Fund information To note the representation of the NHS supporting these investment programmes across Lincolnshire
3.	Executive Summary
	<p>Background</p> <p>On 6 September 2019 the government invited 100 places to develop proposals for a Town Deal, as part of the £3.6 billion Towns Fund. The objective of the Fund is to drive the economic regeneration of towns to deliver long term economic and productivity growth through:</p> <ul style="list-style-type: none"> Urban regeneration, planning and land use ensuring towns are thriving places for people to live and work <ul style="list-style-type: none"> Increasing density in town centres strengthening local economic assets

- including local cultural assets
 - Site acquisition, remediation, preparation, regeneration
 - Making full use of planning tools to bring strategic direction and change.
- Skills and enterprise infrastructure
 - Driving private sector investment and ensuring towns have the space to support skills and small business development.
- Connectivity
 - Developing local transport schemes that complement regional and national networks, as well as supporting the delivery of improved digital connectivity.

Towns Fund Bids

101 Towns were identified including four within Lincolnshire which were Boston, Lincoln, Mablethorpe and Skegness. Each were expected through their “lead” District or Borough Councils to develop a Town Deal Board and then produce a Town Investment Plan.

Mablethorpe and Skegness joined together to create one Board with two separate funds.

Membership requirements were set out in the Towns Fund prospectus. The Boards all include:

- District and County Council members and officers
- The MP representing the town
- Local businesses and investors: Driving economic growth and building productivity will require entrepreneurship and investment from business.
- Local Enterprise Partnerships (LEPs)
- Communities: Each town decided how best to involve their local community, they include local forum leads, YMCA and groups such as the CVS.
- Anchor institutions: Including the NHS, Universities and Colleges, Sports Teams including Boston United and Lincoln City Football Clubs.
- Other strategic partners including Visit Lincolnshire, the Environment Agency and Heritage Lincolnshire.

Lead councils were responsible for the governance and management of the funds reporting into Ministry of Housing, Communities and Local Government (MHCLG) and now Department for Levelling Up, Housing and Communities (DLUHC).

The four Town Fund Investment Plans were developed with specific costed schemes and submitted in October 2020. Gathering local community feedback, ideas and support had to be evidenced in proposals.

The Projects included in each of the Towns Fund are listed in the table below:

Skegness	Mablethorpe	Lincoln	Boston
Learning Campus	Colonnade Sutton on Sea	Hospitality, Events and Tourism Institute	Mayflower Centre Boston College
Foreshore Development	Leisure Centre & Digital Learning Complex	Greyfriars redevelopment	Leisure Centre redevelopment
Town Centre improvements	Town Centre improvements	Drill Hall redevelopment	Boston train station
Railway Station	National Trust Sandilands	Central Market	Centre for Food and Fresh Produce Logistics
Culture House/ Embassy Theatre	Campus for Future Living	Barbican redevelopment	Blenkin Memorial Hall redevelopment
Police Training facility	Hardy's Multi-User Trail	Store of Stories	St Botolph's Library and Lighting
		Wigford Way feasibility work	Healing the High Street including Shodfriars
		Tentercroft Street feasibility work	
		Lincoln City Foundation Community Hub	
		Lincoln Made Smarter	
		Sincil Bank improvements	
		Lincoln Connected	

Awarding of Bids

Following review and government evaluation the four Towns Funds were awarded the following funding from the potential £25m:

- Boston - £21.9m,
- Lincoln - £19m,
- Mablethorpe - £23.9m and Skegness £24.5m

The Boards were then required to develop detailed business cases for each of their schemes to be submitted by end of March 2022. To achieve this each Board set up its own structures to manage this process with investment sub committees or technical subgroups.

The NHS system, through Jacqui Bunce, is represented on the four Boards and in these subgroups. This work has included supporting the design and development of the Campus for Future Living in Mablethorpe providing advice to the architect/construction team; the Mayflower and Leisure projects in Boston and chairing the Lincoln Investment Committee deputising for the CE of Lincoln City of Council where there were conflicts of interest.

Health and Wellbeing Benefits

There are wider health and wellbeing benefits to many of the projects including education facilities, leisure and community facilities, environment and cultural/community schemes.

Across the four Towns Funds the flagship health project is the **Campus for Future Living**. The Campus for Future Living responds directly and proactively to economic growth constraints in Mablethorpe: skills, health, education and opportunity.

This centre will provide a base for the development and testing of medi-tech applications, continuing professional development of clinicians, and both clinical and non-clinical medical placements linked to the Medical School at the University of Lincoln.

Led by a coalition of local, regional national partners, the development of the Campus for Future Living will position Mablethorpe as the centre of a new cluster of health and care related jobs and businesses and draw in the support of Nottingham Trent and Lincoln Universities.

Health Education England and the National Centre for Rural Health and Care have both

committed to work with this site as a national test bed along with other local, regional and national partners. The site is opposite the GP Practice in Mablethorpe who, with the Primary Care Network, are actively engaged in the project.

Current Position

All the projects have been approved locally. The national approval of business cases is in train with several schemes already being announced. All of Boston and Skegness schemes have been approved by DLUHC and announcements have been made. Mablethorpe schemes have been approved by DLUHC with the Campus for Future Living the only one awaiting sign off. Lincoln is awaiting formal approval of four of the schemes. Work has started on the Lincoln Central Market and the Drill Hall is nearing completion.

The Boards are now moving into the delivery phase. There has been the recent announcement of the UK Shared Prosperity Funds and the allocations to District Councils. Each of the Towns Fund Boards have been asked to be part of the governance process for these funding applications, at least in the interim.

4. Management of Conflicts of Interest

There are no conflicts of interest in respect of this paper.

5. Risk and Assurance

Not applicable

5. Financial/Resource Implications

Not applicable

6. Legal, Policy and Regulatory Requirements

There are no legal or policy requirements deriving from this report and presentation. Governance for the Towns Funds, UK Shared Prosperity Funds and Levelling Up bids sits with the District Councils and Department for Housing, Levelling Up and Communities (DHLUC)

7. Health Inequalities implications

All the investment funds – the Towns Funds, Levelling Up and UK Shared Prosperity are part of the Governments drive to reduce inequalities including health and the wider determinants of health and wellbeing including education, skills, employment, culture, environment and community. There are specific projects that have a direct link to health inequalities including the Mablethorpe Campus for Future Living

8. Equality and Diversity implications

Each project within the Towns Funds has had to develop a business case using DHLUC templates. There are no specific equality and diversity implications in this report.

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

Each of the Towns Funds have had to demonstrate the active engagement of the local public and stakeholders. Mablethorpe and Skegness established Place Reference Groups. All used the My Town on-line platforms to receive ideas and questions from the public. Towns Fund meetings have public and private agendas and the public section agendas, and minutes are published.

