

**MEETING OF THE NHS LINCOLNSHIRE  
INTEGRATED CARE BOARD  
TO BE HELD ON  
TUESDAY, 27<sup>th</sup> SEPTEMBER 2022  
BRIDGE HOUSE, THE POINT, SLEAFORD  
at 9.00 AM TO 12.00 NOON**

## 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, 27<sup>th</sup> September 2022**

**Time: 9.00 am to 12.00 noon**

**Location: Bridge House, Sleaford**

### AGENDA

ITEM NUMBER	ACTION	ENCLOSURE/ VERBAL	LEAD	TIME	
<b>1. INTRODUCTION</b>					
i)	Welcome and Apologies		Verbal	Sir Andrew Cash	9.00
ii)	Declarations of Interest		Verbal	Sir Andrew Cash	
iii)	Minutes of Meeting held on 26 <sup>th</sup> July 2022	Approve	Enclosure	Sir Andrew Cash	
iv)	Matters Arising, including Action Log	Note	Enclosure	Sir Andrew Cash	
<b>2. CHAIR AND CHIEF EXECUTIVE UPDATES</b>					
i)	Chair <ul style="list-style-type: none"> <li>Update and Overview</li> </ul>		Verbal		9.10
ii)	Chief Executive <ul style="list-style-type: none"> <li>Update and Overview</li> <li>ICB Development Next Steps</li> <li>Integrated Care Partnership (ICP) Establishment</li> <li>Lincolnshire Quarterly System Review Letter (September 2022)</li> </ul>	Note	Enclosure	John Turner	9.20
<b>3. KEY UPDATES</b>					
i)	Public Health	Note	Verbal	Andy Fox	9.35
ii)	Healthwatch	Note	Verbal	Dean Odell	9.45
<b>4. CORE PURPOSE 1: HEALTH INEQUALITIES (tackle inequalities in outcomes, experience and access)</b>					
i)	<ul style="list-style-type: none"> <li>COVID vaccination update – Health Inclusion approach</li> <li>Kings Fund Expression of Interest – Inclusion Health from day one</li> </ul>			Sandra Williamson/ Steve Clapton Sandra Williamson	9.55

ITEM NUMBER	ACTION	ENCLOSURE/ VERBAL	LEAD	TIME	
<b>5. CORE PURPOSE 2: HEALTH OUTCOMES (improve outcomes in population health and healthcare)</b>					
i)	<ul style="list-style-type: none"> <li>Integrated Performance Report</li> <li>Operational Resilience</li> </ul>	Note	Enclosures	Clair Raybould	10.20
ii)	Quality Section	Note		Martin Fahy	10.35
<b>BREAK 10.50-11.10</b>					
<b>6. CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY</b>					
i)	Finance Report	Note	Enclosure	Emma Rhodes	11.10
<b>7. CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE (help the NHS support broader social and economic development)</b>					
i)	Cost of Living Challenge	Note	Enclosure	Sarah-Jane Mills	11.20
<b>8. GOVERNANCE</b>					
i)	Memorandum of Understanding Lincolnshire Integrated Care Board and NHS England	Receive	Enclosure	Pete Burnett	11.30
ii)	NHS Lincolnshire ICB Constitution – amendments to reflect changes in legislation	Approve	Enclosure	Jules Ellis-Fenwick	11.35
iii)	Report from the Finance and Resource Committee meeting held on 16 <sup>th</sup> September 2022	Receive	Enclosure	Julie Pomeroy	11.40
iv)	Report from the Service Delivery and Performance Committee meeting held on 14 <sup>th</sup> September 2022	Receive	Enclosure	Dawn Kenson	11.45
v)	Report from the Audit and Risk Committee meeting held on 13 <sup>th</sup> September 2022	Receive	Enclosure	Julie Pomeroy	11.50
<b>9. DATE, TIME AND VENUE OF NEXT MEETING</b>					
	Tuesday, 1 <sup>st</sup> November 2022 at 9.30 am at Bridge House, Sleaford	Note	Verbal	Sir Andrew Cash	12.00 close

**Please send apologies to: Jules Ellis-Fenwick, ICB Board Secretary via email at: [julieellis1@nhs.net](mailto: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](http://www.lincolnshire.icb.nhs.uk)

In case of difficulty accessing the papers, please contact – [julieellis1@nhs.net](mailto: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 TUESDAY, 26TH JULY 2022 AT 9.30 AM AT BRIDGE HOUSE,  
THE POINT, SLEAFORD**

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

**22/13 WELCOME AND INTRODUCTIONS**

Sir Andrew Cash welcomed everyone to the first formal meeting of the NHS Lincolnshire Integrated Care Board.

This was a meeting held in public, not a public meeting.

Sir Andrew Cash invited Mrs Ellis-Fenwick to provide an explanation of the format of the meeting on this occasion.

Mrs Ellis-Fenwick advised that going forward all formal Board meetings will be held via Microsoft Teams as Live Events so the audience was expanded with individuals able to access the meeting either digitally or attend in person should they so wish.

For this meeting it had not been possible to establish a Live Event due to some technical issues. However, the meeting would be recorded, and the recording will be made available on the ICB website in the next few days.

Members of the public will be provided with the opportunity to submit any questions to the Board prior to the meeting through the usual proforma published on the website. The Questions and Answers facility will also be available during the Board meeting when the event is 'live'.

All questions and responses will be published on the ICB website.

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

The Board agreed to:

- **Note the briefing.**

## **22/14 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS**

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

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

Declaration of Interest from Committees:  
No items declared.

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

The Board agreed to:

- **Note no interests were declared.**

## **22/15 MINUTES OF THE PREVIOUS MEETING**

The Board considered the minutes of the previous meeting held on the 1<sup>st</sup> July 2022 and agreed to:

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

## **22/16 MATTER ARISING**

Sir Andrew Cash presented the Action Log as included in the pack of papers. There were three actions identified and all marked as delivered but with supporting comments.

### **22/02 - Declaration of Interest Forms**

Mr Turner confirmed that he was now in receipt of declaration forms from all of the Board Members, and this action was now closed.

### **22/03 – Public Health presentation**

Sir Andrew Cash advised that Professor Ward had agreed to provide a presentation on wider public health and population health management which had been arranged to take place later that day. Unfortunately, Professor Ward was currently unwell and therefore not able to provide the presentation, which would be re-arranged to take place on a later day.

## **22/07 – Standards of Business Conduct and Conflicts of Interest Policy**

Mrs Ellis-Fenwick advised that she had looked into whether there is an expiration time period for conflicts of interest and could not find any reference of this in NHS England guidance.

The Board agreed to:

- **Note the action log and supporting verbal updates.**

**22/17**

### **CHAIR AND CHIEF EXECUTIVE UPDATES**

#### **ICB Chair update**

Sir Andrew Cash advised that the Chair and Chief Executive update and overview would be reflective of the current national, regional and Lincolnshire viewpoints, both today and going forward.

Sir Andrew Cash advised that his first reflection is that the ICS and in turn the ICB needs to be really clear and focused on where it can add value with the public and patients, staff, partner organisations and the services we provide across the health and care sector, voluntary sector and care sector. The ICB is a different type of Board and the agendas for the formal meetings have now been structured on the four key aims and what they mean for the organisation and the Lincolnshire population.

The Board has its first Development Session planned to take place on Tuesday, 23<sup>rd</sup> August 2022 and a core focus will be about understanding the Lincolnshire context in relation to those four key aims and to discuss an emerging vision for the Lincolnshire ICS. The session will also aim to:

- Understand and agree the role and purpose of the ICB, including the focus of activities required now and the relationship with the Lincolnshire ICP and the Lincolnshire Provider Collaborative.
- Understand how this correlates to where the ICB and Lincolnshire system wants to be by March 2023, 2025, and 2030.
- Plan and agree ways of working as a Board and across the ICS, including to evaluate and agree the Board Development requirements for the operational year.

IMPOWER have been appointed to support that piece of work and have been holding one-to-one interviews with each of the Board Members as part of the preparation work for the Development Session.

Sir Andrew Cash advised that his second reflection related to operational issues and the temptation to get involved in this, which can very easily crowd out the strategic aspects. The key role of the ICB is to retain a strategic focus.

The third reflection related to reform and changing the model of care. This related to care closer to home and moving to a model which is not only about prevention but also cure. This will not be easy to navigate alongside the numerous operational issues which have to be managed. The aim for Lincolnshire is to be the best delivery system but also in terms of system transformation.

Workforce has to be a top priority for the ICB. Sir Jeremy Hunt published a report the previous day on recruitment, training and retention of NHS workforce, which outlined the scale of the crisis. It is incredibly important for Lincolnshire to retain staff and grow its own; in short create a long term sustainable workforce.

Sir Andrew Cash advised that his final reflection was in relation to culture and organisations and key stakeholders working together as a system whilst at the same time respecting each other's individual statutory and legal duties.

Since the Board last met three weeks ago a meeting had taken place with NHS England national colleagues and senior representatives from United Lincolnshire Hospitals NHS Trust (ULHT) and their coming out of special measures (SOF 4 to SOF 3). The meeting was really positive and all those who participated acknowledged that really good progress was being made, although there was clearly a way to go. However the whole tone of the meeting had been really encouraging.

Sir Andrew Cash ended his update by referring to the two letters included in the pack of papers:

- Mr Richard Meddings, new NHS England Chair which outlined seven key priorities.
- Mr Oliver Newbould, Director of Strategic Transformation, NHS England Central Midlands which outlined the details of the predecessor NHS Lincolnshire CCG Assurance Letter 2021/22 which demonstrated a really positive legacy handed over from the CCG to the ICB.

The Board considered the update and letters. Mrs Kenson sought clarification on where the East Midlands Ambulance Service (EMAS) feeds into the ICS. Sir Andrew Cash advised that there is an NHS Leaders Group which meets on a regular basis with the latest meeting taking place the following day. This group includes EMAS representatives (both Executive and Non-Executive Directors).

Mr Turner added that EMAS are a Trust in Lincolnshire alongside ULHT, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS). The previous CCG and now the ICB enjoy a really close and effective working relationship with EMAS. The current EMAS Chief Executive, namely Mr Richard Henderson, has worked previously in Lincolnshire so is very familiar with the challenges it faces.

As referred to by Sir Andrew Cash EMAS do participate in the NHS Leaders Group and Mr Turner regularly participates in a number of other wider groups/meetings which Mr Henderson attends and also has regular 1:1's with him. The contract arrangements for EMAS are handled on an East Midlands footprint and Derbyshire ICB lead on that on behalf of all five systems in that area, but it is a collective effort. Mr Gaunt has a close eye on the contracting arrangements. There is also routine, sometimes daily, active engagement with EMAS which often involves Mrs Raybould as Director of Operations who deals with urgent and emergency care issues with ambulance handovers being a key challenge currently. Dr Hindocha and clinical colleagues through the clinical directorate are also looking at all of this from the clinical perspective, not just through the operational management frame.

Mr Fahy added that from a patient safety, quality perspective there is a system Quality Committee but alongside that sits the Quality System Group. Mrs Sue Cousland who is his equivalent in EMAS is the lead on that group for patient safety. The ICB Quality leads also sit on that group with Derbyshire ICB colleagues and meetings take place with EMAS on a monthly basis to go through the operational detail. The outcome of those discussions feeds into the Quality report which was included in the pack of papers for consideration later on in the meeting.

Mrs Pomeroy advised that she was supportive of the comments regarding workforce, which needs to be a top priority for the ICB to address going forward. On a separate note, she commented on the digital and IT aspects and that infrastructure; communication and ensuring that is seamless is fundamental along with workforce to the success for the ICB.

Dr Hindocha advised that as a result of the pandemic digital access and usage has increased significantly across the whole of the NHS. Two weeks ago a new clinical digital model for people needing orthopaedic surgery was launched which is much better for the patient in terms of productivity. This needs to be connected to the workforce in terms of the values which brought them to the NHS in the first place.

Dr Baker added that urgent and emergency care is in a challenging position up and down the country due to record demand. There is currently a great opportunity to dissolve the management down to PCN level and expand neighbourhood teams which is the way to reduce the numbers of patients going into hospital. Towards the end of the CCG discussion was held about holding an urgency and emergency care summit and Dr Baker would be supportive of that being progressed as things need to be provided in a different way to put the health and social care system on a sustainable footing for the future.

Sir Jonathan Van Tam advised that he had been very struck by the comments about strategic thinking, adding that it will be very challenging for any ICB to move towards that mindset. The emphasis on service management was much stronger in the CCG and there was a real risk ICBs would continue along the same lines. It will be essential for the ICB to continue to remind itself on the actions it needs to take and to focus on areas which are within its control to change.

This led into a discussion on culture, prevention, changing models of care and the opportunity do things differently across the health and social care sector and voluntary sector. It is evident that there are huge skills and experience across all the constituent parts and that needs to be used in the right way.

Sir Andrew Cash drew the discussion to a close at this point and asked Mr Turner to provide his Chief Executive update.

### **Chief Executive update**

Mr Turner advised that since the Board held its first inaugural meeting on the 1<sup>st</sup> July 2022 there had already been some significant changes and developments across the NHS. Before covering his update he wanted the Board to bear in mind how really busy staff across the ICB are, and the wider health and care system in Lincolnshire.

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

- Her Majesty the Queen had awarded the George Cross to the NHS for 74 years dedicated service. This was a very proud moment for everyone involved in the NHS.
- There was now a new ministerial team in place in Parliament with a new Secretary of State and a leadership contest currently underway to appoint a new Prime Minister.
- Rishi Sunak, MP had indicated the previous day that the NHS is in a critical situation.
- The Health and Social Care Select Committee, which is chaired by Sir Jeremy Hunt, published a report the previous day on Workforce; recruitment, training and retention in health and social care which related to the launch of an inquiry into the reasons staff are leaving the health and care sectors.

As had already been mentioned earlier in the meeting, there is a considerable amount of work to be undertaken in Lincolnshire to address the workforce and digital issues and the opportunities to work very differently in relation to all of that across the whole of the health and care sector. Without the workforce there is quite simply no service.

- NHS England had recently announced they would be downsizing their staffing by 30-40% which is approximately 6,000 to 8,000 posts out of about 22,000. This was likely to be enacted relatively soon and there will be an impact on the ICB in terms of the delegation of responsibility for pharmacy, ophthalmologists and dentists which would take place on the 1<sup>st</sup> April 2023. Aspects of specialised commissioning, screening and immunisation, health and justice and potentially other services were also expected to be delegated by NHS England in subsequent years. These may be best managed on an East Midlands footprint so in parallel with that there is a piece of work taking place on what that might look like, which is likely to rapidly evolve.

- Mr Turner had made it clear to the ICB Executive Team who work very closely with NHS England regional colleagues and with whom there is by and large a really constructive relationship, that they need to bear in mind they are also under significant pressure and trying to do their level best whilst undergoing considerable change.
- The details of the NHS Pay Awards for 2022/23 were published the previous week. Once the specific details were received this would be worked through in terms of the increase and back dated pay and uplifts for staff as appropriate. Mr Gaunt was addressing the financial implications of that through discussions with NHS England national and regional colleagues and how that is funded from additional non ICB resources.
- Alongside the pay awards information was published on reducing locum and agency costs. Lincolnshire currently spends around £40m on locum and agency costs which in itself is an indicator of the challenges around workforce.
- From an operational and system delivery perspective the situation has been very challenging in recent weeks, particularly associated with the recent heat wave which resulted in a very intensive and highly pressured period. The level of response from staff from across the county to manage the situation was simply superb and to be commended, particularly from IT and estates and also ULHT.
- Urgent and emergency care remained under huge pressure as had previously been discussed and the new Secretary of State had shown a particular interest in ambulance handovers.
- Elective care had seen some really good progress in recent weeks, which was really positive, notwithstanding there was still some way to go.
- Cancer – there is some really positive work being undertaken but performance is not where we would want it to be.
- Sir Andrew Cash had already referred to the system meeting with NHS England and ULHT colleagues and Mr Turner reinforced the comment about it being really positive and encouraging but there was clearly a lot more work to be done.
- Community Diagnostic Centres (CDC) had featured recently in national and local media. In Lincolnshire the Grantham CDC was already well established and working effectively.
- Lincolnshire ICB had recently submitted a proposal to NHS England for a second CDC based in Boston with a hub and spoke arrangement definitely in Skegness and Mablethorpe and possibly Spalding. This piece of work was being led by Mrs Raybould and a team including ULHT colleagues. The Board will be kept informed of developments.
- The Local Medical Committee (LMC) had held a recognition and reflection evening event a few weeks ago at the Lincolnshire Showground. Around 400 people attended, and it was really positive event, which was also attended by other ICB Board colleagues.

Finally, as referred to earlier in the meeting a question had been received by a member of the public, namely Ms Jody Clark. Mr Turner read out the question:

‘With the report about health inequalities and one being access to care, can you please update us on when Grantham Hospital will get the 24hr service?’

Mr Turner advised that under the CCG a piece of work called the Acute Services Review (ASR) was carried out over a number of years. This culminated with the development of a Pre-Consultation Business Case (PCBC), which underpinned four Lincolnshire NHS service change proposals relating to Orthopaedics, Urgent & Emergency Care, Acute Medical Beds and Stroke Service. At its meeting held on 25<sup>th</sup> May 2022, the CCG Board approved proposed changes to the four clinical services. including the establishment of a 24/7 Urgent Treatment Centre at Grantham Hospital.

Whilst it was acknowledged that it was important to ensure those decisions are enacted as soon as possible there are legal and procurement regulations which the ICB will need to abide by. As such it was not possible at this time to be specific about a date for implementation of the 24/7 UTC at this time, but as it was anticipated this was likely to be in the first half of 2023. The Board would be kept informed of developments as the process moves forward.

The Board considered Mr Turner's update and the response to the question received. Whilst it was acknowledged that there are legal and procurement regulations which must be correctly applied and followed, those present reinforced the message to move forward with any changes which can be implemented at pace as a Lincolnshire system, whilst at the same time being mindful of clinical safety and due process where applicable.

This led into a discussion on risk, different levels of risk appetite between the ICB and its main partner organisations, gain share arrangements as implemented across the system four weeks ago (referred to by Mr Gaunt) and establishment of a system wide Board Assurance Framework. It was agreed that this would be an appropriate debate for a future Board Development Session.