Each Towns Fund has a website:

[Welcome to Boston Town Deal Website | Boston Town Deal Website](#)
[Home - Connected Coast](#)
[Lincoln Town Deal – City of Lincoln Council](#)

11. Author(s)

Jacqui Bunce, Programme Director Strategic Estates, Partnerships and Planning
Jacqui.Bunce@nhs.net 07796175964

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

Peter Burnett, Director of Strategic Planning, Integration and Partnerships

Strategic Partnerships

Jacqui Bunce - Programme Director
Strategic Estates, Partnerships and Planning



Why are we involved?

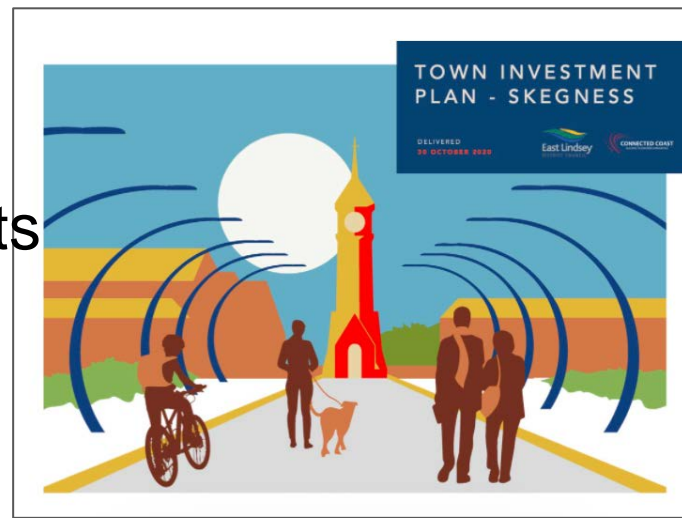
- ICS/ICB – two of the four pillars –
 - Reducing Health Inequalities
 - Economic and social development
- Strong links to wider determinants of health and wellbeing
- NHS as an anchor partner

Towns Funds

- The Towns Fund for England was announced in July 2019 is a **£3.6 billion fund for 'struggling' towns across England to support local economic growth.**
- Focused on urban regeneration, planning and land use; skills and enterprise infrastructure; and transport and digital connectivity.
- 101 Towns were invited to bid for up to £25m each.
 - Four in Lincolnshire: Boston, Lincoln, Mablethorpe & Skegness (Working together as Connected Coast)
 - Boards chaired by “Business” – mixed representation
 - Investment Plans for £25m were submitted in October 2020
 - Funding pots agreed in March 2021. 12 months to submit to business cases to March 2022

Towns Funds

- Plans were reviewed and the projects evaluated and the Towns received between £19m and £24.5m in April 2021.
- Had 12 months to submit business cases for the projects that had been agreed.
- Sub Groups and Investment Committees established
- Business Cases submitted to DLUHC
- Announcements being made as projects are being approved



£24.5m



£23.9m



£21.9m



£19m

Boston

- A new bespoke learning centre for adults will be developed that will include higher education in a unique learning environment aimed at being inclusive to the whole community. Led by Boston College, the 'Mayflower' will enable business and learners to connect, create, and innovate. Almost £10m has been confirmed for this project;
- Next to the new Mayflower there will be a redeveloped leisure complex which will provide additional facilities which forms part of a transformational development of this area of the town;
- Boston train station will be extensively refurbished by East Midlands Railway. Improvements will include a full refurbishment of the main station building and external areas, reconfiguring the layout to best utilise the space to include new community and start up business facilities.



Boston - Early funding used to support four projects

1. Experience Boston - Trade, Travel and Influence - £80,000

The monoliths and brass plaques are interpretative schemes, guiding people through our place and raising awareness of the wider offer of the town of Boston.



2. Boston Town Heritage Project - £277,700

Renovating shop fronts in the eastern area of the town's historic market place for the benefit of local businesses, the local community and visitors to the town.



3. Boston College Digital Transport and Logistics Academy - £182,976

New courses will be introduced that provide skills training for Lincolnshire's established logistics and transportation industry with a focus on digital innovation and technologies for the future.



4. Haven High Academy 3G Pitch Development Project - £120,000

Accelerated funding has enabled Haven High to unlock this much needed facility that will be used not just by the school, but the wider community.



Groundworks commence at Haven High Academy for the 3G pitch



Completion of the 3G pitch

Skegness:

- A £14m Towns Fund grant award has been approved for the learning campus which is set to offer vocational skills training across a range of much needed subjects;
- Skegness Foreshore which will see underutilised areas of the Skegness Foreshore brought to life and new audiences for activities such as concerts, festivals, and outdoor cinema;
- The town centre transformation, which will bring improvements to the shop fronts, signage, and public realm;
- As the gateway to the Lincolnshire coast, Skegness railway station will benefit from transformational improvements including new retail units;
- And, the creation of one of the first culture houses in the country at the Embassy Theatre in Skegness.

Skegness



FE Campus



Skegness
Foreshore



Town Centre
Transformation



Railway Station
Development



Police Training Centre



Hardy's multi-user path



Cultural Skegness

Mablethorpe

- The Colonnade at Sutton on Sea will be redeveloped after £4.1m Towns Fund grant award was approved for this project;
- A new purpose-built leisure centre and digital learning complex is set to be developed on the site of the current Station Sports Centre in Mablethorpe;
- In addition, Mablethorpe town centre will be transformed through a programme of shopfront and building repairs and improvements, and public realm enhancements;
- With the National Trust, an accessible, eco-friendly and sustainable visitor hub will be developed to explore the Sandilands Nature Reserve and coast.

Mablethorpe

PROJECT DESCRIPTION

The National Trust purchased the former Sandilands clubhouse and golf course in March 2020, with a commitment to transform it into a nature reserve and visitor centre.

The centre will be an accessible, eco-friendly and sustainable Visitor Hub to explore the Sandilands Nature Reserve and coast. It will provide a flexible space with a local Food & Beverage offer, toilet and changing facilities, along with a visitor reception. This will enhance the townscape, which will become more attractive for residents and visitors. This project will open up opportunities for employment and volunteering with on-site Ranger and Property teams. This will increase the skills and knowledge of local residents with an interest in conservation, land management and habitat creation.