Mrs Kenson referred back to the earlier discussion on workforce and digital and sought clarification on where these areas sit from a governance perspective. It was noted those two areas were currently under review as part of the stocktake of the provider collaborative. An update would be provided once this piece of work is complete.

Sir Andrew Cash drew the discussion to a close.

The Board agreed to:

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

22/18

## KEY UPDATES

### Public Health

Mr Andy Fox provided a verbal update on a few key current key Public Health issues and highlighted the following:

- In the last seven days there had been 1300 positive COVID cases in Lincolnshire. Those were the cases Public Health were aware of, as there has been a change in the testing policy which has seen a significant reduction in the number of tests coming through as positive in Lincolnshire.
- In terms of overall trends in relation to positivity and total tests from a national and local perspective there are signs the situation is starting to plateau. Numbers are still increasing nationally but in Lincolnshire they have levelled off during July 2022, with the number of positive cases coming through reducing, which was very encouraging.
- Previously there have been waves in the number of positive COVID cases and that pattern was not likely to change, with the next wave expected to happen in Autumn.
- The current main variant in Lincolnshire is the BA5 version of Omicron.
- The number of patients in hospital in Lincolnshire have started to drop over the past week. The numbers of patients in ICU have been relatively low throughout the current wave.
- Planning has commenced for the Autumn vaccination programme. The Joint Committee on Vaccination and Immunisation (JCVI) recently published a statement on the COVID-19 vaccination programme for Autumn 2022 and there have been some changes to the eligible cohorts. The eligible cohorts has slightly changed with those aged 50-64 still eligible to receive the vaccine, but front line staff social care staff not eligible to receive the COVID booster as in previous years.
- There are indications coming through of a significant flu wave in the Southern hemisphere. It is expected that a similar picture will materialise in the Northern hemisphere.
- Monkeypox – the number of cases has increased in England, with well over 2,000 in the UK. Research is taking place into the rates of transmission.

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

## **Healthwatch**

Mr O'Dell provided a verbal briefing and highlighted the key themes received by Healthwatch in recent months as followed:

- Dental services – there is a real challenge and issues in relation to access to dental services. This links to inequalities around access but also from the public health perspective in terms of prevention and fluoridisation in water, which is an issue for Lincolnshire, but particularly in the East of the county.
- NHS Dentistry - there has recently been an increase in payments for dental treatments. The impact on Lincolnshire patients was not clear at this time.
- There have been reports/feedback received of some quite harrowing experiences of people going into hospital and through A&E. This particularly related to experience of very long waits with patients sitting in corridors and chairs for considerable periods of time.
- Communication between hospitals/services had also been flagged as being quite poor in some cases – this needs to be improved.

Healthwatch is currently going through an interesting period with their contract running from October to the following September, and a piece of work was taking place on some annual planning. This provides the ICB with the opportunity to influence some of the areas that Healthwatch might look at (setting their priorities for the coming year). Currently areas which had been identified were Children and Young People, particularly around Mental Health, Self-Harm and Social Care and experiences people are having whilst waiting for clinical intervention. A piece of work was also planned more generally with LPFT on mental health.

The Board considered the update. Mrs Raybould advised that she had recently spoken to Dr Hindocha in relation to the planned Risk Summit on Emergency and Urgent Care and reviewing an engaging with people to understand why people access services in the way that they do. Their experiences are also really important to help design services going forward and establish a set of expectations.

Mrs Connery added some context to the update in relation to mental health and advised that LPFT and the local authority are leading a joint piece of piece of work on children and young people transformation over the next 12 months. The consultation and engagement process had commenced, and liaison was currently taking place with Healthwatch as part of that. This was just at the information gathering stage at the moment but once this gained traction the ICB would receive feedback. The one area which does need to be strengthened in Lincolnshire is community assets for children and young people.

Mr Turner advised that there will be plenty of opportunities for updates on the piece of work as referred to by Mrs Connery. In terms of NHS Dentistry there are some real challenges within the county, with Lincolnshire currently regarded as one of two out of 11 systems which the NHS England regional team are most concerned about in respect of dentistry with significant variation across different parts of the county, which is more apparent in the East area.

Mr Turner and Mrs Williamson have been working closely with the Regional dentist and with his team of colleagues on a number of areas. There is a considerable amount of work taking place with renegotiation of the national contract and consideration of regional initiatives.

There are numerous opportunities for integration of dental services and how the situation can be improved both in terms of population health and service provision.

In summary there is a considerable amount of work taking place, further opportunities around integration of dental services and the Board would be kept informed of developments.

The Board was advised that Anglian Water would be carrying out major works on the water system in Lincolnshire in 2024 and 2025 and they would be removing fluoride from all of the county's water supply during that time. Currently fluoride is only available in the water supply in the West of the county, not East.

On a final note, in terms of communications there are a number of pieces of work being progressed which are reflective of previous comments made earlier in the meeting about doing things with the people of Lincolnshire and not to them. To enable the breadth and depth of debate to take place on this area it was proposed and agreed that this would be better suited to take place at a future Board Development Session.

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

The Board agreed to:

- **Note the verbal updates.**

**Councillor Woolley stepped out of the meeting at this point.**

## **CORE PURPOSE 1: HEALTH INEQUALITIES**

**22/19**

### **LINCOLNSHIRE HEALTH INEQUALITIES APPROACH**

Mrs Williamson advised that nationally NHS England and Improvement has outlined the approach to support the reduction of health inequalities at both national and system levels which is referred to as 'Core20PLUS5'. The approach defines a target population cohort and identifies five focus clinical areas requiring accelerated improvement and this has been embedded within the ICS Health Inequalities and Prevention Programme.

The paper included in the pack of papers is a summary report which detailed an overview of the progress that has been made during 2021/22 on delivery of the Lincolnshire ICS plans to tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire. The report presented also highlighted the key areas of the Lincolnshire approach and how 'Core20PLUS5' and health inequalities will continue to be embedded in all ICS system work for 2022/23.

The attached 2021/22 Year End Report (Appendix 1) provided details of progress against the National Five Strategic Priorities and 'Core20PLUS5' as well as agreed local priorities and in meeting Lincolnshire ICS objectives. Mrs Williamson advised that she would not go through the appendix in detail; it was for information unless the Board had any specific questions to raise in relation to it.

Mrs Williamson advised that CORE20 refers to a framework to support actions specifically looking at the 20% most deprived in Lincolnshire defined by areas of deprivation. The Plus5 element is for an ICS to identify whether there is any other population group that would be considered to have a less than average experience in outcomes or experience in relation to some aspects of the care they have received.

The five areas have been given some clinical focus of where targeted action is required in terms of addressing health inequalities on a national level but referring back to the Lincolnshire perspective these already fit neatly with what had already been identified in the Health and Wellbeing Board Strategy and the Joint Strategic Needs Assessment (JSNA).

Building on that context in Lincolnshire there is a long standing track record of really good joint partnership working between NHS organisations, Primary Care, Health and Wellbeing Boards, Local Authority Public Health, Social Care and children's services and voluntary sector organisations.

Strong collaboratives have been formed, mostly on the back of COVID-19 which generated an opportunity for those organisations and sectors 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.

The ICB Chief Executive (formerly the Lincolnshire CCG 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. This is led and delivered by Mrs Williamson and Mr Andy Fox who was in attendance at the meeting.

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, the fastest.

The background paper highlighted outcomes and by this it means increasing life expectancy and quality of life for people living in Lincolnshire and to reduce the gap between the healthiest and least healthy populations within the county.

In terms of the Framework for action and how this is going to be progressed, this will be taken forward under three areas, which were detailed in the report. Work is already underway to look at access to services and this relates back to the comments made earlier in the meeting by Mr O'Dell in respect of dental services.

The report also included a summary of the 2022/23 Health Inequalities Programme Plan and Mrs Williamson provided a quick overview of the key areas of focus for the programme and specific workstreams.

Mr Fox added that the work on health inequalities is incredibly important for a number of reasons, which were outlined for information and reflected in the programme of work detailed in the paper. In short, it is the right thing to do and the ICB and indeed the Director of Public Health have a legal duty to tackle inequalities as does NHS England. It is about proactive and preventative care and changing the way people interact.

Mrs Connery advised that acknowledging the points made there is also another element to this; it is not just about access to services, it is also about experience, outcomes and inequality of those two aspects which she had discussed with Mrs Williamson. One of the key priorities of the Mental Health, Learning Disabilities and Autism Alliance is to have a mental health, learning disabilities and autism informed society and workforce as a considerable amount of the inequalities relate to lack of reasonable adjustment and understanding mental health capacity as examples. This relates back to the earlier discussion about moving swiftly on these areas which can be progressed across all providers to reduce inequalities in those areas.

Mr Fox added that Mrs Williamson is working on a Plan on a Page which will summarise the Health Inequalities Strategy and what that looks like over the next five years.

Following further discussion on wider determinants, continuation of the clinical priorities past 2023, and the potential to establish a dashboard going forward to show progress at a glance, Sir Andrew Cash drew this item to a close.

The ICB Board agreed to:

- **Note the report.**

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

Councillor Woolley re-joined the meeting.

## CORE PURPOSE 2: HEALTH OUTCOMES

22/20

### INTEGRATED QUALITY AND PERFORMANCE REPORT

#### Performance Section

Mrs Raybould advised that the report included in the pack of papers has been adapted for the ICB and some of the data related to the former NHS Lincolnshire CCG. New reporting arrangements would be developed going forward with the System and Delivery Performance Committee but in the interim the report presented is a hybrid of previous reports combining the COVID-19 and Recovery report with the Integrated Quality and Performance report.

In short the report has been updated on this occasion to include some additional system wide data but there are sections where the information is from May and June. As part of Mrs Raybould's update the latest 'live data' would be provided where available.

In terms of the backdrop in relation to COVID, this had already been covered under the Public Health update but to add the number of patients currently in hospital and community in county was 64, which was almost half what it was 10 days ago. This was really positive.

All Urgent and Emergency Care services were continuing to operate under significant pressure and that was particularly noticeable in Emergency Departments and Ambulance. Ambulance handovers and delays tend to be referred to as a barometer but in reality this is not just about EMAS, it is a symptom of the whole way in which urgent and emergency care pathways operate. This reflected previous discussions held during the meeting that current models of care need reviewing to increase integration in the community which would result in a different flow being seen into hospitals.

The system is currently off trajectory for these indicators and is reflective of the picture being seen nationally and is due to a combination of demand, workforce pressures and lack of discharges from hospital where patients no longer need acute care, COVID-19 and recent heatwave impact but also as outlined is the wrong model. The key to unlocking delivery across UEC/Elective and cancer is integration in community pre/post as referred to and the provider collaborative - Lincolnshire Health and Care Collaborative (LHCC) is working to implement rapid interventions to improve flow and discharge.

In the report there is detail on the Integrated Discharge Hub (IDH) which has been launched at Pilgrim hospital, Boston which is a multi-agency approach and is working very well and is starting to understand how single agency systems and processes need to integrate to ensure it meets the objectives. This relates to the reference made by Dr Baker earlier about ensuring primary care and neighbourhood teams are part of the process. Hospitals need to carry out some transformation work as well; this is not just about the community.

The system Elective Activity Coordination Hub has a robust waiting list management process in place over 78 weeks to ensure patients are treated at the earliest opportunity and to ensure the ICB meets 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. One 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 treatment date, the extended trajectory a mix of complexity, capacity and choice.

ULHT has supported United Leicester Hospitals (UHL) with mutual aid for long waiting patients in Leicestershire, predominantly around orthopaedics which have been carried out at Grantham and District Hospital and those patients in the main will be treated in July unless they have chosen a later date.

Most diagnostic modalities had restored to greater than pre-COVID capacity. However, the fire at Lincoln County Hospital at the end of March continued to impact on recovery, particularly with CT and MRI scans, although mitigation plans are in place to minimise the disruption as much as possible. The recent heatwave has further impacted MRI.

Mrs Rayould advised that Community Diagnostic Centres had already been referred to earlier in the meeting so that would not be covered again but information was included in the report.

The backlog for cancer patients has shown an improvement for both 62 and 104 days from the peak last month. Performance data for June has improved further to under 400 patients in line with trajectory. 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.

Colorectal is over 50% of the COVID backlog in ULHT and similar for other providers which again had been discussed earlier in the meeting. There is system deep dive on this area the following day which is a joint meeting held with the East Midlands Cancer Alliance team, ULHT and other Lincolnshire colleagues.

This will help focus on the short, medium and long term solutions and long term transformation work as referred to by Mrs Williamson under her health inequalities update.

Patients continue to be monitored via multiple mechanisms and are clinically prioritised at Trust level from a clinical harm perspective.

Learning Disability Health Checks - delivery over April and May was 238 Health Checks, which is 78 ahead of the position in 2021/22 but 15 behind plan for 2022/23. It is too early for a robust performance projection, but current data indicated delivery of the 85% target by year end.

The Mental Health Urgent Assessment Centre is now open 24/7 with direct 'drop offs' from police and ambulance and A&E referrals. Self-referrals will be introduced shortly, and this is actively helping UEC pressures, particularly over recent weeks.

Pre pandemic there were a number of patients in Mental Health Acute Out of Area beds, but in April this year this had reduced to zero. With the very odd exception this position was being maintained.

Mrs Rayould handed over to Mr Fahy at this point to present the Quality Section of the report.

### **Quality Section**

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

- Mortality metrics - All Summary Hospital-Level Mortality Indicator (SHMI) and Hospital standardised mortality ratio (HSMR) are now on trend for all of the ICB's main providers – ULHT, Northern Lincolnshire and Goole Hospital NHS Trust (NLAG) and North West Anglia NHS Foundation Trust (NWAFT). This was really positive as previously this had been an area of concern.
- Mental Health - Performance of early intervention in psychosis (EIP) waiting times continued to be poor with further deterioration from 9% to 0% seen within two weeks, which is much lower than the 60% standard. The current wait for the service, is three weeks as opposed to two. There is a robust plan in place to deal with the staff vacancies issue and the performance is expected to improve however full recovery is not likely to be seen until September 2022.
- The report included some new data on Children and Young People (CYP), particularly around first contact. During the pandemic access to mental health support and psychological support for young people was a challenge but the report showed that

services were performing well but there was some challenge particularly around new metrics for CYP, for example in relation to Eating Disorders.

- Serious Incidents and Never events - There were no new never events to report this month across all our providers, 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 were no significant themes to identify from a patient safety perspective, pressure ulcer reporting has increased in LCHS and there is some focused work as part of the system quality group looking at this area.
- Care Home Quality sector - Nothing to escalate.
- There are five Suspensions in place by Health and Lincolnshire County Council across the East & West localities and there has been a total of 10 Default Notices by Lincolnshire County Council across all localities.
- Special Education Needs and Disability (SEND) - The online e-learning resource for professionals who work with CYP and with SEND called a 'Rough Guide to not putting your foot in it' funded by NHSE and in collaboration with Lincolnshire Young Voices and the local authority was completed and launched on the 8<sup>th</sup> July 2022. The SEND team have been nominated for a national award for their work.
- Ockenden Insight Quality Assessment visit to ULHT (three day process) - maternity services were inspected by the regional quality team in June 2022. The purpose of the visits was to provide assurance against the seven immediate and essential actions from the Ockenden report. The inspection report made reference to the outstanding senior leadership team who are credible, well liked and respected with clear executive and NED visibility across maternity services.
- The Maternity Voice Partnership (MVP) Chair is driving some innovative work around the support for military families which will inform opportunities for spread of good support practices across England.
- Primary care quality - nothing new to report by exception. The ICB has 84 practices and none of those were currently rated as inadequate. There were four rated as requires improvement, which were detailed in the paper presented.
- ICB senior representatives continue to meet regularly with the Practice Teams to receive assurance on continued actions to address concerns and to support. LMC were also supporting those practices.

The Board considered the update. Councillor Bowkett referred to the four practices currently rated as requires improvement and challenged that position, particularly in respect of some practices on the East Coast who in recent years had not received particularly good outcomes following their Care Quality Commission (CQC) inspections. Mr Fahy advised that the programme of assessment has not changed; face to face inspections simply did not happen due to COVID-19 but were now being re-instigated. The CQC do have an annual cycle of planned practice visits and it might be helpful for some colleagues from CQC to attend a future Board Development Session to provide more information and some assurance around their inspections. The ICB Quality Team also regularly visit those practices and receive regular intelligence on those which is not indicating any concerns.

Sir Andrew referred to the updates on areas where performance had improved and emphasised there were four or five areas where performance should never go back and that needs to be an agreed principle going forward. As an example the colorectal deep dive was referred to and Sir Andrew requested that more information on this area was included in the next Integrated Performance Report in September, which was noted by Mrs Raybould.

**Action: Mrs Raybould**

Mrs Pomeroy commented on the discussion held earlier in the meeting around getting more focus on what the system is doing and where the ICB can really influence areas, which would no doubt be picked up by Mrs Kenson under the work of the Service and Performance Delivery Committee, which was supported and noted.

The ICB Board agreed to:

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

## **CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY**

**22/21**

### **FINANCE REPORT**

Mr Gaunt presented the Financial Management Report for June 2022 (end of Quarter One) which set out the financial position of the Lincolnshire NHS System and the newly formed ICB. As referred to by Mrs Raybould under the previous item, the format of this report was a hybrid from the previous CCG and the ICB with the inclusion of some system wide information.

The report included information on the summary financial position which was one of the key areas for noting by the Board. There was also information included on the financial context which by and large referenced the planning process which the organisation had just gone through, and then the revenue position which in future will be supplemented with capital data and the last section is on risk. The Board was being asked to note the content of the report and to endorse the actions underway.

The Board was advised that the Lincolnshire Integrated Care System (ICS) planned to deliver a £1.0m surplus position by 30<sup>th</sup> June 2022 (month three). At month three the system reported a £2.1m favourable variance to the plan by delivering a £3m surplus. The CCG position in that was favourable by £7.0m. The providers collectively were adverse by £4.0m but £5.0m of that represented an adverse variance to plan which was all vested in one organisation.

The transition from a CCG to an ICB means that any underspend or overspend is novated between organisations and so the £7.0m will move to the ICB in Quarter Two above the planned allocation.