A CATALYST FOR CHANGE: PARTNERSHIPS & CONNECTIONS

Local Community

Climate and Environment Leads

Voluntary and Community Sector

Job Centre Plus

NHS Attraction Strategy
(Recruit, Retain, Upskill, Innovate)

Clinical and non-clinical placements - 'Wider system'

Workforce

University of Lincoln
(including Medical School)

Academic Research,
Evaluation and
Population Health

International Institute of
Rural Health (IIRH)

Diabetes
Research

Population
Health Research

Driven by the focus on the East Coast

Complimentary funding bids:
Health inequalities (NHS)
Green social prescribing (DEFRA/NHS)

Local Health
System

Mental Health
Transformation Programme

Mental Health

Community Cafe

Local community aspirations and opportunities

Job Readiness

Social Prescribing

Innovation, digital and tech

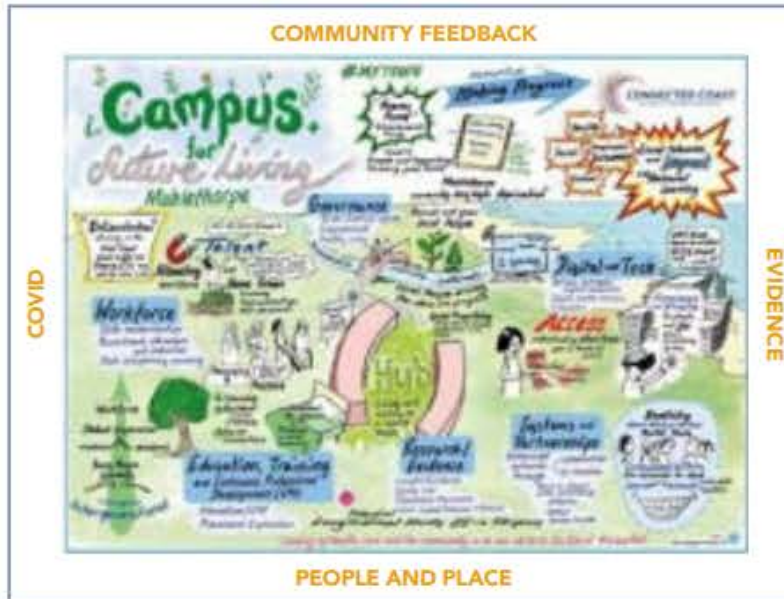
Mansfield Compare
and Contrast

Nottingham Trent
University (MTIF)

Private sector
partnerships

Better Ageing
East Lindsey first 'age
friendly district in UK

National Centre for
Ageing Better



Strategic focus to tackle health inequalities:
Coastal Primary Care Network

*Future
Workforce*

*Tracking Health
Inadequacies*

*Pilot
Opportunities*

Health Education England

National reach, influence
and ability to test,
innovate and pilot in a
rural and coastal area

Advancing
dental care

National Centre for
Rural Health and Care

Generalist doctors
programme -
'Future Doctors'

Information and good practice opportunities:
Rural Services Network Conference
NHS Confederation Conference

Partnership

Greater Lincolnshire Local Enterprise Partnership

Financial Inclusion Partnership

Magna Vitae

GPs

Lincoln



Lincoln City Football Club Community Hub



Central Market and City Vibrancy



Lincoln Connected



Food Partnership – Store of Stories



Barbican Production and Maker Hub



Drill Hall Development



Hospitality, Events and Tourism (HEAT) Institute



With a focus on helping local people build resilience, The Store of Stories will provide low cost locally supplied waste and surplus food and other essential items.

Levelling Up

- The Levelling Up Fund is designed to invest in infrastructure that improves everyday life across the UK.
- The £4.8 billion fund will support town centre and high street regeneration, local transport projects, and cultural and heritage assets.
- Competitive process Councils can bid for up to £20m capital
Second Round of bids to be submitted in early July
- City of Lincoln, East Lindsey, Boston and South Holland Councils are planning to submit bids

Levelling Up Round 1

- Lincolnshire County Council receive up to £20m towards improving the A16 corridor in Lincolnshire
- West Lindsey Council received £10m for Gainsborough projects including:
 - Improving Whittons Gardens,
 - creating a new park at the Baltic Mill,
 - building a new cinema,
 - refurbishing the bus station,
 - bringing an extension to our heritage led regeneration,
 - creating new homes in the town centre above shops, and
 - improving the Market Place

UK Shared Prosperity Fund (UKSPF)

Replaces European Funding

- Specifically European Social Fund aimed at skills and business support and European Regional Development Fund (larger predominantly capital schemes).

Key funding pot for delivering the Government's Levelling Up agenda

- The purpose of the UKSPF is to Improving life chances in our area by providing equality of opportunity. The fund gives local leaders the flexibility to use the fund to enhance and support their area and communities to be levelled up.

Allocated to unitaries/districts/devolved areas

- Should Greater/Lincolnshire become a devolved area then any future UKSPF programmes would be delivered by that body.

Overarching objective

Building Pride in Place and Increasing Life Chances

Investment Priorities

Community and Place

Supporting Local Business

People and Skills

Levelling Up White Paper Mission

Mission 9. By 2030, pride in place, such as people's satisfaction with their town centre and engagement in local culture and community, will have risen in every area of the UK, with the gap between the top performing and other areas closing.

Mission 7. By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years

Mission 8. By 2030, well-being will have improved in every area of the UK, with the gap between top performing and other areas closing.

Mission 11. By 2030, homicide, serious violence, and neighbourhood crime will have fallen, focused on the worst-affected areas.

Mission 1. By 2030, pay, employment and productivity will have risen in every area of the UK, with each containing a globally competitive city, with the gap between the top performing and other areas closing.

Mission 2. By 2030, domestic public investment in Research & Development outside the Greater South East will increase by at least 40% and at least one third over the Spending Review period, with that additional government funding seeking to leverage at least twice as much private sector investment over the long term to stimulate innovation and productivity growth.

Mission 1. By 2030, pay, employment and productivity will have risen in every area of the UK, with each containing a globally competitive city, with the gap between the top performing and other areas closing.

Mission 6. By 2030, the number of people successfully completing high-quality skills training will have significantly increased in every area of the UK. In England, this will lead to 200,000 more people successfully completing high-quality skills training annually, driven by 80,000 more people completing courses in the lowest skilled areas

Mission 7. By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years

Mission 8. By 2030, well-being will have improved in every area of the UK, with the gap between top performing and other areas closing.

Lincolnshire Councils UKSPF Allocations

Funding is 90% revenue and over three years to March 2025. Bids to be submitted by 1st August 2022. From October 2022 plans expected to be approved and funding released

District	Allocation
Boston	£2,194,351
ELDC	£4,438,286
NKDC	£3,195,139
South Holland	£2,693,049
SKDC	£3,898,582
Lincoln	£2,810,773
WLDC	£2,700,436
Lincolnshire County Council *	£4,021,672

* to develop investment plan for bespoke adult numeracy programmes, against a national menu of interventions – Multiply Scheme

BOARD COMMITTEE

HANDOVER TEMPLATE

Committee: Finance Committee	Name of the Committee Chair: Mr Graham Felston
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Date: 17th June 2022	Author: Mr Matt Gaunt, Director of Finance and Contracting
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Summary of Key issues/areas of focus in 2021/22:
<ul style="list-style-type: none"> Preparation and review of the annual operating plan for H1 and H2 2021/22, Q1 CCG 2022/23 and Q2-Q4 Lincolnshire ICB 2022/23. Management reporting of CCG and Lincolnshire ICS, preparation of forecast outturns – review of financial risk and escalation of issues to CCG Board. Review and approval of Lincolnshire system risk and gain share arrangements and ‘break-glass’ mechanism. Preparation of ICB operating arrangements, financial governance and decision making arrangements.

Position of these key issues/areas of focus as of 30th June 2022:
<ul style="list-style-type: none"> All complete

Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of:
<ul style="list-style-type: none"> The risk position in the current annual operating plan stands at £34.8m and has no mitigation worked up. The ICB Finance Committee will need to be sighted on the letter that will be written to Nicola Hollins DOF at Midlands Regional team setting out the nature of the risk and the support requests that align to them. Because the ICB started part way through the financial year the allocation available is interdependent with the CCG expenditure position i.e. the allocation is fixed for the financial year rather than for the CCG and ICB. So there is a potential for ICB allocation to reduce (or increase) based on final CCG closing position which is subject to audit process independent of the ICB.

- The operation of the system wide risk and gain share, and that it has been triggered because the Care Closer to Home initiative is failing to deliver the outcomes expected of it.
- The ICB Internal Audit team need to be commissioned to produce a report for the ICB Audit and Risk Committee covering the most recent HFMA publication - Improving NHS financial sustainability: are you getting the basics right? <https://www.hfma.org.uk/online-learning/bitesize-courses/detail/improving-nhs-financial-sustainability-are-you-getting-the-basics-right>.

BOARD COMMITTEE
HANDOVER TEMPLATE

Committee: QPEC

Name of the Committee Chair: Fenella Chambers

Date: 7th June 2022

Author: Martin Fahy, Director of Nursing & Quality

Summary of Key issues/areas of focus in 2021/22:

- **Urgent & Emergency Care**
- **Cancer**
- **Elective Care**
- **Maternity - Ockendon Review; Nottingham University Hospitals Maternity Services**
- **Never Events and Serious Incidents**
- **Mortality**
- **Infection, Prevention and Control**
- **Primary Care**
- **Covid Vaccination**
- **Safeguarding**
- **Patient Feedback – Healthwatch; Complaints**
- **HealthLinc House**
- **CHC – Personal Health Budgets;**

Position of these key issues/areas of focus as of 30th June 2022:

- **Urgent & Emergency Care** - continues to be significant pressures; EMAS continue to experience pressures which impact risk in the community and ambulance handover delays are continuing to contribute to this. 'Failure to deliver safe and effective services in the Emergency departments' (previously referenced Acute 4) is on the Corporate Risk Register (LCCG1.04) and current risk rating is 16.
- **Cancer** - 62 and 104-day cancer standards have improved and there is an increase in the number of patients receiving treatment in the 62-day standard, however colorectal remains an area of concern. 'Non-delivery of performance and quality standards for Cancer' (previously referenced Acute 2) is on the Corporate Risk Register (LCCG1.02) and current risk rating is 16.
- **Elective Care** - 102,553 patients waiting for treatment which is above plan, however plans are on track to eliminate any 104 week waits by the end of June 2022.
- **Maternity - Ockenden Review; Nottingham University Hospitals Maternity Services** - a system action plan to act upon the Ockenden recommendations has been written, with internal Trust assurance through ULHT Maternal & Neonatal Oversight Meeting which reports through ULHT Quality Committee to Board and also through to the LMNS (Lincolnshire Maternity Neonatal Services). An NHSEI led site visit taking place 22/23 June 2022 to visit to test compliance with the immediate and essential improvement actions (IEA) which the LMNS will participate in. There are approximately 780 Lincolnshire women who are cared for in the Nottingham maternity system every year, it has now been confirmed Donna Ockenden has been appointed as Chair of the new independent review into maternity services at Nottingham University Hospitals NHS Trust and the CCG Nursing & Quality team are continuing to liaise to ensure the CCG is sighted on any Lincolnshire women or babies impacted by the issues highlighted through this review process.
- **Never Events and Serious Incidents** – there have been 2 Never Events reported since April 2022, both from ULHT (United Lincolnshire Hospitals NHS Trust), one in April and one in May, both were no/low harm incidents and investigation is currently taking place. There was a total of 42 serious incidents reported between 6 April 2022 – 10 May 2022, this represents an increase when compared to the previous two months where the level of serious incidents reported was recorded as (n=26) and (n=29) respectively and the increase in reporting of serious incidents related particularly to LPFT (Lincolnshire Partnership NHS Foundation Trust) and ULHT.
- **Mortality** - NWaFT (North West Anglia Foundation Trust), in particular the Peterborough site, remains a concern. A quality assurance meeting took place end of May 2022, further assurance had been requested and concern escalated to Cambridge and Peterborough CCG as lead commissioners. Work continues to establish a Medical Examiner office for Primary Care in Lincolnshire to review all non-coronial deaths at pace, however, there was some slippage in timeframe for the pilot. The LeDeR (Learning Disability Mortality Reviews) Annual Report was presented to the July 2021 QPEC which highlighted that key themes relate to the Mental Capacity Act and the application of it and when people lack capacity.

- **Infection, Prevention and Control** – have achieved reduction in the number of cases now reported for MRSA and C-Difficile and recognition of the significant amount of work that has been undertaken to support this area.
- **Primary Care** – Lakeside; Marisco; Spalding and Branston Practices have all been rated as “Requires Improvement” by the CQC and the CCG is continuing to support these Practices
- **Covid Vaccination** – 7th June 2022 QPEC meeting update identified 1,769,538 vaccines have been delivered in Lincolnshire with approximately 624,643 firsts, 593,466 seconds, 489,488 booster doses and 61,941 Spring Boosters.
- **Safeguarding** – Lincolnshire has undertaken a benchmarking exercise in relation to the Birmingham/Solihull Joint Targeted Area Inspection which has highlighted areas for improvement, particularly in relation to sharing of health information and securing appropriate health representation at strategic meetings. Actions are being taken forward to address this and the LSCP (Lincolnshire Safeguarding Childrens Partnership) has agreed to include in the LSCP risk register.
- **Patient Feedback – Healthwatch; Complaints** – last update to QPEC from Healthwatch was March 2022 where it was noted that HealthWatch Lincolnshire are undertaking a patient experience survey commencing from April 2022 on clear, understandable information that is important to help make the right health and care decisions; and a report was in the process of being compiled that details hospital discharges including the trolley waits, delayed transfers of care, capacity constraints and the demand for domiciliary services. The last update from Complaints was presented at the March 2022 meeting, for the six-month period (Quarter 1 and Quarter 2) from 1 April 2021 to 30 September 2021; the Annual Complaints Report for 2020/21 was submitted to QPEC in August 2021
- **HealthLinc House** – had received an inadequate CQC inspection rating in April 2021 but is now closed, work is taking place to consider the learning.
- **CHC – Personal Health Budgets(PHBs); Liberty Protection Safeguards (LPS)** - for 2021/22 the CCG achieved the 2021/2022 year end NHSE target for the number of PHBs in place and it is anticipated the further 500 target set for 2022/2023 to be achievable. LPS when implemented will replace the current DoLS (Deprivation of Liberty Safeguards) and Court of Protection (CoP) processes, for the CCG/ICB this will expand current responsibilities to include all patients that are fully funded through CHC in the community and going forward in care homes, for authorisation.

Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of:

- **Risk Register** – the discussion at June 2022 Lincolnshire Quality Committee highlighted the need for system risk register to be developed but the Board sub-committee decision making needs to be within the context of agreed ICB risk appetite and related risk management processes
- **Policies** – were ratified by QPEC following recommendation from Clinical Policy Sub-Group or CHC Programme Board. Discussion at the June 2022 Lincolnshire Quality Committee

highlighted there is further work that needs to take place before the Quality Committee membership would feel comfortable in ratifying ICB specific policies.

BOARD COMMITTEE

HANDOVER TEMPLATE

Committee: Audit and Risk Committee	Name of the Committee Chair: Peter Moore/Graham Felston
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Date: 20 June 2022	Author: Matt Gaunt/Bill Gregory
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Summary of Key issues/areas of focus in 2021/22:

- Internal Audit 21/22 Progress Report and audit findings and improvement recommendations (at each meeting apart from the extraordinary one in June 2021)
 - Internal Audit Reports – ‘Deep Dive’ on Mental Health, Learning Disability & ASD Team, Health Protection Report, Data Security & Protection Toolkit (DSPT) Report, Audit Follow Up Review 2020/21, STP/ICS Review 2020/21, Primary Care Commissioning – Part 2 2020/21, Conflicts of Interest Review, Urgent & Emergency Care, Safeguarding, Finance, Primary Care and Complaints
- Counter Fraud Progress Report (at each meeting apart from the extraordinary one in June 2021)
- Preparation and oversight of statutory reporting and legal compliance: Annual Governance Statement 2021/22, ISA 260 Final Report 2021/22 and Draft ISA 260 2021/22 Letter of Representation 2021/22, Information Governance Toolkit 2021/22.
- Governance Report (presented on a monthly basis and provides an update on the Hospitality and Sponsorship Registers, Losses and Compensations, Single Price Quotations (Waivers) and the Declaration of Interest Registers.
- CCG Transition Plan & Due Diligence Checklist and ICB Readiness to Operate Statement and the Lincolnshire ICB – Transition Programme Reporting, Assurance and Oversight.
- Update on the Board Assurance Framework and CCG Risk Management Arrangements
- Mental Health Investment Standard Compliance Statements
- Information Governance Updates and action plans
- Approval of policies:
 - Counter Fraud & Corruption Policy
- The Transition Programme Board was formalised in December 2021, Chaired by SRO for transition (Matt Gaunt) with senior representation for each workstream (Finance, HR, Governance, Quality, IT & IG). The Programme Board has met monthly and regularly reported progress to the Audit and Risk Committee.

- The System Strategy and Planning Director (Pete Burnett) and ICS Strategy Director (Tom Diamond) have been members of the Programme Board to ensure alignment with the process for developing the Readiness to Operate.
- Each workstream lead developed and has been implementing a transition plan for their areas of responsibility. The Programme Board has monitored overall progress and dealt with risks and issues as they have arisen.
- The national Due Diligence checklist has been a key part of the planning and implementation process for the Programme Board. This is a live document and is held in shared document repository currently maintained by the CCG Company Secretary, along with supporting evidence.
- Internal Audit have also provided independent assurance on the transition process to the Audit Committee. This has included attendance at all Programme Boards and Finance Workstream project meetings, review of workstream plans, and governance arrangements.
- Internal audit performed three specific reviews on the completeness and accuracy of higher risk Due Diligence information – Contract Register, Staff Transfer Information and Quality Governance Metrics. These audits have found the relevant Due Diligence information to reconcile to the source information, but at the same time identified a small number of areas where processes could be improved going forward. The formal audit report findings will be handed over to the ICB audit committee for any follow up.
- The preparation and audit of the 2021/22 accounts and annual report is now substantially complete

Position of these key issues/areas of focus as of 30th June 2022:

There are a number of transition tasks that will necessarily take place in the final run up to 30 June (to ensure the latest position is taken into scope).

- Final circulation of all suppliers and contracts with new organisation details
- Final sign off of Staff Transfer details
- Transfer of all email accounts that will remain live post transition
- The Annual Report and Accounts were finalised and submitted on the 23rd June including any associated documentation (such as Letter of Representation and Statement of Accountable Officer Responsibilities) was signed and submitted by the 23rd June 2022.
- The Audit and Risk Committee Annual Report, including Self-Assessment was presented to and approved by the Committee for submission to the CCG Board at its meeting held on the 15th June 2022 (as attached).
- All external audit work was complete at that stage.

- As at the 30th June 2022 the only item outstanding is any actions from the Internal Audit reports, which will be picked up through the Trac system and regular updates provided to the ICB Audit and Risk Committee going forward.

There are also a small number of issues that are reliant on national processes or guidance, again it would be appropriate for the ICB Audit Committee to follow these issues up:

- Arrangements for participation in the National Fraud Initiative for ICBs has not been confirmed. There is low risk for the CCG/ICB in this, but it is good practice to participate
- Completion of the Information Governance Toolkit for the ICB.

Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of:

- The Scheme of Delegation/SFI sign off limits for the ICB have been reviewed and signed off by the CCG Audit Committee. Once the ICB management structure and functions have settled, it is likely these will need to be refreshed during 2022/23 to ensure they remain fit for purpose.
- The Transition date of 1 July 2022 means that the final accounting period for the CCG will be 1 April 2022 to 30 June 2022. A national timetable for closing down and auditing this accounting period has been published, and the ICB will need to make arrangements to implement this.
 - CCG (Annual Accounts for months 1-3) – submission on the 22nd July 2022.
 - CCG Draft Annual Report (months 1-3) – submission on the 5th October 2022.
- The ICB will inherit the Subject Access Requests (SAR) and Freedom of Information Requests (FOI). These are overseen by Arden GEM CSU who will continue to maintain the registers.
- The development of the system Quality Strategy has been highlighted through the Due Diligence process as work in progress.
- It is recommended that CCG Risk Register at 30 June (as attached) is handed over and reviewed in the context of the ICB as soon as possible.
- The transition programme has necessarily focussed on its core activities; however its work has highlighted a number of opportunities to improve efficiency and effectiveness for the ICB. These do not present a material risk to transition, but provide an opportunity for further improvement, and include:
 - Stocktake of software, laptops and mobile devices actually in use
 - Documentation of contractual arrangements for individual care placements
 - Specification and contracting for clinical advisors to the ICB
 - Reviewing accommodation requirements alongside the exit of the Cross O'Cliff lease.
- The Internal Audit Plan for 2022/23 needs to be agreed.