Mr Gaunt referred to the provider position and advised that at the end of Quarter One it was expected that there would be between a £2m and £3m adverse position in light of planned low levels of COVID and ULHT was clocking up approximately £1m pandemic costs per month. The efficiency programme was also behind and as such the risk gain share agreement (as referred to earlier in the meeting) was enacted about four weeks ago.

The report indicates that there are 150 more beds than target and also much higher bank agency. The trajectory is actually about £50m reduction, not £40m as mentioned by Mr Turner under his update. In summary the risks are COVID-19 pandemic costs, bed occupancy and high pay costs and these are the principal drivers of a £5.2m deficit in ULHT.

In summary, recovery and acceleration of delivery through the mechanics of the risk and gain share arrangements and with improved transformation plan within the Lincolnshire Health and Care Collaborative (LHCC) will get efficiency back on track.

The last stage in the process was underway to establish an 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.

The third area of work, which the system was asked to carry out, is an internal audit review of financial governance arrangements, particularly around financial control. The audit work associated with this will identify areas of strength of the underlying financial governance principles and will be commissioned in August.

On a final note, which was again influenced by a national direction of travel, is a look back at pay and non-pay controls to reduce system bank and agency spend, focusing on increased Use of frameworks and price cap compliance.

The Board considered the paper and agreed the report provided a robust summary of the current position.

Mrs Pomeroy referred to the £19m efficiency costs identified in the report, and there only being eight months of the year to go. This is one of the main financial risks and will no doubt be a key part of the discussion and focus of the Finance and Resource Committee over the coming months.

Mr Turner advised that to come through the next few months in better shape, it is essential that the discharge flow issues around the hospitals is addressed as that will have a significant impact on a number of areas which form part of the recovery programme.

This is not the only gain but one of the most significant and there is a huge amount of work underway in relation to this which included Mr Gaunt and Dr Hindocha, and numerous other colleagues across the system.

Sir Andrew advised that the Board do need to undertake detailed consideration of the recovery programme although it was acknowledged a formal business meeting might not be the best forum for this; it would be better suited to a Development Session. This would be reflected on. Dr Baker referred to agency staff and asked whether the ICB is aware how much is spent in primary care. Mr Gaunt advised that the ICB does not receive that information.

The Board agreed to:

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

Mrs Jacqui Bunce - Programme Director, Strategic Estates, Planning and Partnerships joined the meeting at this stage to support the next item on the agenda and to go through the contents of the presentation included in the pack of papers on Strategic Partnerships.

Sir Andrew welcomed Mrs Bunce to the meeting.

## **CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE**

**22/22**

### **TOWNS FUNDS PARTNERSHIP**

Mr Burnett introduced the next item and advised that tackling inequalities in outcomes, experience and access and supporting broader social and economic development are two of the core purposes of an Integrated Care System (ICS). The paper presented highlighted the partnership work that is taking place to support social and economic investment in Lincolnshire with specific reference to the Towns Fund, Levelling Up and UK Shared Prosperity Funds.

Mrs Bunce went through the contents of the presentation and highlighted the following:

- Why are we involved?
- The Towns Fund for England announced in July 2019 – 101 Towns invited to bid for up to £25m each. Four in Lincolnshire submitted: Boston, Lincoln, Mablethorpe and Skegness (Working together as Connected Coast).
- Overview of each development in the four towns.
- Levelling Up (designed to invest in infrastructure that improves everyday life across the UK)
- UK Shared Prosperity Fund (UKSPF) – key funding pot for delivering the Government's Levelling Up agenda
- Lincolnshire Councils UKSPF Allocations

The Board considered the contents of the report and supporting presentation.

Mr Burnett commented that this work is a huge part in reducing health inequalities and is more than just about healthcare and an area the ICB needs to get more involved in as it moves forward.

Mr Fahy advised that as alluded to by Mrs Bunce this is an ideal opportunity to capitalise on other partners premises, including consideration of opening up NHS premises to the public in a way that is not currently done; it is about a shift in thinking which came across really strongly during the presentation.

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

- **Note the investments and projects within the Towns Funds across Lincolnshire and the UK Shared Prosperity Fund and Levelling Up Fund information**
- **Note the representation of the NHS supporting these investment programmes across Lincolnshire.**

## GOVERNANCE

22/23

### CCG COMMITTEES END OF REPORT YEAR REPORT

Sir Andrew Cash invited Sir Jonathan Van-Tam and Mrs Kenson, as the ICB Non-Executive Director leads, to provide verbal updates on the recent meeting of the Primary Care Commissioning and Delegated Function Committee and the preparation work being undertaken for the first meetings of the Quality and System Delivery and Performance Committees. It was reported that going forward the Board would receive regular written reports to each meeting from the respective Board Committees.

Sir Jonathan Van-Tam advised that the meeting of the Primary Care Commissioning and Delegated Functions Committee had taken place on Wednesday, 20<sup>th</sup> July 2022. The initial focus of the meeting had been on several operational issues which needed addressing, with the majority of the discussion taking place on the Johnson GP Surgery in Spalding and the associated issues with the current contract and provider. A number of options were explored to secure the continuity of patient care including a managed list dispersal to an alternative practice and premises.

From a strategic perspective there was real acknowledgement by those present of the need to move towards a much more radical rethink of the strategic offer that is needed to re-set primary care in Lincolnshire and bolster longer term resilience in a system that feels quite fragile at present.

The Board discussed the update and Dr Hindocha confirmed his support to the comments about the strategic offer for primary care specifically in terms of resilience, which would be a fundamental foundation on which to build on going forward. A piece of work had already commenced on areas such as secondary access and it was anticipated that an update on this would be brought to the Board in October/November 2022, which was duly noted.

Councillor Woolley referred to the Johnson GP Surgery in Spalding and advised that it was important to acknowledge the contribution of health staff and colleagues in that area who assisted with ensuring comprehensive communication was promptly issued to patients and stakeholders, including the local MP. This was to be applauded, which was acknowledged and noted by the Board.

Dr Baker supported Sir Jonathan Van Tam's comments about primary care in Lincolnshire and its long term sustainability, adding that PCNs and potentially GP Federations have a huge role to play going forward in ensuring practices in their area are stable for the future with a common set of goals and fundamental objectives. This model would be encouraged for adoption across the county.

In summary it was evident that there is a strong unity of purpose and the ICB would need to evolve its thinking in terms of the long term sustainability of primary care. Some of the work had already been commenced by the Primary Care Commissioning and Delegated Functions Committee in terms of ensuring a sustainable, innovative and dynamic primary care sector going forward.

Mrs Kenson advised that the first meeting of the Service Delivery and Performance Committee had not yet taken place, but a number of preparatory briefings had taken place with Mrs Raybould and Mr Burnett who are the Executive Leads about key system priorities as referred to earlier in the meeting under the performance update.

Mrs Kenson added that she had also had a meeting with the two provider Non-Executive Directors from Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS), namely Di Bailey and Gail Shadlock. The NED representative from ULHT had not yet been confirmed but the dates of the meetings had now been set from September through to March 2023.

The first meeting of the Service Delivery and Performance Committee in September would primarily be about 'setting the scene' and making sure a system view approach is adopted from the start. The Terms of Reference will be reviewed to ensure they are fit for purpose, reflective of relevant system objectives and demonstrate what the Committee can do best to add value.

Mrs Kenson advised that there were two areas where it was not currently clear where they sit under the current governance structure and how the ICB has oversight and is assured which are the green agenda and estates infrastructure. There was also the potential for cross-over with the Finance and Resource Committee.

Mr Turner advised the Board that Mrs Sarah Connery, Chief Executive, LPFT who is the Mental Health representative on the ICB is the system lead for estates, and is supported by Mrs Jacqui Bunce, Programme Director – Strategic Estates, Partnerships & Planning. The green agenda forms part of the estates infrastructure.

Mr Burnett added that a large majority of other systems in the Midlands region had not adopted the same approach as Lincolnshire ICB in that they were not proposing to include partner members on their Board Committees – they were in effect only 'in-house'. As such it was acknowledged that it will take the ICB Committees a little longer to get working and to begin to see the benefits of working in a system way.

Mrs Jolly made an observation in terms of the health inequalities work and how that is linked into population forecasting and it appeared the process was not currently clear. This was discussed and it was noted that this was addressed through Public Health, but it would be helpful for this to be set out in a clear road-map to show how this feeds into the Health and Wellbeing Strategy.

Mr Turner added that looking at the Census information the Lincolnshire population has increased by approximately 50,000 over the last 10 years, which raises questions about what that has meant for general practice and health services with the expansion and evolution of health care in the county and associated social determinants. The direction of travel is clear but there is evidently work to be progressed to ensure everyone is joined up and on the same page.

Mrs Ellis-Fenwick advised that the pack of papers included the end of year handover reports from each of the predecessor CCG's Board Committees which were produced as part of the close down process. These included:

- Audit and Risk
- Quality and Patient Experience
- Primary Care Commissioning
- Finance and Performance

These reports had been produced to provide information to the incoming ICB Members.

The Board agreed to:

- **Note the verbal updates.**
- **Note the CCG Committee Handover reports.**

**22/24 DATE AND TIME OF THE NEXT MEETING**

Sir Andrew Cash thanked everyone for their attendance and drew the meeting to a close.

The next meeting of the ICB Board will take place on Tuesday, 27<sup>th</sup> September 2022 at 9.30 am at Bridge House, Sleaford.

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**Chair Signature**

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**Date**

Not Delivered
In Progress
On Track to Deliver
Delivered

## ACTION LOG - PUBLIC

<b>Date of Meeting:</b>	Tuesday, 27 <sup>th</sup> September 2022
<b>Agenda Item:</b>	1 (iv)
<b>Reporting Officer:</b>	Sir Andrew Cash, Interim ICB Chair

Date of Meeting	Minute Number	Item	Action	Lead	Due Date	Progress
26/07/22	22/20	Integrated Quality and Performance Report	Additional information to be included on colorectal in the report for the September meeting.	Mrs Raybould	September 2022	Delivered.



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15<sup>th</sup> September 2022

***By email***

John Turner  
Lincolnshire ICB Chief Executive

Dear John

**LINCOLNSHIRE QUARTERLY SYSTEM REVIEW MEETING – 15<sup>TH</sup> SEPT 2022**

Thank you to you and your System colleagues for a productive and informative meeting today with Regional colleagues.

Overview

We began the meeting, highlighting some of the areas that we considered to be positive within Lincolnshire.

Lincolnshire is a good system to work with and a team who are receptive to feedback and support, whilst also happy to challenge.

You have successfully transitioned to an ICS and also achieved a signed off MOU. We are very pleased with your NED appointments and it is clear to see the strategic development and system working as an ICB.

The work you have undertaken and progressed around the Provider Collaborative is encouraging and engagement with the Local Authority has been positive to see.

We wanted to acknowledge and congratulate you on progressing the ASR, ultimately to the point where you now embark on the implementation plan, without any legal challenge, which has been a major achievement.

You are maintaining a good position against the 104 week backlog position but be mindful of the need to achieve zero. Your support towards providing mutual aid to UHL has been recognised and appreciated. The progress being made around the elective hub expansion is positive and the volume of activity now going through your new Community Diagnostic Centre has been excellent.

A further major achievement has been the approval in July of the Boston UEC.

We recognise the work undertaken to produce a strong workforce plan, but deliverability is key recognising the local challenges around workforce.

There has been good recovery in primary care against 19-20 activity levels for face to face contacts and would like to thank and recognise John's efforts in his Primary Care and Specialised Commissioning Delegation leadership across the Midlands.

Despite all of this great work, there remains some key challenges within Lincolnshire, that we focused on during the meeting.

- **UEC**- particularly around the ambulance handover delays, which is just below the threshold of challenged providers, but needs to be improved
- **Cancer**- the breast screening trajectory is of some concern (March 23 against a target of Nov 22), lower GI tumour site is a particular challenge and as part of this, the diagnostics pathway and 62 day backlog, all of which are specific problems
- **78 weeks**- despite the good work around 104 weeks, 78 weeks is a concern, due to the volume in your backlog required to be cleared through the winter period
- **Winter plans**- we discussed in more detail your winter plans as there is heavy reliance on releasing 122 beds, currently in use as part of the care closer to home programme. This feels high risk and the associated link to finance, adds pressure to delivery of this scheme
- **Finance**- currently off plan in M4, with a £10m deficit in M5. 45% efficiencies remain unidentified- with care closer to home reduction of beds as a cornerstone in delivery
- **Workforce**- has been and remains a significant challenge as a thread throughout all of the areas of concern, recruitment and use of agency is key to resolving a number of issues
- **Leadership capacity**- concern was raised due to a number of senior level positions becoming vacant and the ability to deliver a challenging agenda over the coming months with significant gaps.

#### Urgent and Emergency Care, including ambulance handover delays:

We highlighted that whilst handover delays were not flagging specifically, Lincolnshire is sitting just below the threshold of most challenged providers and regularly has challenging days. As such, we want to keep you out of this level. We acknowledge that there is an extensive programme of work, but currently it is not reflecting a material impact on AHD. There needs to be sharp focus on what can make a difference this week and the week after, to achieve some real improvement.

We discussed the North Bristol approach, recognising the need to risk share outside of EMAS and ED. A 60 day trial is starting at the end of September.

You outlined your focus on discharge and flow, with ongoing pressure across the system being seen. You have commissioned further reablement and health packages and looking at the care workforce to integrate discharge better.

You mentioned the patient schedule and risk workshop planned for October, for clinicians and senior team to look at the risk based approach. NHSE offered support with this if required.

Strategically, you have moved your gold calls into the weekly winter oversight group and have confirmed the need for a reset following the winter planning event this week.

You have identified further integration opportunities between primary and secondary care and non-conveyance work, which is an essential requirement for winter.

Also confirmed was that the Demand and capacity schemes are due to start in October but trying to be brought forward. As part of these, there are the 122 beds to be moved to community capacity, with an aim to then re-open beds as part of surge. Issues in delivery for this is directly related to recruitment.

Other areas of focus will be on attendance avoidance, operational oversight with an agreed investment in Shrewd, alongside the setting up of a system ops centre for winter.

We recognised the amount of work being planned, but it is important to now see pace and delivery showing the impact and output around improvement.

#### Operational delivery:

##### **Electives:**

You have four outstanding 104 week waits, one of which is attributed to UHL. Key is ensuring you achieve the planned zero in October and sustain this.



There is some concern around the 78 week position, due to the high volume to get through during winter, with around 1,000 at risk of breaching 78 weeks. Whilst there is a trajectory in place and you report being slightly ahead, the risk remains.

You highlighted that the risk and impact of the unexpected Bank Holiday Monday cannot be underestimated. You have 1,800 going through out patients, and whilst taking into consideration the situation, you have considered the length of time patients are waiting, so aiming to continue as much as possible with the planned activity. All patients have been contacted but expect around 20% of activity may be lost.

You continue with work around the Independent Sector outsourcing in gastro and for respiratory, you are seeking mutual aid. Dermatology is the 3<sup>rd</sup> area for support being sought. You are meeting with UHL around trade off support for respiratory in exchange for geriatrics in addition to mutual aid already in place, NHSE will support this conversation.

We reaffirmed the TIF request, where there is opportunity due to underspend in other schemes, which you are working to a submission as soon as possible.

### **Cancer:**

We highlighted that by addressing one tumour site (LGI), would get you much further forward on delivering your trajectory against the 62 day backlog.

You explained the work around the Lower GI- FIT pathway. Significant work has taken place within primary care. There is strong clinical engagement and leadership and as a result, the pathway is in place and working well. You evidenced where there had been 300 patients not given a date 10 days ago, this is now down to 40 and you are dating at 7 days - which is excellent news. You reminded us that this will not impact performance now, but will be an improved, sustainable position in a months' time. You confirmed that the backlog will be reduced by half at the end of October.

Breast screening in Boston is proving to be a challenge in terms of recovery. An action plan has been received but reflecting recovery in March 23 (target date is Nov 22). You outlined the work completed on symptomatic cases and screening, which has seen a 7-month improvement on symptomatic treatment times, but you confirmed that you have not created the right space for screening. However, focus is now on capacity being shifted to address this.

### **Mental Health, Learning Disabilities & Autism:**

Improving access to IAPT is a key risk but you continue to work with Lincoln University to identify what good looks like.

You have put forward a dementia transformation board with an aim to improve dementia diagnosis. Recruitment is an issue around some pathways, which you are trying to address.

CYP is seeing increasing demand, whilst losing staff capacity.

Positively, the MH Urgent assessment has been successful and EIP is meeting the 2 week access target.

### **Finance**

Finance is a significant cause for concern in Lincolnshire. We met with you four weeks ago and did a stocktake review of Q1 position. The key themes you were experiencing in the financial position continues around agency use, covid and difficulties in delivering efficiencies.

You were positive around interventions and the work/approach to address efficiency gaps, agency and productivity concerns. You are looking at performance and planned delivery for rest of the year, reflecting on a £10m deficit position, and a projected £32m gap with significant phasing into the latter part of the year and into winter.



Lincolnshire has made a lot of progress around enablers, controls and improvements, but you accept the role around risk and supporting change. The double lock approach, with its system and organisational controls towards overspend is helping to provide a sustainable finance position.

There is a system approach - teasing through wicked issues rather than putting in stop gap plans. Care closer to home is the big focus as it has a huge impact around all elements (finance and operational).

Whilst cautious around the challenge, you are seeing a sustained run rate lower year on year from complex MH and continued Packages of Care, due to success of care homes on frameworks. This could mitigate up to 50% of the system's unidentified plan.

However, Lincolnshire will still be reporting a risk of £26m for full year, but you confirmed you are not accepting this as your final position, and you are undertaking further work to address this.

You confirmed that you had confidence around programme management capacity to deliver the challenge and have plans in place but need to ensure capacity is used in the right place. You know where pressures are and what is needed to be done; the Region now needs to see the plan and receive confirmation that the plan can be delivered. We will keep working closely with you.

#### Summary:

There is clearly a lot of work to do around finance and we remain nervous around the risk and challenge in finance.

Today has seen a good conversation and content, with a strong level of detail and real innovation being evidenced.

There is a strong emphasis on Health Inequalities and it is clear the ICB is adding value.

We would also like to thank Simon Evans as this is his last meeting, his dedication and work has added huge value to the system and organisation.

#### Actions:

- 60 day trial of the North Bristol model to begin end of September
- Patient schedule and risk workshop in October to consider risk based approach. NHSE offered support with this if required
- Various areas are being sought for mutual aid (respiratory, gastro and dermatology). NHSE to support where possible to identify areas of mutual aid
- To address the gap in the financial plan and associated risks

Thank you once again for your time and transparency of the conversation.

If you have any queries in relation to this letter, please do not hesitate to contact me.

Yours sincerely

Oliver Newbould  
**Director of Strategic Transformation (Northants, LLR and Lincolnshire) and  
Director of Intensive Support  
NHS England and NHS Improvement – Midlands**



Copies:

Andrew Cash

Lincolnshire ICS Chair Designate

## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date: 27<sup>th</sup> September 2022**

**Location: Bridge House, Sleaford**

<b>Agenda Number:</b>	4 (i)
<b>Title of Report:</b>	COVID vaccination update – Health Inclusion approach
<b>Purpose:</b>	To Note Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration
<b>Appendices:</b>	Health Inclusion Vaccine Uptake Strategy presentation

<b>1.</b>	<b>Key Points for Discussion:</b>
<p>Presentation update to support discussion:</p> <ul style="list-style-type: none"> <li>• Strategy and Results of vaccine uptake plans in areas of health inequality across Lincolnshire June – August 2022</li> <li>• The next steps of the inclusion and health inequality strategy in relation to the covid 19 vaccination programme.</li> </ul>	
<b>2.</b>	<b>Recommendations</b>
<p>The ICB Board is asked to note and consider all the information in this report and the actions being undertaken.</p>	
<b>3.</b>	<b>Executive Summary</b>
<p><b>I. Background – COVID Vaccination Programme</b></p> <p>The Lincolnshire COVID Vaccination Programme continues to make excellent progress in vaccinating the population across the county. The strong Lincolnshire partnership approach within the NHS and with colleagues in Local Government, the Care Sector, and the Voluntary Sector continues to be an impressive hallmark of our programme. The continued dedication and hard work of NHS staff, volunteers, and partners is hugely appreciated.</p> <p>As the Spring Booster campaign came to a close in June 2022 activity within the two mass vaccination sites (Lincoln and Boston) began to fall, enabling the sites to focus their attention on providing an evergreen offer for patients who were eligible for a vaccination (1st dose, 2nd dose or 1st Booster dose) that they had yet to come forward for.</p>	

Vaccine uptake within Lincolnshire since the beginning of the programme has been very good, frequently exceeding regional and national averages across the cohorts and doses, however there are certain areas of the county that are outliers in this field and have considerably lower vaccine uptake rates.

## **II. Covid-19 Vaccination Health Inclusion strategy for areas of low uptake**

The COVID vaccination programme has made fantastic progress, however we are not complacent. We know there is variation in the level of uptake across different geographies and communities and we are working hard to ensure that everyone who is eligible is protected.

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), community engagement, multi-sector partnership working, localised multi-language comms and pop-up vaccination sites.

Our Covid19 vaccination work to date has included tailored approaches to support uptake of specific health inclusion groups for example Homeless, Travellers Community and population groups where analysis shows uptake is lower than average (ethnicity/deprivation)

We have 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 Baltic and Balkan descended communities) and uses our learning to date as well as data dashboards to monitor progress and tailor responses to increase uptake. During the summer 2022 – to support planning for autumn (seasonal booster) and ongoing development of our approach in addressing vaccine uptake inequalities within Lincolnshire – a more detailed deep dive into uptake rates was undertaken to understand the data at an LSOA (Lower Super Output Area) level, providing understanding of uptake rates throughout the phases of the programme at a PCN (Primary Care Network) level and through local conversations with PCNs to understand patient behaviour.

The areas identified for lowest uptake in Lincolnshire fell into one of two categories:

- either it was an area of the county that had high deprivation or
- it was an area where a large proportion of the population didn't identify English as their first language.

To address the low uptake in these areas, two key strategies were identified as described below:

### **Providing access at a more local level:**

- Commissioning the use of a vaccination bus (previously used as a Covid Testing bus) and two other mobile units allowed us to be flexible with where we offered vaccination clinics and take vaccines out to locations where people could be vaccinated without having to travel far or go out of their way. Popular locations included supermarket car parks and town centres.
- Pop-up vaccination clinics were put on in community locations such as church halls and community centres
- Walk in sessions at mass vaccination sites. As well as offering vaccinations out in the community we also continued to offer vaccinations at our established sites that

the population were familiar with. We offered walk in sessions so that the public could arrive at a time that suited them and were not restricted to an appointment time.

### **Encouraging Uptake through local engagement**

Acknowledging that improving access alone would not be enough encourage vaccine uptake, we would need engagement plan at a local level – examples shared below on the approach taken:

- Over the summer we attended a range of local of events engaging with patients and discussing concerns that they might have had about having a vaccination. Being able to have clinical staff at these events was a big part of their success as many of the people that we spoke to relayed that they had felt more comfortable and reassured speaking to clinicians rather than operational colleagues.
- Through our work with PAB languages and Boston Borough Council we came to understand that many of the translated materials that were readily available did not provide the level of information that patients were looking for and sometimes did not actually translate correctly. It is also through our work with PAB and with PCN's that we now have a much better understanding of what translated materials are required in different areas of the county, this means that any future engagement events that are held we are properly equipped with materials translated in the appropriate languages and are not alienating any groups of patients.

### **III. Examples of good practice/ interventions - shared learning**

- Establishment of Inclusion and Health Equality Team - providing a co-ordination function working with the Health Inequality, Equality & Diversity, Public health and Communication & Engagement Leads, together with the PCNs, Neighbourhood Team and District Leads connecting with existing networks across the Lincolnshire system to connect with those who hold trusted relationships with their communities.
- Being clear who you are targeting and where they work, live and play - using data, evidence and intelligence from health, public health, and community resources.
- Partnering with social and multi-agency linked support workers to engage with target groups and including our agenda in their engagement with communities they've already built trusting relationships with. Our local city council Social and Community Engagement Officer promoted the events by speaking with local businesses and sharing posters and information about the event.
- Enhanced safety-netting offer from Neighbourhood Teams to PCN's to follow up appropriately to trends in areas of low vaccination uptake, in place and includes deployment of volunteers to make contact where this hasn't been established
- Working in partnership with community faith leaders plus community and online groups to communicate with the people they connect with via social media and other comms approaches. These leaders and groups are key to advocating and communicating vaccination health promotion.
- Ongoing progress in vaccinating our homeless/rough sleeper population, including support through roving and pop-up clinics in shelters, churches, and city centre practices.
- Vaccination Bus mobilisation in areas of high transmission rates, low up take, vaccine hesitancy, workplace outbreaks and HMO's.
- A range of reasonable adjustments continue to be offered for specific cohorts e.g. those on the LD register.

#### IV. Case Study Example

The collaborative effort of health and social care organisations both statutory and non-statutory to support vaccination of rough sleepers and those experiencing homeless across Lincolnshire has been a great example of multi-agency working.

Building on existing trusted relationships and networks including the HHH team (Holistic health for Homeless,) District Council, YMCA, Nomad, Rough Sleeper Team, Intervention Team, Primary Care networks and Faith network, the vaccination work has taken a proactive and agile approach with “pop-up” clinics and wider health and social care support being offered. Led by Neighbourhood lead - Beckie McConville [rebecca.mcconville@nhs.net](mailto:rebecca.mcconville@nhs.net)

#### V. Outcome

Inclusion Health uptake:

During the period 1st June 2022 to 21st August 2022 the Lincolnshire system administered 563 first dose, 2,038 second dose and 4,241 first Booster dose vaccinations to patients aged 16+, these are all vaccinations that patients had been eligible for several months (some more than a year) and was only possible due to the dedicated outreach and health inequality work undertaken by the teams.

Lincolnshire Uptake to date

First Dose	2nd Dose	Booster	Spring Booster
596,928	565,786	467,068	84,396*

\*Only available to those aged 75+ (Lincs uptake 83%)

#### VI. Next Steps

During the Autumn phase of the Covid 19 vaccination programme we expect to vaccinate between 325,000 and 375,000 patients, below are some of our plans to ensure that we take the learning from the summer to ensure that the most vulnerable patients in Lincolnshire have access to a Covid 19 vaccine.

- COVID vaccination CO-ADMINISTERED with a flu vaccination – to provide maximum protection to patients who are eligible for both a covid 19 seasonal booster vaccine and the flu vaccine we are encouraging sites to offer both vaccines in a single session, we anticipate that this will increase uptake for both flu and covid vaccines.
- Work in partnership with health protection colleagues to design a package of materials that can be given to patients attending vaccination sites. We see vaccination sites as an ideal place to give patients information that relates to a range of medical issues and can signpost them to the appropriate service, where this information is likely to be changing over a period of time (e.g time of flu clinics or where patients can go to have their blood pressure taken) we will look to build on the success of the Lincolnshire ICB grab a jab page and create a similar area on the website for other services.

- Continued outreach – the vaccination programme team have retained the use of two mobile vaccination units for use in the Autumn programme, although operating this model over the winter months will provide different challenges than it did during the summer when the vaccination team attended many different locations with the vaccination bus, we believe that these mobile units will be key to us accessing locations where uptake is low.

**4. Management of Conflicts of Interest**

None to be noted

**5. Risk and Assurance**

Include details of risk and assurance implications (such as in the item on the ICB Risk Register)

**6. Financial/Resource Implications**

As noted in the report

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

None to be noted

**8. Health Inequalities implications**

As noted in the report

**9. Equality and Diversity implications**

As noted in the report

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

**11. Report previously presented at**

Proposals within the paper discussed at the Executive Planning COVID vaccine group

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

Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration [Sandra.williamson6@nhs.net](mailto:Sandra.williamson6@nhs.net)  
 Author: Steve Clapton (Locality Lead – Vaccination Programme). [steven.clapton@nhs.net](mailto:steven.clapton@nhs.net)

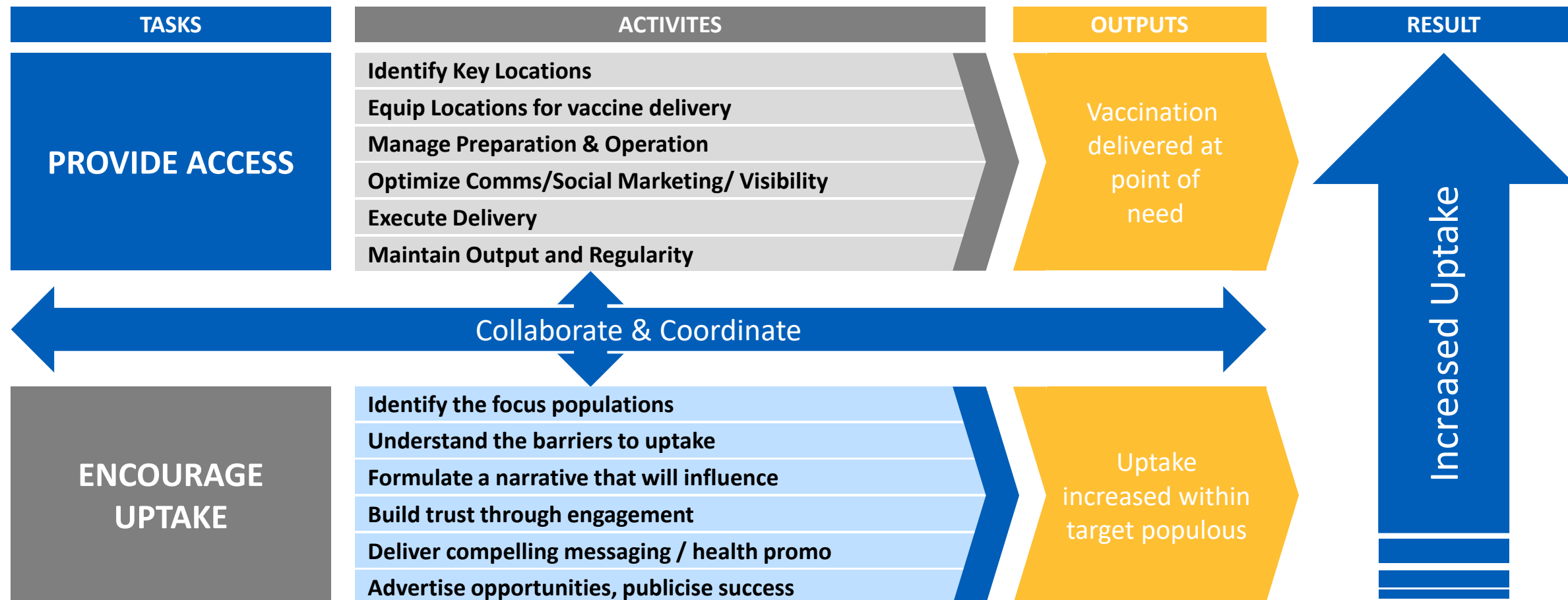
# Vaccination Health Inclusion strategy for areas of low uptake



Lincolnshire  
Integrated Care Board



# Strategy



# Objectives & Tasks

## Provide Access

Outreach and Pop-Up Sessions

Vaccination Bus

Focussed session at MVC



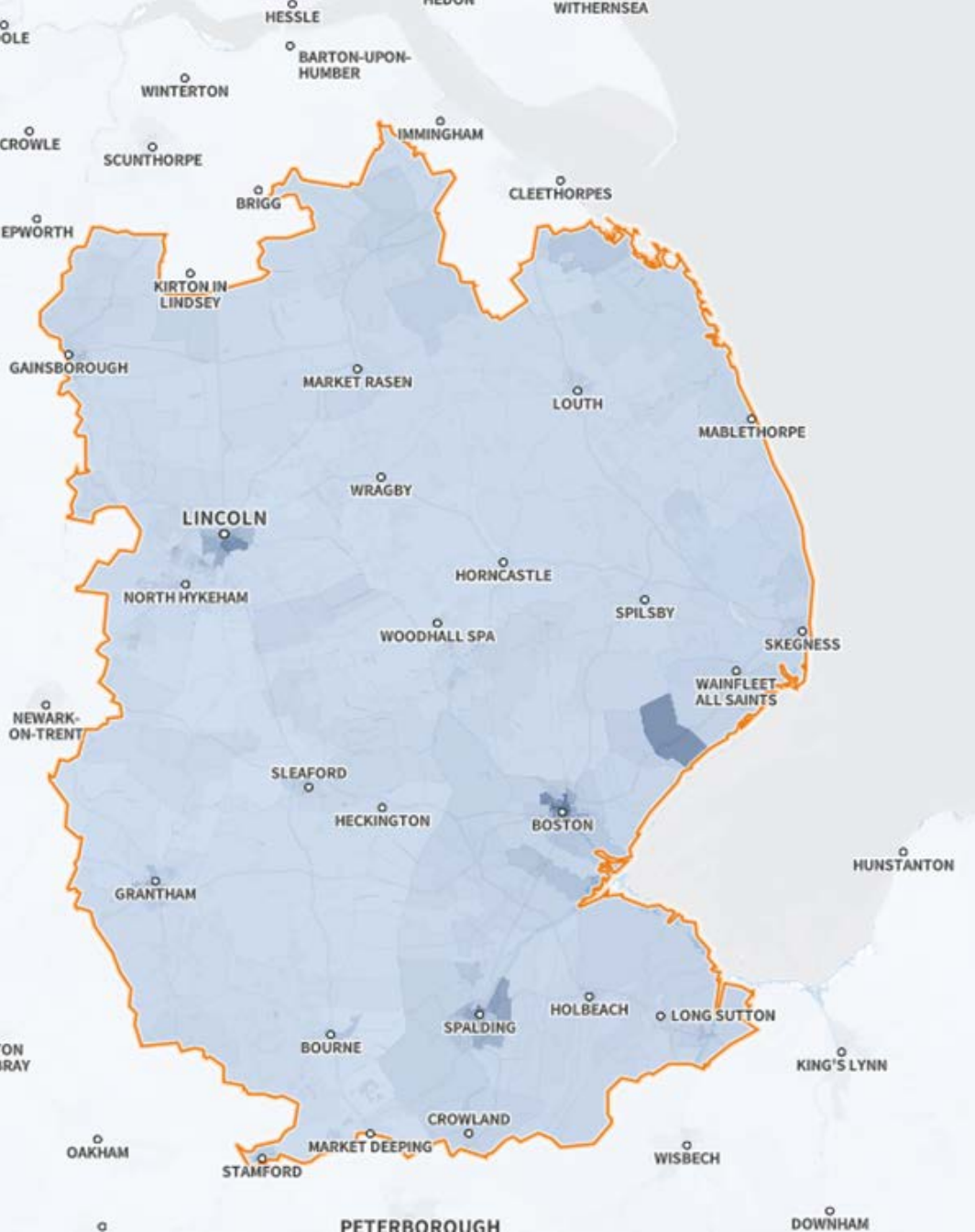
## Encourage Uptake

Engagement Events

Integrated Health Services

Tailored Communications Plan



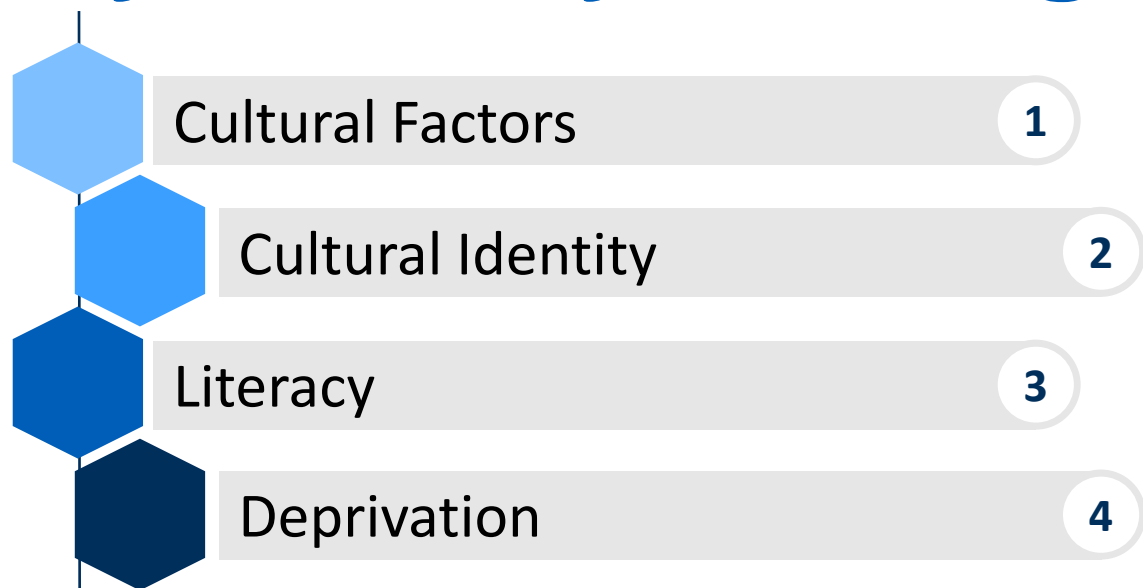


# Data

Darkest areas represent lowest uptake for:

- Covid-19 not vaccinated ages 16+ count
- Source: GP registration data linked to NIMS, last updated 17.03.22

# Key Primary Findings



## Key Challenges for increasing vaccination and wider primary care uptake

- Meaningful and effective communication and engagement
- Overcoming social & ethnicity barriers

# Success Criteria



## Provide Access

1

Number, location and frequency of community vaccination access points is established

2

Lowest uptake/highest deprivation locations are prioritised

3

Access points are optimally communicated via multimedia and community partnerships. Access points are highly visible on vaccination days – signage & promos

4

Communication with the live list of community partners is maintained and developed, noting those closest to the communities in focus

5

A closing of the gap between uptake in the focus locations and the wider county is evident per quarter of continuous activity

# Success Criteria



## Encourage Uptake

1

A multilingual social marketing/communication and engagement strategy for vaccine health promotion is in place. High visibility on vaccination days – signage & promos

2

Vaccine health promotion, as per the strategy, is embedded within and co-promoted with the "Every Contact Counts" approach throughout the workforce with direct public/patient contact.