- Internal Audit need to be commissioned to produce a report for the ICB Audit and Risk Committee covering the most recent HFMA publication - Improving NHS financial sustainability: are you getting the basics right? <https://www.hfma.org.uk/online-learning/bitesize-courses/detail/improving-nhs-financial-sustainability-are-you-getting-the-basics-right>

AUDIT & RISK COMMITTEE MEETING

Date of Meeting:	15 th June 2022	Agenda item:	7
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Title of Report:	Audit and Risk Committee Annual Report 2021/22
Report Author and Title:	Graham Felston, Non-Executive Director and Acting Chair of the Audit and Risk Committee
Appendices:	Audit and Risk Committee Annual Report 2021/22

1.	Purpose of the Report (including link to objectives)
To present the Audit and Risk Committee Draft Annual Report 2021/22 for consideration.	

2.	Recommendations
The Audit and Risk Committee is requested to approve the Annual Report 2021/22 for submission to the Board.	

3.	Executive Summary
<p>The aim of the Audit and Risk Committee is to provide one of the key means by which the Board ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the Officers of the Board.</p> <p>As defined within the “Audit Committee Handbook (2014)”, the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas.</p> <p>The Code requires that the Committee should publicly report on its work and how it has discharged its responsibilities.</p> <p>The Annual Report therefore outlines how the Committee has complied with the duties delegated by the Governing Body through its terms of reference and identifies key actions to address developments in the Committee’s role.</p> <p>The Audit and Risk Committee is asked to consider the contents of the report and identify whether any amendments are required prior to submission to the Board for consideration.</p>	

4.	Management of Conflicts of Interest
None.	

5.	Finance, QIPP and Resource Implications
None.	

6.	Legal/NHS Constitution Considerations
The Audit and Risk Committee is required to produce an Annual Report as identified within the Audit Committee Handbook 2014.	

7. Analysis of Risk including Assessments

Not applicable.

8. Outline engagement – clinical, stakeholder and public/patient

Not applicable.

9. Outcome of Impact Assessments

This is dependent upon the findings and actions resulting from specific audit reports and committee meetings.

10. Assurance Departments/Organisations who will be affected have been consulted

Insert details of the departments you have worked with or consulted during the process:

Finance	X
Commissioning	
Contracting	
Medicines Optimisation	
Clinical Leads	
Quality	
Safeguarding	
Other	X

11. Report previously presented at:

Not applicable.

12. For further information or for any enquiries relating to this report, please contact

Contact Name: Jules Ellis-Fenwick
Email: julieellis1@nhs.net
Tel 07825 938794

ANNUAL REPORT OF THE AUDIT AND RISK COMMITTEE 2021/22

1. PURPOSE

The purpose of this report is to brief the Board on the work of the Audit and Risk Committee during the last financial year. This report covers the period 1 April 2021 to 31 March 2022.

This report therefore outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

The Audit and Risk Committee is requested to **consider** and **approve** the report for submission to the CCG Board.

2. BACKGROUND

The Audit and Risk Committee is established with approved Terms of Reference that are aligned with the NHS Audit Committee Handbook published by the HFMA and the Department of Health.

3. OPERATION OF THE COMMITTEE

The Committee met six times in the year and discharged its responsibilities for scrutinising the management of risk and controls, which affect all aspects of the CCG's business.

The membership of the Audit and Risk Committee during 2021/22 comprised:

Name	Role	Period
Mr Pete Moore	Non-Executive Director - Governance and Chair of the Audit and Risk Committee	Full year
Ms Sue Liburd	Non-Executive Director	Full year
Mrs Fenella Chambers	Non-Executive Director	Full year

The following chart details attendance by the Non-Executive Directors during the year:

	13/04/2021	18/05/2021	09/06/2021	21/09/2021	14/12/2021	09/03/2022
Fenella Chambers	A	A	A	A	A	A
Sue Liburd	A	A	A	X	A	A
Pete Moore	A	A	A	A	A	A

The following people are also in attendance:

Mr Matt Gaunt, Director of Finance and Contracting
 Mrs Julie Ellis-Fenwick, CCG Board Secretary
 Internal Audit representatives, PwC
 External Audit representatives, Ernst and Young
 Local Counter Fraud Specialist, PwC

The Committee reviewed its Terms of Reference in April 2021 and identified some amendments in relation to virtual working arrangements, which were approved.

The Chair of the Committee has reported to the Board following each meeting and presented an Escalation Report.

4. PRINCIPAL REVIEW AREAS

4.1 Governance, Risk Management and Internal Control

The aim of the Audit and Risk Committee is to provide one of the key means by which the CCG ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the Officers of the CCG and members of the Board.

In discharging these duties the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (Annual Governance Statement) which are supported by the Head of Audit opinion and other opinions provided.
- The comprehensiveness of assurances in meeting the Governing Body and the Accountable Officer's assurance needs and reviewing the reliability and integrity of these assurances.
- The adequacy of relevant policies, legality issues and the Codes of Conduct.
- The policies and procedures related to fraud and corruption.

The CCG identifies, evaluates and controls its risks through the Committee structure it has in place. The CCG embeds risk management through:

- The CCG committees (including the Audit and Risk Committee)
- Board Assurance Framework (BAF)
- Risk Register
- Policies and Procedures
- Standing Financial Instructions (referred to as Delegated Financial Authority Limits) and Standing Orders

All staff are responsible for the identification and management of risk appropriate to their own role in the organisation. The use of Quality Impact Assessments, Privacy Impact Assessments, Data Protection Impact Assessments and Equality Impact Assessments as part of our project management framework also helps to identify risks.

The Board Assurance Framework is directly related to an organisation's agreed strategic objectives and sets out the key strategic risks that may prevent the objectives from being met. The BAF provides assurance that the CCG's strategic objectives are being effectively delivered and identified risks are being managed in line with agreed risk appetite.