3

Positive feedback from the public during or after multi-sector engagement activities

4

Consistent high levels of vaccine health promotion/engagement with the public by the multi-sector partner organisations (as per the DLUHC plan).

# Next Steps

1

Blended Approach between mass vaccination and local/convenient offer (Mobile units, Road Safety Partnership Vehicle, Drive Thru site and popular outreach venues)

2

Utilise cultural learning from summer – specific language translation in certain areas of the County, tailored Comms plans

3

Co-administration of Covid and Flu vaccines

4

Health promotion and engagement at covid vaccination sites

**BOARD COVER SHEET**

**Public Meeting of NHS Lincolnshire Integrated Care Board**

**Date: 27<sup>th</sup> September 2022**  
**Location: Bridge House, Sleaford**

<b>Agenda Number:</b>	4 (i)
<b>Title of Report:</b>	Inclusion Health Learning Programme with the King’s Fund
<b>Purpose:</b>	For Information. Andy Fox, Consultant in Public Health
<b>Appendices:</b>	

<b>1. Key Points for Discussion:</b>
<p>The Lincolnshire Integrated Care System has been chosen by The King’s Fund as one of 7 systems nationally to participate in a series of learning events (Action Learning Sets) focused on ‘Inclusion Health’ Groups.</p> <p>These populations include those who are homeless, Roma, Gypsies and Travellers, sex workers and vulnerable migrants. These groups typically experience the worst health outcomes, and an Inclusion Health approach should support a robust Health Inequalities approach by ensuring that inequalities for these groups are not unintentionally exacerbated.</p> <p>Representatives from the ICS will attend these Action Learning Sets as part of a programme of shared peer learning designed to explore two themes:</p> <ul style="list-style-type: none"> <li>• <i>how to develop consistently good services across the whole inclusion health cohort?</i></li> <li>• <i>how to scale up from examples of good practice in a given neighbourhood to achieve system wide success?</i></li> </ul> <p>The King’s Fund will issue a final report privately to participants; reflecting the intentions of participants, identified enablers and inhibitors to success, and lessons from the programme which might have wider application. This will be framed in such a way as to be of use in developing local documents &amp; strategies.</p> <p>There will be a programme of 6 Action Learning Sets running through the winter into Spring 2023, and each will have a specific theme.</p> <p>These Action Learning Sets will be facilitated by the King’s Fund and by leading national 3<sup>rd</sup> sector organisations Pathway and Groundswell, who both have significant experience in working with excluded populations and homeless populations respectively.</p>

Lincolnshire's system submitted an Expression of Interest to the King's Fund, outlining what we expected to be able to share, and gain, from participating in the programme. In this, it was emphasised that Lincolnshire's ambition was to seek to understand how to apply an evidence-based, effective health inclusion approach into a rural, coastal county with specific challenges regarding deprivation and a lack of a single urban centre & service hub.

In late August Lincolnshire's ICS were informed we had been chosen to participate as the only representative from the Midlands. Other systems engaged in the work are:

- Norfolk
- South Yorkshire (Doncaster)
- NE London
- Sussex
- Hampshire
- Devon

The King's Fund have indicated that developing evidence & understanding best practice for an effective inclusion health approach in a rural area will be a key element of the programme, and this is reinforced by the number of rural ICSs who are engaged with the work.

It is acknowledged that there are multiple organisations across the Lincolnshire ICS working in areas relevant to Inclusion Health, including NHS trusts, Local Authority Districts and third sector organisations, and this programme of work would be intended to support & inform existing practice, rather than replace or supercede work that is underway.

## **2. Recommendations**

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

## **3. Executive Summary**

- Lincolnshire's system has been chosen to participate in national work led by The King's Fund to develop practice regarding effective approaches to improve the health of 'health inclusion' groups. This work will run to Spring 23.
- This work will look to address how to develop consistently good services across the whole inclusion health cohort, as well as how to scale up from examples of good practice in a given neighbourhood to achieve system wide success.
- It is proposed that a working group be created to oversee the engagement with the King's Fund work and to provide oversight of implementation of any recommended & agreed actions for the system.

## **4. Management of Conflicts of Interest**

None declared

## **5. Risk and Assurance**

No risk & assurance implications identified

## **6. Financial/Resource Implications**

No financial & resource implications identified at this stage

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

The requirement to address health inequalities is a statutory duty for NHS organisations, the local authority and the Director of Public Health.

**8. Health Inequalities implications**

The nature of this work should ensure that inequalities are addressed through developing system learning & expertise on effective practice regarding Inclusion Health

**9. Equality and Diversity implications**

None identified

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

None identified at this stage

**11. Report previously presented at**

n/a

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

Sandra Williamson – [Sandra.williamson6@nhs.net](mailto:Sandra.williamson6@nhs.net)

## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date: 27<sup>th</sup> September 2022**

**Location: Bridge House, Sleaford**

<b>Agenda Number:</b>	5 (i)
<b>Title of Report:</b>	Integrated Quality & Performance Report – September 2022
<b>Purpose:</b>	To Note Tim Fowler, Associate Director of Contracting and Performance
<b>Appendices:</b>	None

<b>1.</b>	<b>Key Points for Discussion:</b>
<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 &amp; 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>	
<b>2.</b>	<b>Recommendations</b>
<p>The Board is asked to note this report and consider the actions underway.</p>	
<b>3.</b>	<b>Executive Summary</b>
<p><b>Overview</b></p> <p>The September integrated performance report incorporating constitutional standards, quality and safety measures and elective recovery activity, presents CCG and system performance updated to August where available. The focus areas continue to be urgent care pathways, cancer, elective treatment backlog, long waiters and mental health.</p> <p><b>Never Event</b></p> <ul style="list-style-type: none"> <li>There was a never event reported in relation to Lincolnshire patients in July 2022. The Never Event was reported by ULHT, relating to wrong site surgery, reported on 21 July 2022.</li> </ul>	

### **Urgent & Emergency Care**

- The number of people waiting more than 12 hours in A&E increased to 1,088, from 752 in July
- Ambulance response times decreased to 9 minutes 18 seconds for Category One incidents (7 minute standard) and 53 minutes and 7 seconds for Category Two incidents (18 minute standard)

### **Cancer**

- In August, 498 patients were waiting over 62 days, increasing from 480 in July
- The number of patients waiting 104 days or more reduced in August to 125, from 144 in July

### **Elective backlog**

- The total waiting list size for Lincolnshire patients at all hospitals has increased by 2,545 to 109,112 in July
- The number of patients waiting more than 78 weeks increased to 626 from 512 in June

### **Mental Health**

- Performance of early intervention in psychosis (EIP) waiting times is now at 19% seen within 2 weeks, improving from 6% in June but still much lower than the 60% standard

### **Primary Care**

- The Hereward CQC report was published on 18th August with an overall rating of 'Good'

#### **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](mailto:t.fowler1@nhs.net)  
telephone: 07810 770476

# Integrated Quality & Performance Report (Board)

September 2022



Lincolnshire  
Integrated Care Board



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# System Delivery Overview Update

## Urgent & Emergency Care

The services across the Urgent and Emergency care pathways in Lincolnshire continue to be under significant pressure. This is caused by a combination of demand, ongoing workforce pressures and limited flow through acute and community beds. From a demand perspective, while the overall numbers of patients accessing services remains relatively stable, the level of acuity and the time profiles of the demand are impacting on service delivery. Ambulance Handover Delays continue to occur and currently the system is not achieving the handover improvement trajectories developed. 4 and 12 hour breaches in ED remain very high with 12 hour breach level being the highest recorded in recent years.

The development of the winter plan including utilisation of the winter capacity and demand funding has commenced, with strategic oversight.

## Cancer

The backlog for cancer patients has grown for both 62 and 104 days. Levels of 2ww referrals have increased and are at 126% compared to pre COVID levels. The colorectal backlog currently accounts for 62% of the overall backlog, daily recovery meetings are underway utilising a rapid improvement methodology, working as a system to reduce the backlog and improve performance. Mutual aid and private provider support is being investigated to support. The system is currently in Tier 2 for cancer performance in England. 28 Day Faster Diagnosis performance is improving slowly but steadily across the majority of tumour sites. Patients continue to be monitored via multiple mechanisms and are clinically prioritised as previously reported at trust and system level.

# 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. United Lincolnshire Hospitals Trust (ULHT) had no patients waiting over 104 weeks by the national target of the end of June for capacity reasons. There were 24 x 104+ patients in total across a range of Providers at the end of July with Nottingham and Leicester having the highest numbers of Lincolnshire patients. ULHT has supported University Hospitals, Leicester (UHL) with mutual aid for long waiting patients in Leicestershire across two specialties.

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.

Outpatient recovery is the biggest area of challenge and is where the majority of patients are currently waiting. Approximately 10% of patients are waiting for a daycase or inpatient procedure, with the remaining 90% of patients waiting for an outpatient appointment or diagnostic. There are multiple workstreams to support this recovery including increasing clinic efficiency, increasing the use of advice and guidance and the roll out of patient initiated follow ups.

# System Delivery Overview Update

## **Emergency Preparedness, Resilience & Response (EPPR)**

2 EPPR incidents have been declared since the last Board Report, firstly Operation Silver Puncture was an NHS focused incident following the data security breach affecting the Adastra IT system used by DHU, our 111 provider. This caused some short-term operational issues as a result of losing IT ability and the need to evoke Business Continuity plans, from an operational perspective these issues are now resolved. Secondly, Operation London Bridge was enacted upon the late Queens death, this was a multiagency incident led locally by the Local Resilience Forum (LRF) and the ICB attended both SCGs and TCGs to represent NHS partners across Lincolnshire.

Due to the late Queens death the weeklong Flood Exercise was cancelled and has been rearranged during November 2022.

## **Learning Disabilities**

Delivery from April to July is 551 Health Checks, 148 ahead of 21/22 but 12 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 September integrated performance report incorporating constitutional standards, quality and safety measures and elective recovery activity, presents CCG and system performance updated to August where available. The focus areas continue to be urgent care pathways, cancer, elective treatment backlog, long waiters and mental health.



### Never Event

- There was a never event reported in relation to Lincolnshire patients in July 2022. The Never Event was reported by ULHT, relating to wrong site surgery, reported on 21 July 2022.



### Urgent & Emergency Care

- The number of people waiting more than 12 hours in A&E increased to 1,088, from 752 in July
- Ambulance response times decreased to 9 minutes 18 seconds for Category One incidents (7 minute standard) and 53 minutes and 7 seconds for Category Two incidents (18 minute standard)



### Cancer

- In August, 498 patients were waiting over 62 days, increasing from 480 in July
- The number of patients waiting 104 days or more reduced in August to 125, from 144 in July



### Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals has increased by 2,545 to 109,112 in July
- The number of patients waiting more than 78 weeks increased to 626 from 512 in June



### Mental Health

- Performance of early intervention in psychosis (EIP) waiting times is now at 19% seen within 2 weeks, improving from 6% in June but still much lower than the 60% standard



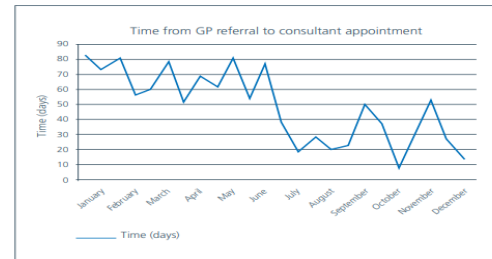
### Primary Care

- The Hereward CQC report was published on 18<sup>th</sup> August with an overall rating of 'Good'

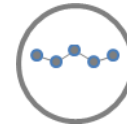
# Run Charts Key

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.

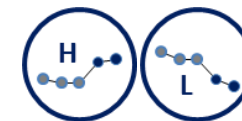
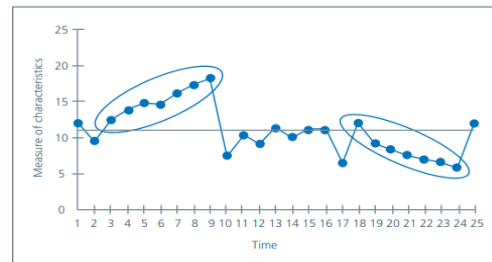
Extreme Values



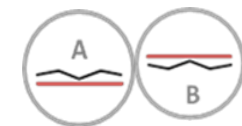
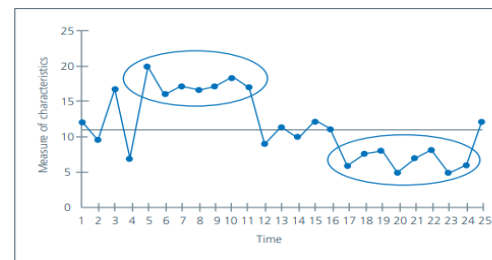
Normal Variation



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%	Aug-22	71.8%	65.2%	71.4%		↓		-
% Suspected Cancer Referrals First Seen Within 14 Days	93%	Jul-22	60.4%	77.7%	77.8%		↑		-
Patients receiving treatment for cancer within 62 days of an urgent GP referral	85%	Jul-22	49.0%	52.2%	61.6%		↓		-
RTT: % of incomplete pathways within 18 weeks	92%	Jul-22	53.9%	57.4%	61.0%		↓		-
Percentage waiting six weeks or less for a diagnostic test	99%	Jul-22	58.0%	62.7%	72.1%		→		-

## Urgent Care










Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
A&E attendances- patients waiting over 12 hours (ICB)	0	Aug-22	1088	N/A	N/A		↑		Page 16
A&E attendances- time to first clinical assessment within 60 minutes (ULHT)	-	Aug-22	47.1%	36.5%	37.7%		↑		-
Ambulance response times - Mean response time- Category 1 (ICB patients)	00:07:00	Aug-22	00:09:18	00:08:44	00:09:08		↓		-
Ambulance response times - Mean response time- Category 2 (ICB patients)	00:18:00	Aug-22	00:53:07	00:43:17	00:42:44		↓		Page 16
Ambulance handover times - number of handover delays of > 2 hours (Lincoln)	-	Aug-22	271	N/A	N/A		↓		Page 17
Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)	-	Aug-22	246	N/A	N/A		↑		Page 17

# Performance Overview

## Cancer

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
Total 62 Day Backlog (ULHT)	-	Aug-22	498	N/A	N/A		↑		Page 19
Total 104 Day Backlog (ULHT)	-	Aug-22	125	N/A	N/A		↓		Page 19
Faster diagnosis standard- % of patients told cancer diagnosis outcome within 28 days (ICB)	75.0%	Jul-22	63.3%	68.7%	71.1%		↑		-

## 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%	Jul-22	8.3%	7.8%	5.5%		↑		-
Patients waiting over 104 weeks for treatment (% of total ICB waiting list size)	0%	Jul-22	0.02%	0.06%	0.04%		→		Page 21
Patients waiting over 78 weeks for treatment (ICB)	0	Jul-22	626	-	-		↑		Page 21
Total waiting list size (ICB)	-	Jul-22	109,112	N/A	N/A		↑		Page 22
Total elective spells (ICB)	11,187	Jul-22	9,361	N/A	N/A	-	-		Page 22

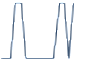







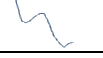

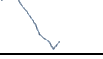



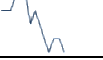



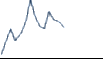











# Performance Overview

## 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%	Jun-22	1.84%	N/A	1.62%		↓		-
IAPT recovery rate - people who complete treatment who are moving to recovery (ICB)	50%	Jun-22	51.8%	N/A	0.0%		↑		-
Inappropriate Out of Area Placements(OAPs) in mental health services for adults in non-specialist acute inpatient care per 100,000	0	Jun-22	25.7	123.0	108.0		↓		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%	Jul-22	19%	N/A	N/A		↑		Page 25
Estimated diagnosis rate for people with dementia (ICB)	66.7%	Aug-22	61.6%	61.2%	62.1%		↑		-
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%		↓		-
Children & Young People (CYP) with MH disorder receiving treatment (one contact) in the reporting period last 12 months	6400	May-22	7240	N/A	N/A		↑		Page 27
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%	22/23 Q1	48.7%	N/A	N/A		↑		Page 27
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%	22/23 Q1	80.0%	N/A	N/A		↓		-













# Performance Overview

## Quality

Indicator	Standard	Period	Performance	Midlands	England		Trend		Further Detail
Never events (ULHT)	0	Jul-22	1	N/A	N/A		↑		Page 28
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	Apr-22	1.0577	1.0397	1.0013		↓		-
Hospital Standardised Mortality Ratio (HSMR) (ULHT)	100.00	Jul-22	94.95	N/A	N/A		↑		-
Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	1.000	Apr-22	1.0358	1.0397	1.0013		↑		Page 30
Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	1.000	Apr-22	1.1042	1.0397	1.0013		↓		Page 30
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%	Q1 22/23	26.4%	23.6%	33.2%		↑		-
Number of patients of people with a learning disability receiving inpatient care (ICB)	13	Sep-22	18	-	-		↑		Page 31
Rate per 1000 of people with a learning disability receiving inpatient care (ICB)	0	Aug-22	51	44	41		↑		-
Cumulative Learning Disability Healthchecks (ICB)	563	Jul-22	551	N/A	N/A		↑		Page 31
Care Home Quality	-	-	-	-	-	-	-	-	Page 33
Serious Incidents Reported (Lincolnshire patients)	-	Jul-22	39	N/A	N/A		↓		Page 34
Ockenden Response	-	-	-	-	-	-	-	-	Page 35

# Performance Overview

## Primary Care

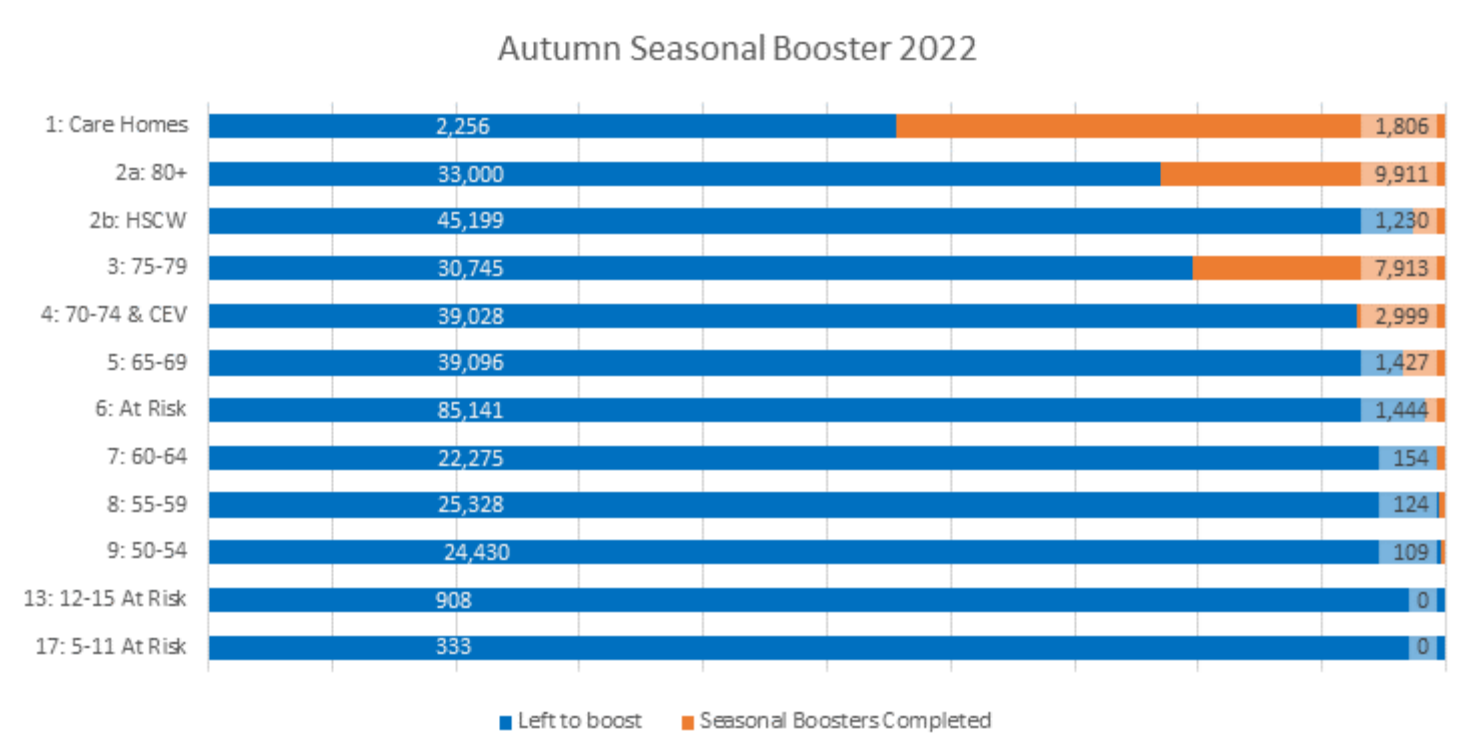
Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
Primary Care CQC- number of practices rated as 'Inadequate' by CQC	0	Aug-22	0	N/A	N/A	N/A	N/A	N/A	Page 37
Primary Care CQC- number of practices rated as 'Requires Improvement' by CQC	-	Aug-22	4	N/A	N/A	N/A	N/A	N/A	Page 37
GP Appointments- percentage seen by a GP	-	Jul-22	34.3%	34.7%	37.4%		↓		Page 38
GP Appointments Mode- percentage seen face to face	-	Jul-22	69.1%	58.0%	63.4%		↑		Page 38
GP Appointments- time from booking to appointment same day	-	Jul-22	47.8%	50.0%	47.2%		↓		Page 39
GP Appointments- time from booking to appointment 1-6 days	-	Jul-22	23.7%	25.8%	24.7%		↓		Page 39
The number of extended access appointments booked excluding did not attends (ICB)	5723	Jul-22	5625	N/A	N/A		↑		Page 40
The percentage of available GP extended access appointments utilised (ICB)	80%	Jul-22	73.9%	N/A	N/A		↓		Page 40

# Covid-19 Vaccinations

## Update

- The Autumn booster programme went live 5<sup>th</sup> September 2022 with Care Home visits
- Eligible patients able to book appointments at vaccination centres from w/c 12<sup>th</sup> September 2022
- This will be delivered in partnership by PCNs, the Mass vaccination centres, the Hospital Hub and Community pharmacies, as has been the case in previous phases of the vaccination programme.
- The following groups are eligible for an Autumn booster covid vaccination
  - aged 50 or over
  - pregnant
  - aged 5 to 49 years and at high risk due to a health condition
  - aged 5 to 49 years and at high risk due because of clinical vulnerabilities
  - aged 5 to 49 years and live with someone who has clinical vulnerabilities
  - aged 16 to 49 years and are a carer
  - living or working in a care home for older people
  - frontline health and social care workers

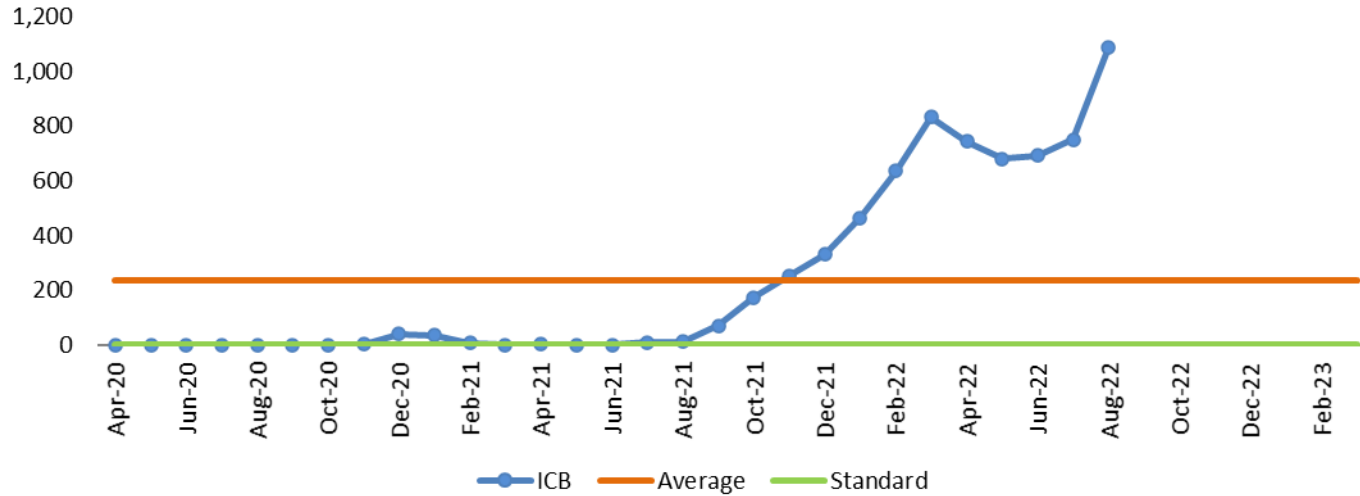
# Covid-19 Vaccinations



# Urgent Care

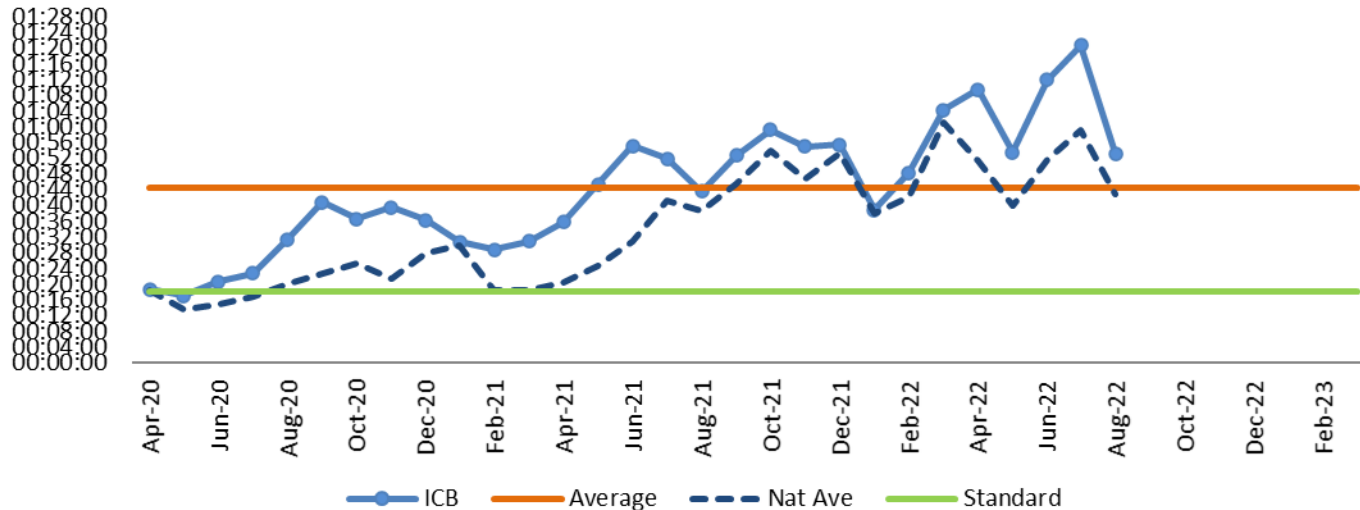
Cause	Actions To Recover
<p>The Lincolnshire system has remained under significant levels of pressure throughout July and into August with prolonged periods of System Level OPEL 4 declarations.</p> <p>The main challenges faced by the system have been around system wide workforce, capacity for supported discharge and flow through all bedded services. This has continued to impact on the level of performance against national indicators and on the ability to release crews who have attended acute sites resulting in further increasing ambulance handover delays.</p> <p>Type 1 activity has continued on an increasing trajectory, with 4 hour and 12 hour breaches continuing to be very high with both trending upwards over the last 3 months.</p> <p>Bed occupancy has remained high, but has been stable over the last here months. However while the number of patients in beds over 21 days also remains high, it has again reduced and is on a downward trajectory.</p> <p>Due to limitations around flow in acute settings, the average clinical handover time for ambulance crews remains high. At the Lincoln County site there were further increases in the number of crews waiting over 60 mins and over 2 hours in July, with a small reduction being seen in August. The number of delays at this site in July were the highest they have been in the last 2 years and still remain higher than any other period.</p> <p>The number of UTC attendances reduced slightly in July after two months of high attendances but overall Type 3 activity remains relatively consistent. 4 hour UTC performance for July was 94.1%</p> <p>CAS activity remains high, as does the average call back time. Available activity was pre Adastra cyber- attack. Due to the recent reporting issues within DHU the 111 activity is not available post June.</p> <p>Urgent Mental Health - overall referrals into crisis teams has increased slightly, but emergency referrals continue to reduce. The number of PCR and CVR referrals remain low in number. There continue to be gaps in provision of CVR and PCR but with mitigations in place; this could account for the low numbers. However, utilisation of the Mental Health Urgent Assessment Centre continues to increase and support patients in a more appropriate setting that ED.</p> <p>Within primary care the June data suggests a further increase in the percentage of patients seen face to face, and utilisation of extended access appointments remaining stable at between 70% and 80%.</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 now includes:</p> <p>Delivery of the 100 day discharge plan (impact expected 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>Delivery of the system Capacity and Demand plans, and development and agreement of the System Winter plan.</p> <p>Maximising use of alternative pathways of care</p> <p>Strategic oversight of the current pressures and development winter mitigations</p>

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



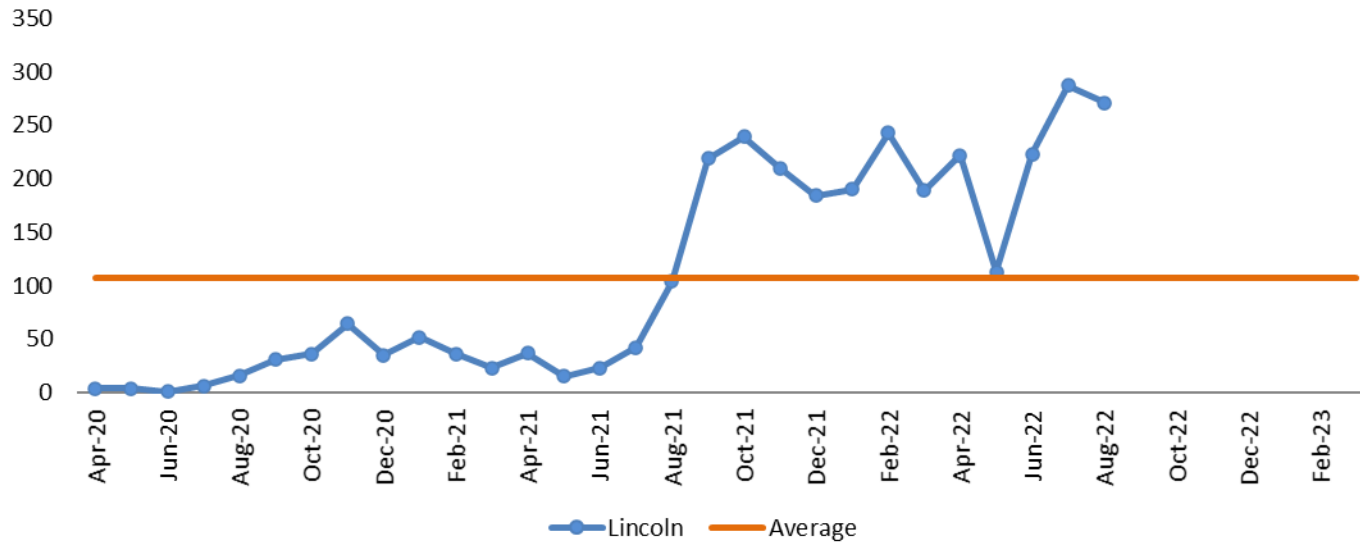
Indicator
A&E attendances- patients waiting over 12 hours (ICB)
Standard
0
Period
Aug-22
ICB
1088
England
N/A
Trend

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



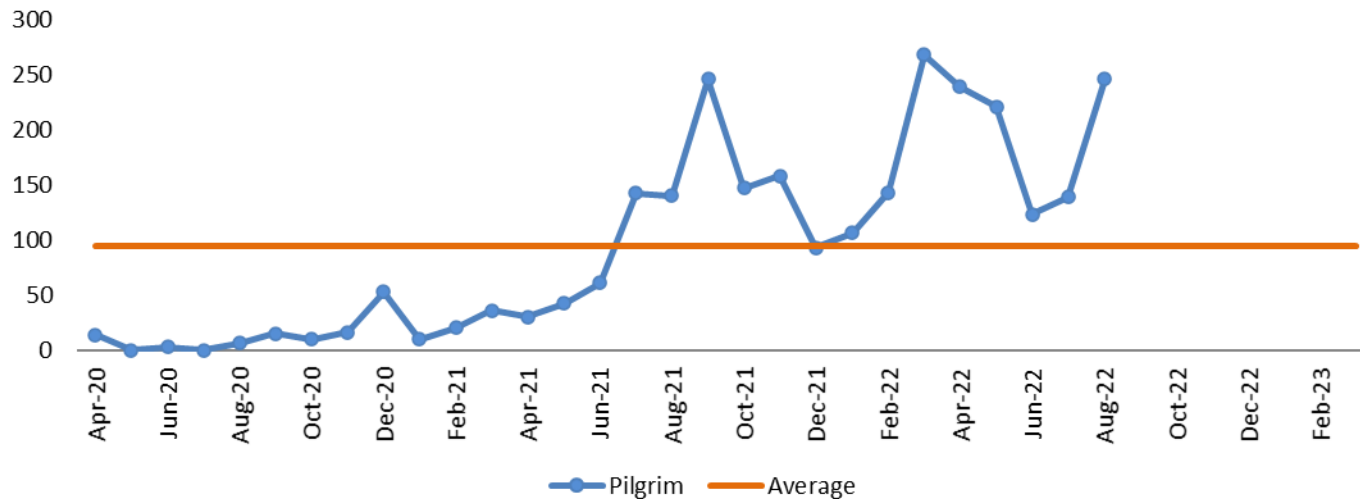
Indicator
Ambulance response times - Mean response time- Category 2 (ICB patients)
Standard
00:18:00
Period
Aug-22
ICB
00:53:07
England
00:42:44
Trend