In February 2021 the CCG agreed six 'themed' objectives through to March 2022. These objectives are mapped to four principal risk themes as illustrated below:

Category	Objective	Executive Lead	Mapping to risk theme
Quality	Commission high-quality, safe and effective services to drive continuous improvement in patient outcomes.	M Fahy	2, 3, 4
People Centred	Promote service improvement by working with the population to design services which help people to achieve their goals and lead healthy, independent lives.	C Raybould	1, 4
Health Inequalities	Tackle health inequalities and wider causes of ill health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire.	S Williamson	1, 2, 3, 4
Communities	Proactively commission a model of high-quality, integrated care at a local level that delivers improvement in health outcomes.	SJ Mills	1, 2, 3, 4
Collaboration	Foster establish and enhance collaborative ways of working throughout a partnership network that delivers measurable improvement in health outcomes.	A Rix	1, 2, 3
Insight led	Develop a systemwide understanding of need to drive good decisions based on evidence and learning from previous or existing work.	M Gaunt	1, 4

The CCG identified four strategic risk themes which have the potential to prevent the CCG from achieving its stated objectives. Each strategic risk has an identified Executive Risk Owner, who is responsible to overseeing the implementation of identified mitigating actions and for ensuring that their respective BAF template is regularly reviewed and updated. These are as follows:

Strategic Risk Themes	Owner
Systems Leadership/ Reputation	Accountable Officer
Quality, safe and effective services	Director of Quality and Nursing
Financial sustainability	Director of Finance and Contracting
Service transformation	Director of Operations

The six themes have been unpinned by four operational objectives in 2021/22.

4.2 Risk Management Group and Risk Management Strategy and Framework

At the request of the CCG Executives, Mr Martin Fahy, Director of Nursing set up a working group to reinstate the previous CCG's Risk Management Group. The first meeting took place on 29 April 2021 and the first objective of the Group was to revise the Terms of Reference and the Risk Strategy and Management Framework to align to the single CCG. During the review it was agreed that there would be an extra step in the governance process, which means that the oversight Committee for the group is now the Senior Managers Operational Delivery Group (SMODG) with an overarching oversight by Audit & Risk Committee.

4.3 CCG Risk Register

It had been agreed at a Joint CCG Risk Management Group, prior to COVID-19, to use the format of the Risk Register which had previously been used by South and South West Lincolnshire CCG's. There were 71 legacy risks, dating from 2015, from Lincs East and West CCG's which were still held on Datix. Following review in 2021 it was agreed to archive 62 of these risks as it was felt that they had now been superseded or were no longer relevant and to receive further review of the nine risks which were not archived.

A considerable amount of work has been taking place in 2021/22 to have a baseline Risk Register in place prior to moving into the ICB on the 1st July 2022.

The CCG risk scoring matrix is detailed below:

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

5. INTERNAL AUDIT

During 2020/21, the Internal Audit Service was provided by PricewaterhouseCoopers (PwC) PwC.

Throughout the year the Committee has worked effectively with Internal Audit to strengthen the CCG's internal control processes through discussion and debate over recommendations and deadlines.

The Committee has placed great emphasis on the findings of each internal audit review and the timely implementation by management of action to address these findings.

6. EXTERNAL AUDIT

The External Audit Service was delivered by Ernst and Young.

The External Audit work can be divided into two broad headings:

- a) To audit the financial statements and provide an opinion thereon;
- b) To form an assessment of the CCG's arrangements for its use of resources.

The Committee considered the external audit plan including the risks identified by the external auditors and their planned response to them, together with progress reports throughout the year. The Committee also met separately with the auditors to ensure there were no issues the auditors wished to raise privately.

The external auditors also provided regular technical updates throughout the year.

7. COUNTER FRAUD

The Committee has reviewed and agreed the Counter Fraud Plan and has discussed and noted regular updates during 2021/22. Recommendations have been logged on a tracker document and reviewed by the Committee at each meeting.

8. REVIEW FOR 2021/22

The work programme of the Committee in 2021/22 was aligned to the Annual Plans agreed with External Audit, Internal Audit and Counter Fraud at the beginning of the financial year. The Committee has completed a Self-Assessment of its work, which is attached to this report for consideration by the CCG Board.

9. CHAIR'S OVERVIEW AND CONCLUSION

In conclusion, the Committee has met its duties delegated by the Board and would like to thank all members and attendees for their contribution in 2021/22.

Graham Felston
Non-Executive Director and Acting
Chair of the Audit and Risk Committee
June 2022

LINCOLNSHIRE CCG AUDIT AND RISK COMMITTEE

SELF-ASSESSMENT CHECKLIST – 2021/22

Area/Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the Audit and Risk Committee have written Terms of Reference that adequately define the Committee's role in accordance with relevant guidance?	Y		The TOR were reviewed in April 2021 and approved.
Have the Terms of Reference been adopted by the Board?	Y		
Are the Terms of Reference reviewed annually to take into account governance developments and the remit of other Committees within the organisation?	Y		As identified above.
Are Committee members independent of the management team?	Y		
Are the outcomes of each meeting; the actions taken and the Committee's view on the organisation's systems of internal control reported to the next Board meeting?	Y		
Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board?	Y		Prepared and considered by the Committee at its June 2022 meeting.
Does the Committee assess its own effectiveness periodically?	Y		
Has the Committee established an annual work plan of matters to be dealt with across the year?	Y		Forward plan in place for 2021/22.
Are the Committee papers distributed in sufficient time for members to give them due consideration?	Y		Agenda and papers are usually issued one week in advance of the meeting.
Does the Committee review its risks regularly?	Y		
Has the Committee been quorate for each meeting this year?	Y		
Compliance with the law and regulations governing the NHS			
Does the Committee review assurance and regulatory compliance reporting processes?	Y		Internal and external auditors provide updates of current issues.
Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Y		DOF&C presents items to the Committee. Each report from IA, EA, and CF includes references/links to topical papers.

Internal Control and risk management			
Has the Committee formally considered how it integrates with other committees that are reviewing risk – for example, risk management, quality and clinical governance committees?	Y		
Has the Committee reviewed the robustness and effectiveness of the content of the organisation's assurance framework?	Y		
Has the Committee reviewed the robustness and content of the draft Annual Governance Statement before it is presented to the Board?	Y		The Chair of the Committee has reviewed the AGS along with the DOF&C. The Board has received the draft Annual Report for consideration which includes the AGS.
Is the Committee's role in reviewing and recommending to the Board the Annual Report and Accounts clearly defined?	Y		Yes – as set out in the Scheme of Reservation and Delegation.
Does the Committee consider the external auditor's report to those charged with governance including proposed adjustments to the accounts?	Y		
*Internal Audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives, responsibilities and reporting lines?	Y		
Does the Committee review and approve the internal audit plan at the beginning of the financial year?	Y		
Does the Committee approve any material changes to the plan?	Y		
Is the Committee confident that the audit plan is derived from a clear risk assessment process that links closely to the assurance framework?	Y		Planning process is closely aligned to risks.
Does the Committee receive periodic progress reports from the Head of internal Audit?	Y		Update at each meeting.
Does the Committee effectively monitor the implementation of management actions arising from internal audit reports?	Y		Audit recommendation tracker presented at each meeting.
Does the Head of Internal Audit have a right of access to the Committee and its Chair at any time?	Y		
Is the Committee confident that internal audit is free of any scope restrictions and, if not, has it considered the impact of these on the annual Head of Internal Audit opinion?	Y		
Is the Committee confident that that internal audit is free from any operational responsibilities or conflicts of interest that could impair its objectivity?	Y		
Does the Committee hold periodic private discussions with the Head of internal Audit?	Y		At least annually or on request.
Has the Committee evaluated whether internal audit complies with the Public Sector Internal Audit Standards?	Y		
Has the Committee agreed a range of internal audit performance measures to be reported on a routine basis?	Y		
Does the Committee receive and review the Head of Internal Audit's annual opinion?	Y		