### 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
Aug-22
Lincoln
271
England
N/A
Trend

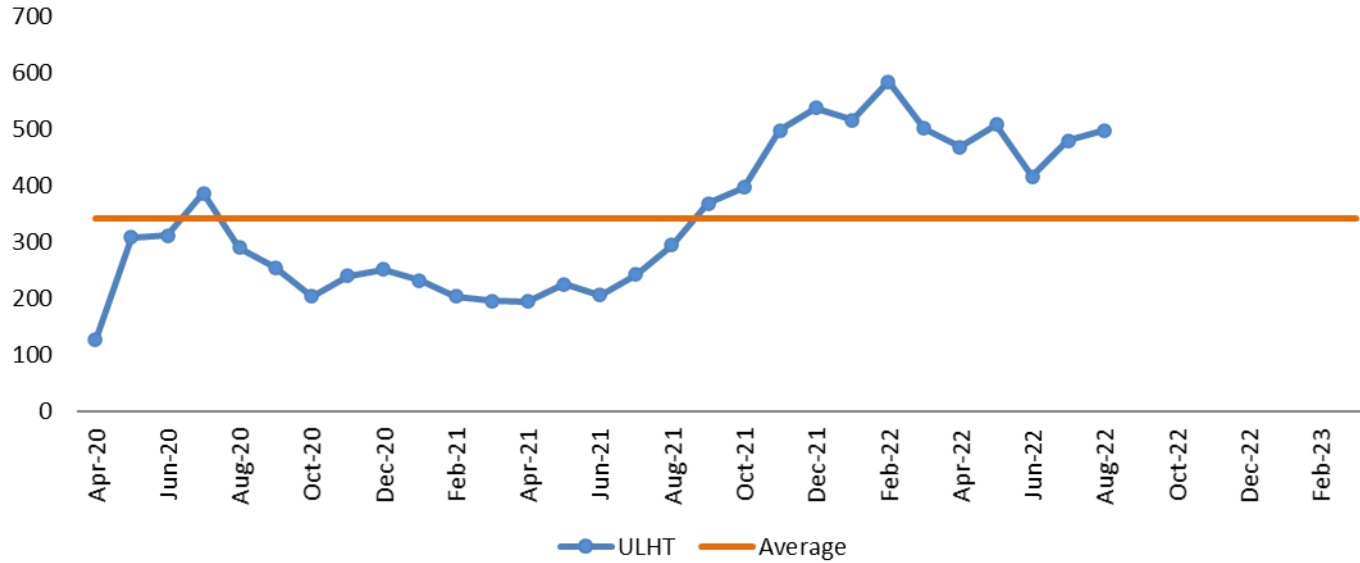
### Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)



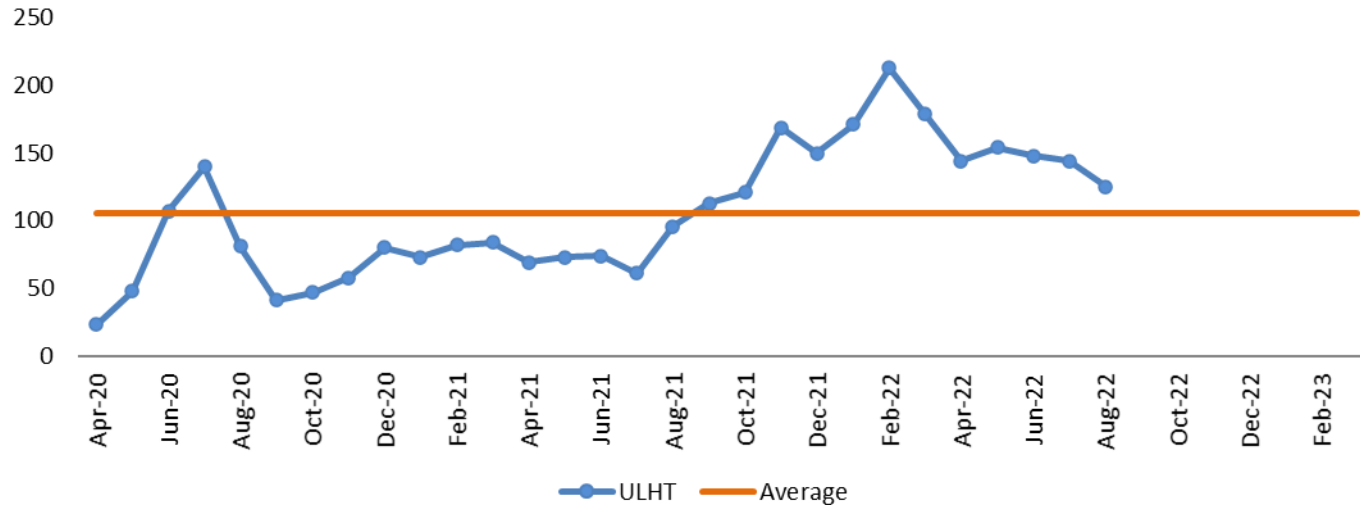
Indicator
Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)
Standard
-
Period
Aug-22
Pilgrim
246
England
N/A
Trend

Cause	Actions To Recover
<ul style="list-style-type: none"> <li>• The backlog position is again increasing and is off trajectory at 531 patients over 62 days. Colorectal continues to account for the largest part of the backlog - 59%, the colorectal backlog is now at 311 patients.</li> <li>• Referral rates remain higher than previous years, they are currently at 122% against baseline.</li> <li>• Colorectal and Lung referrals continue in high numbers as 128% and 145% respectively above baseline.</li> <li>• Significant delays continue to exist for a2ww breast referral first appointment, with wait times up to 19 days.</li> <li>• Significant reduction in availability of 1<sup>st</sup> OPAs for lung due to capacity issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Daily colorectal recovery meetings with Executive lead – Simon Evans. Focus is on reducing wait time for 1<sup>st</sup> OPA. Patients now being seen within 7 days.</li> <li>• The simulation tool for lower GI recovery is being utilised to establish how large the gap is in staffing required to stabilise the service and then future proof.</li> <li>• Steering group launched to help implement FIT across Primary Care to aid in stratifying Colorectal referrals in Secondary Care.</li> <li>• New process agreed between Radiology and Respiratory teams to discharge normal CTs at radiology to reduce workload for Respiratory consultants. Currently reviewing of CTs takes 30 hours per week. Advert out for Nodule ACP. Any additional capacity created will be utilised for Lung first OPAs.</li> <li>• Breast team are putting on extra capacity for 1<sup>st</sup> OPAs and continuing to redirect referrals onto Mastalgia Pathway where appropriate.</li> </ul>

## Total 62 Day Backlog (ULHT)



## Total 104 Day Backlog (ULHT)



### Indicator

Total 62 Day Backlog (ULHT)

### Pre-Pandemic Level

81

### Period

Aug-22

### ULHT

498

### England

N/A

### Trend



### Indicator

Total 104 Day Backlog (ULHT)

### Pre-Pandemic Level

22

### Period

Aug-22

### ULHT

125

### England

N/A

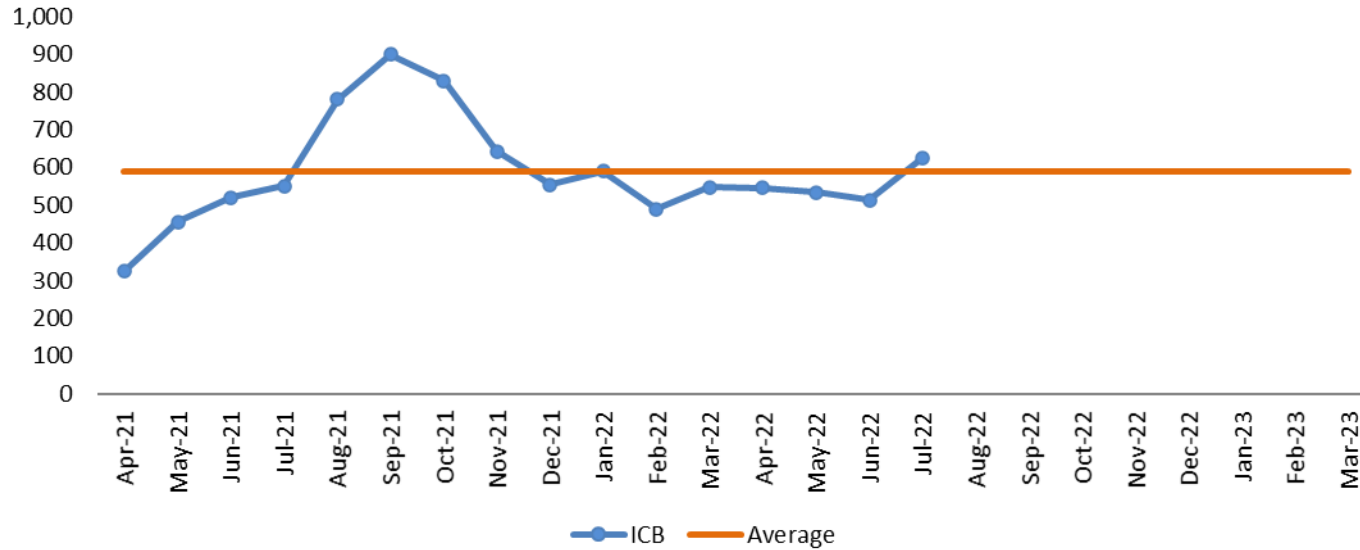
### Trend



# Planned Care & Diagnostics

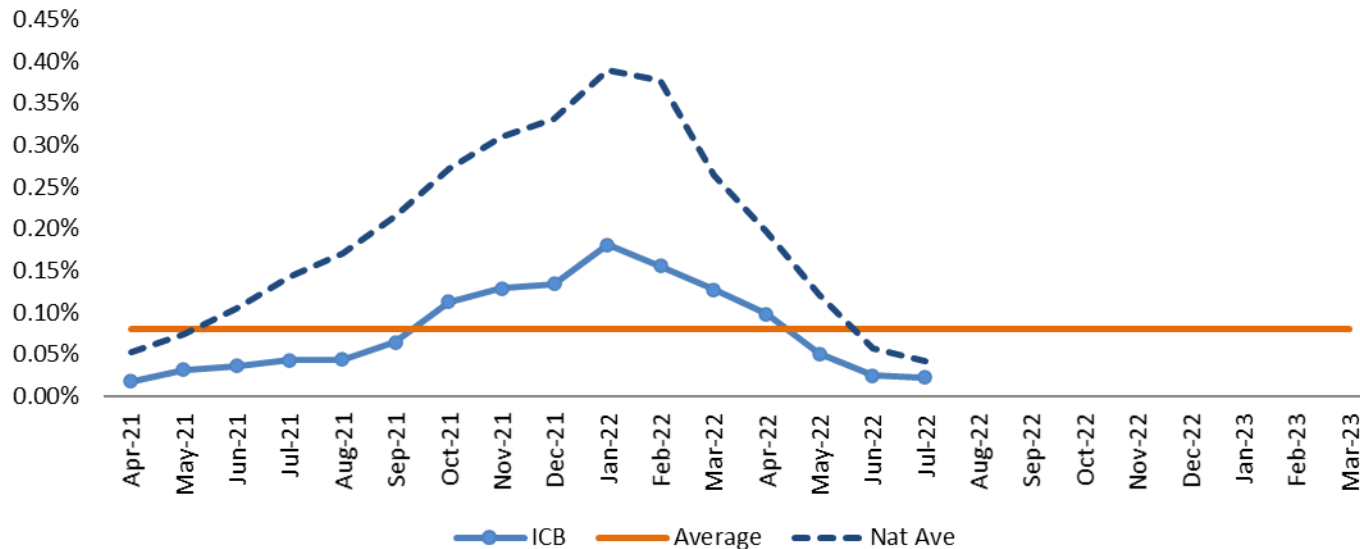
Cause	Actions To Recover
<ul style="list-style-type: none"> <li>• It is important to view and read this in the context of the current National Covid Restore Agenda and the move away from a focus on constitutional standards to the expectation of focus upon cancer and clinical urgency.</li> <li>• This 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.</li> <li>• Hospitals continue to experience patients who are reluctant to travel to alternative sites where wait times may be quicker.</li> <li>• Workforce levels continue to be a challenge for Providers</li> </ul>	<ul style="list-style-type: none"> <li>• July validated position shows 104 week waiters continuing to reduce but the end of June deadline for eliminating 104 week waits proved challenging for some Providers; Nottingham and Leicester particularly. There were 24 x 104+ patients in total across a range of Providers at the end of July. All providers are expected to have zero patients waiting over 104+ weeks by end of Sept.. ULHT continues to perform well on 104+ waits and has been supporting Leicester with their long waiters in 2 specialties.</li> <li>• Focus now is on achieving zero 78+ week waiters by the end of March 23. ULHT Outpatients Recovery &amp; Improvement Group (ORIG) and High Volume Low Complexity (HVLC) are progressing with a number of schemes to address productivity and efficiency that will support a reduction in the waiting list size. The EACH continue to support patient transfer from ULHT to Independent Sector Providers (ISPs) for a number of specialties. Work is also on-going to increase ISP capacity.</li> <li>• Outpatient recovery is the biggest area of challenge and is where the majority of patients are currently waiting. Approximately 10% of patients are waiting for a daycase or inpatient procedure, with the remaining 90% of patients waiting for an outpatient appointment or diagnostic. There are multiple workstreams to support this recovery including increasing clinic efficiency, increasing the use of advice and guidance and the roll out of patient initiated follow ups.</li> <li>• The business case for the expansion of services at Grantham Community Diagnostic Centre (CDC) has now been approved by the CDC Project Board and was submitted to the NHSE Regional Team on 26 Aug 2022.</li> <li>• The locations for a second CDC on the east coast have also been agreed by the CDC Project Board, with the hub to be located in Boston and spokes at both Skegness and Mablethorpe. A further spoke at Spalding may also be provided subject to additional funding being received. Investigations are now underway to identify suitable sites in both Boston and Skegness. A business case for the second CDC is being prepared for submission in the Autumn.</li> </ul>

## Patients waiting over 78 weeks for treatment (ICB)



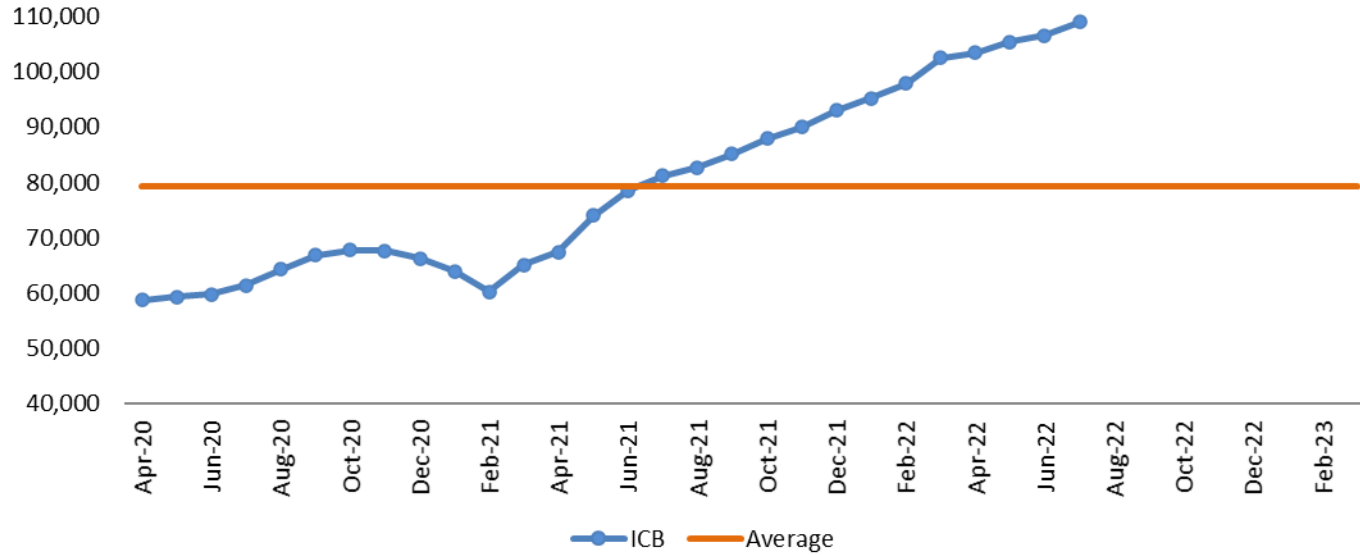
Indicator
Patients waiting over 78 (total patients)
Period
Jul-22
Standard
0
ICB
626
Trend

## Patients waiting over 104 weeks for treatment (ICB)



Indicator
Patients waiting over 104 weeks for treatment (% of total waiting list size)
Period
Jul-22
Total 104+ Breaches
24
ICB
0.02%
England
0.04%
Trend

## Total Waiting List Size (ICB)



### Indicator

Total Waiting List Size (ICB)