*External Audit			
Do the external auditors present their audit plans and strategy to the Committee for agreement and approval?	Y		
Does the Committee receive and monitor actions taken relating to prior years' reviews?	Y		
Does the Committee review the external auditor's ISA 260 report (the report to those charged with governance)?	Y		As part of Accounts approval process
Does the Committee review the external auditor's value for money conclusion?	Y		
Does the Committee hold periodic private discussions with the external auditors?	Y		At least annually or on request.
Does the Committee assess the performance of external audit?	Y		Carried out externally.
Does the Committee require assurance from external audit about its policies for ensuring independence?	Y		
Has the Committee approved policy to govern the nature and value of non-audit work carried out by external auditors?	Y		
Does the Committee receive information on all non-audit work undertaken by external audit?			N/A
Does the Committee review the proportion of audit and non-audit work every time the external auditors change?			N/A
Counter Fraud and Security			
Is the Committee aware of NHS Protect requirements in relation to counter fraud and security activity?	Y		
Does the Committee review the planned counter fraud and security work at the beginning of the financial year and in particular its scope and coverage?	Y		
Does the Committee satisfy itself that the work plan is derived from clear processes based on risk assessments and that coverage is adequate?	Y		
Does the Committee receive notification of any material changes to the plan?	Y		
Does the Committee receive periodic reports about counter fraud and security activity?	Y		At each meeting
Does the Committee effectively monitor the implementation of management actions arising from counter fraud and security reports?	Y		As part of audit recommendations tracker.
Do those working on counter fraud and security activity have the necessary technical knowledge and experience to ensure that work is carried out as it should be?	Y		
Does the Committee receive and review an annual report on counter fraud and security activity?	Y		
Does the Committee receive and discuss reports arising from inspections by NHS protect in relation to the quality of the counter fraud provision?			N/A
Annual report and accounts and disclosure statements			
Is the Committee's role in the approval of the annual report and accounts clearly defined?	Y		
Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?	Y		

Does the committee specifically review: <ul style="list-style-type: none"> • Changes in accounting policies? • Changes in accounting practice due to changes in accounting standards? 	Y Y		None so far
<ul style="list-style-type: none"> • Changes in estimation techniques? • Significant judgements made in preparing the accounts? • Significant adjustments resulting from the audit? • Explanations for any significant variances? 	Y Y Y Y		
Does the Committee ensure it receives explanations for any unadjusted errors in the accounts found by external auditors?	Y		
Does the Committee receive and review a draft of the organisations' Annual Governance Statement?	Y		
Does the Committee receive and review a draft of the organisation's Annual Report and Accounts?	Y		
Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements (for example, as set by the Care Quality Commission)	Y		As necessary
Other Issues			
Does the Committee report regularly to the Board through verbal and written reports and make clear recommendations where necessary, including escalating items for consideration?	Y		Escalation Reports are presented to the Board.
Does the Committee meet the appropriate number of times to deal with planned matters, development and liaison?	Y		
Are arrangements in place to call ad hoc meetings when necessary?	Y		
Has the Committee reviewed its performance in the year for consistency with its: <ul style="list-style-type: none"> • Terms of reference? • Programme for the year? 	Y Y		As part of Audit and Risk Committee Annual Report.

BOARD COMMITTEE

HANDOVER TEMPLATE

Committee: Primary Care Commissioning Committee (PCCC)	Name of the Committee Chair: Gerry McSorley
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Date: 15 June 2022	Author: Nick Blake
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Summary of Key issues/areas of focus in 2021/22:

- GP practice risk, resilience and quality issues (monitored through the Practice Risk Register)
 - Lakeside Stamford quality (following CQC inspections) and access issues
 - GP practice and PCN workforce issues: recruitment and retention
- GP practice and PCN estates issues (monitored and managed through the Primary Care Estates Group)
- GP Practice contractual and commissioning issues including dispensary closure, practice merger and procurements
- PCN membership and boundary changes
- Winter Access Fund 2021/22 – planning and delivery
- Primary care recovery and access to primary care
 - Including Extended Access delivery and preparation for transfer to PCN delivery in 2022

Position of these key issues/areas of focus as of 30th June 2022:

- Ongoing GP practice risk issues include:
 - Lakeside Stamford: quality issues and remedial actions following CQC reinspection in March 2022. Primary Care and Quality teams reviewing actions and monitoring progress.
 - Caskgate: estates and recruitment issues. Ongoing support from LMC and CCG.
 - Richmond MC: staffing (following Crossroads list absorption) and financial issues

- Church Walk: staffing and contractual issues
- Ongoing Estates issues:
 - CHP review of primary care estates is progressing
- Ongoing support to GP practices is in place through the Primary Care and Quality Teams as well as the LMC
- Ongoing GP contractual issues:
 - Spalding GP Practices: proposed list dispersal process underway
 - Stackyard transfer to ELLR CCG area
 - Sidings practice procurement process and issues relating to unexpected costs for the incoming provider
- All PCN changes are completed
- Winter Access Fund work is now completed
- Extended Access transfer to PCNs is going ahead as planned – no significant issues

Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of:

- Lakeside Stamford remains in special measures – progress over the next 3-6 months to address issues highlighted by the CQC and to ensure care is safe is critically important. Ongoing work is planned with Lakeside with a review scheduled for 23 June 2022.
- PCN and GP practice staff recruitment and retention remain a challenge with consequent impact on service delivery and resilience. The CCG continues to work with PCNs and practices to support through the dedicated Primary Care People’s Group and programme lead. Optimising use of PCN workforce funding for Additional Roles is being managed through the PCN Business Managers Group with CCG/ICB support.
- Other factors affecting GP practice resilience include the ongoing risk of workforce absence through covid infection, increased patient demand and patient care back logs due to the pandemic.
- Rapid roll out of digital technology and online consultation systems during the covid pandemic to primary care without a comprehensive training and support offer to practice teams represents a risk to practice team resilience and patient access. A digital review is underway to optimise use and outcomes and to identify support requirements.
- PCN maturity and development is variable across the County, this may affect the delivery of some elements of the Network Contract DES as well as some PCNs having the capacity to engage fully with wider system programmes. The Primary Care Team and PCNA are supporting PCN development.
- The transfer of Pharmacy, Optometry and Dentistry commissioning responsibilities from NHSE/I to the ICB is ongoing and due to be completed in April 2023.