### Period

Jul-22

### ICB

109,112

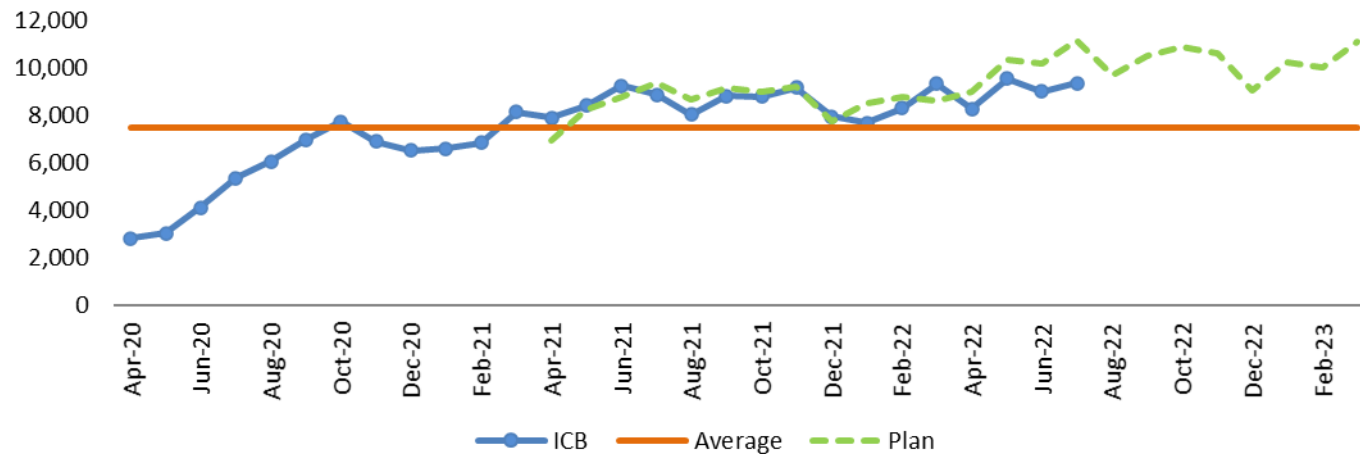
### England

N/A

### Trend



## Total Elective Spells (ICB)



### Indicator

Total elective spells

### Period

Jul-22

### Plan

11,187

### LCCG

9,361

### Trend



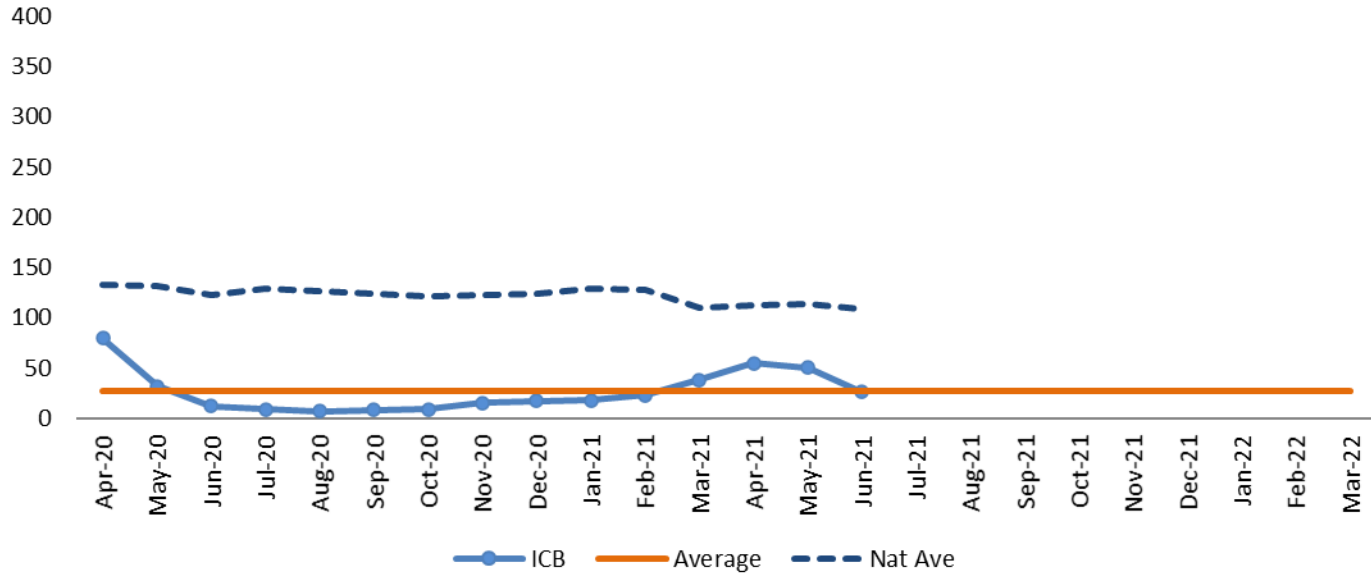
# Elective Recovery

Indicator	Period	Plan	LCCG	Trend	
First Outpatient Attendances	Jul-22	28,953	17,974		
F/up outpatient attendances	Jul-22	41,877	30,663		
Total elective spells	Jul-22	11,187	9,361		
Total referrals	Jul-22	21,190	19,986		
Diagnostics- Magnetic Resonance Imaging	Jul-22	4,544	5,064		
Diagnostics- Computed Tomography	Jul-22	10,403	10,570		
Diagnostics- Non-Obstetric Ultrasound	Jul-22	6,968	8,112		
Diagnostics- Colonoscopy	Jul-22	727	816		
Diagnostics- Flexi Sigmoidoscopy	Jul-22	391	395		
Diagnostics- Gastroscopy	Jul-22	622	798		
Diagnostics- Echocardiography	Jul-22	1,208	1,623		

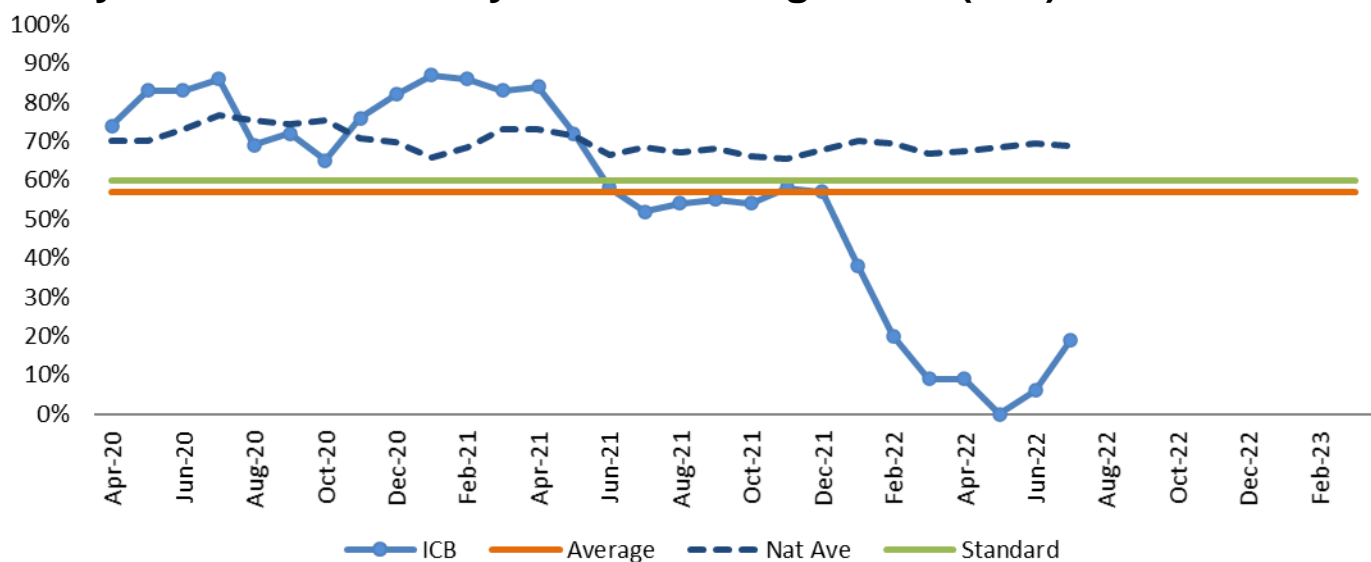
# Mental Health- Acute

Cause	Actions To Recover
<p><b>Early Intervention in Psychosis waiting times:</b></p> <ul style="list-style-type: none"><li>• The service is recovering, proactively managing as outlined in the previously submitted Integrated Performance Report. Performance has improved to 19% from 6% last month.</li><li>• The current wait for the service, although over 2 weeks, is 3 weeks</li></ul>	<p><b>Early Intervention in Psychosis waiting times:</b></p> <ul style="list-style-type: none"><li>• Bank and agency staff supporting EIP delivery.</li><li>• Benchmarking has been undertaken against the recently published NCAP Audit.</li><li>• Demand is outstripping service capacity – Service remodelling continues and a business case has been developed to expand the team.</li></ul>

## Mental Health Out of Area Placements (Lincs)



## Early Intervention in Psychosis Waiting Times (ICB)



<b>Indicator</b>
<b>Inappropriate Out of Area Placements in mental health services for adults in non-specialist acute inpatient care per 100.000 (ICB)</b>
<b>Standard</b>
<b>0</b>
<b>Period</b>
<b>Jun-22</b>
<b>Total Out of Area Bed Days</b>
<b>165</b>
<b>ICB</b>
<b>25.7</b>
<b>England</b>
<b>108.0</b>
<b>Trend</b>



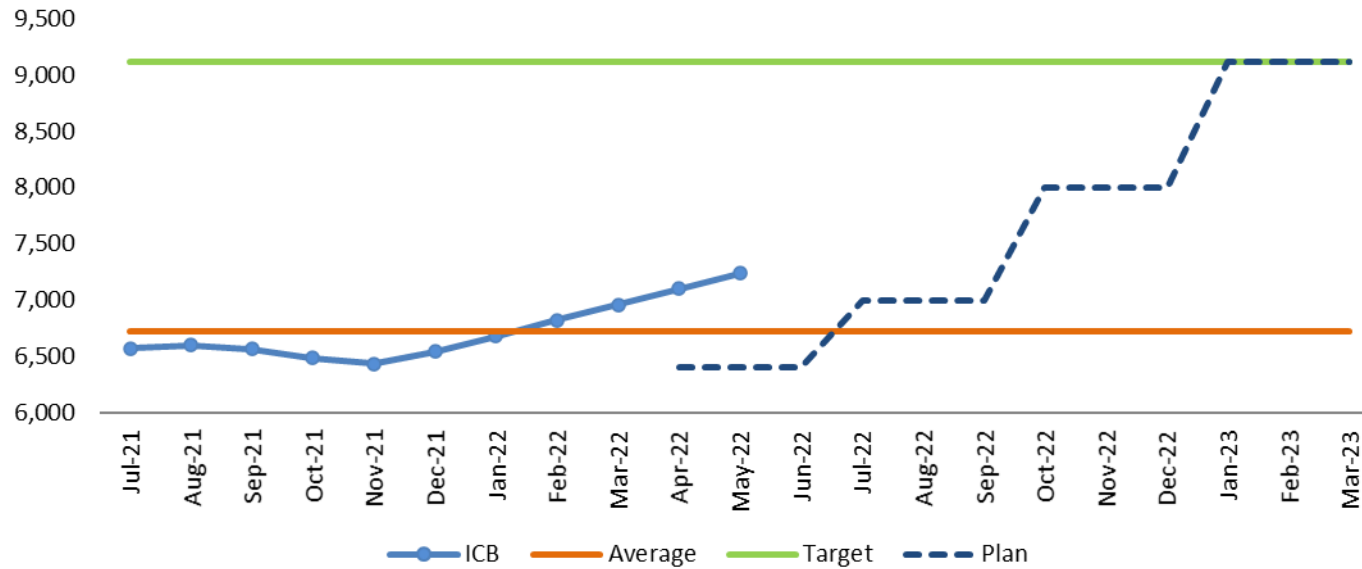
<b>Indicator</b>
<b>People experiencing first episode psychosis or ARMS that wait two weeks or less to start a NICE recommended package of</b>
<b>Standard</b>
<b>60%</b>
<b>Period</b>
<b>Jul-22</b>
<b>Seen &lt; 2 Weeks</b>
<b>15</b>
<b>Total Patients</b>
<b>85</b>
<b>ICB</b>
<b>19.0%</b>
<b>England</b>
<b>N/A</b>
<b>Trend</b>



# Mental Health (Children & Young People)

Cause	Actions To Recover
<p>Lincolnshire has well established partnership arrangements in place to support children and young people (CYP), however, there are areas of note in relation to both achievement of performance requirements and impact on quality of care.</p> <p>There have been significant increases in the overall demand for CYP mental health services, in particular eating disorders, as well as the acuity of cases first being referred to services for the first time. This is reflective of the national picture, within the context of the COVID pandemic. In addition, until 2021/22 CYP MH had received only minimum MHIS investment locally to cover inflationary increased prior to 2021/22. Impacts are exhibited in delivery against KPIs in relation to:</p> <ul style="list-style-type: none"> <li>• <b>CYP MH Access</b> – Lincolnshire forecast to be approximately 1 year behind the trajectories in the LTP, predicting to achieve the 2021/22 figure during 2022/23. A Recovery Action Plan has been completed outlining rationale and actions to address this. The access target increase does not appear to take account for the training year and staged implementation of individual Mental Health Support Teams (MHSTs).</li> <li>• <b>CYP ED</b> – number of eating disorder (ED) referred cases commencing treatment within 4 weeks (routine); and within 1 week (urgent) are below national standard of 95%.</li> </ul> <p><b>Additional Concerns</b></p> <ul style="list-style-type: none"> <li>• Tier 4 bed availability cannot always meet demand, with sometimes lengthy waits, and CYP are being placed across the country out of region.</li> <li>• There is currently a gap in the Autism diagnostic pathways for young people aged 16-18 years old, where they are too old for the CYP pathway but too young for adult services.</li> <li>• There is no service to undertake assessments or treatments for CYP for tics or Tourette's.</li> </ul>	<p><b>CYP MH Access</b></p> <ul style="list-style-type: none"> <li>• MHSTs will create open access to mental health support for all CYP covered by an MHST through schools/colleges, they are focused on areas of significant need/inequality, including deprivation, youth crime, high parental mental health concerns etc. Roll-out is happening in Lincolnshire in line with the national programme, with 50% coverage expected by 2025.</li> <li>• Following SDF/SR funding in 2021/22, a further £1.2m local baseline increase is included in the plan for 2022/23 to meet NHS Long Term Plan expected growth, increase in demand for CYP mental health services and to reduce wait times; the impact of this investment will be assessed over the next 12 months but is already starting to show improvement in June and July 2022 with less CYP waiting overall and less waiting over 12 weeks. In addition the one contact figure for Lincolnshire further increased to 7,100 in April 2022, 700 above the local target of 6,400.</li> <li>• The pilot of the new Here4You Access Team continues to demonstrate improved referrals, being navigated to the right service, resulting in the reduction of referrals directly into CAMHS.</li> </ul> <p><b>CYP ED</b></p> <ul style="list-style-type: none"> <li>• Additional investment is starting to demonstrate an impact in this area which has experienced significant increased demand and acuity of referral since COVID. A trajectory has been set that predicts that the target will be recovered by Q4.</li> <li>• Local indicators show that for Q1 there was only 1 urgent wait breach due to cancellation by the family. There were 5 routine wait breaches due to CYP being inpatient at the time of referral and therefore had initial liaison (1), CYP had a joint assessment with the core team as appropriate (1), CYP and family did not attend (DNA) (2) and another was one day over target timescale (1).</li> </ul> <p><b>Additional Concerns</b></p> <ul style="list-style-type: none"> <li>• Provider Collaborative have processes in place to escalate and locate beds nationally, where they are available, individual Lincolnshire cases are escalated where appropriate beds cannot be secured and collaborative system approaches are being adopted to manage these on a case by case basis. Bed availability is increasing as other areas in the nregion implement enhanced community support.</li> <li>• Proposals are being developed to extend the adult Autism pathway to include young people from age 16, and commission all-age tics/Tourette's assessment and support.</li> </ul>

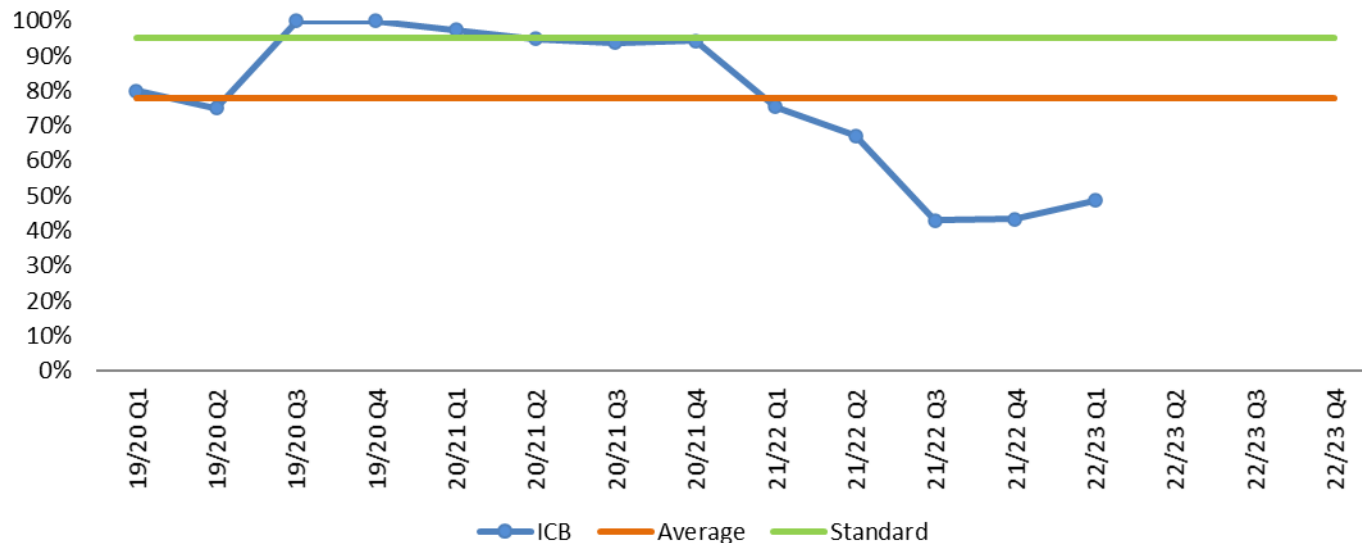
## CYP with mental health disorder-one contact (ICB)



Indicator
Children & Young People (CYP) with MH disorder receiving one contact in the reporting period last 12 months
Plan
6400
Period
May-22
CYP Receiving One Contact
7,240
ICB (variance to plan)
840
Trend



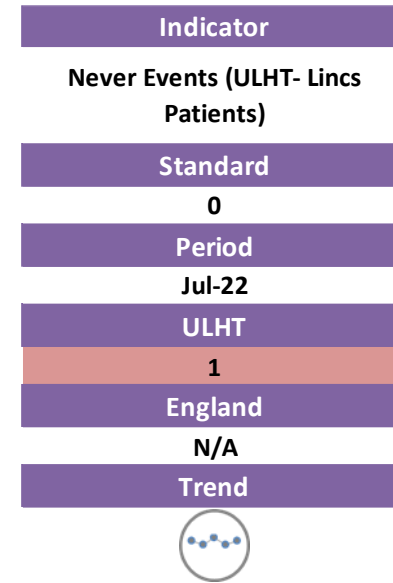
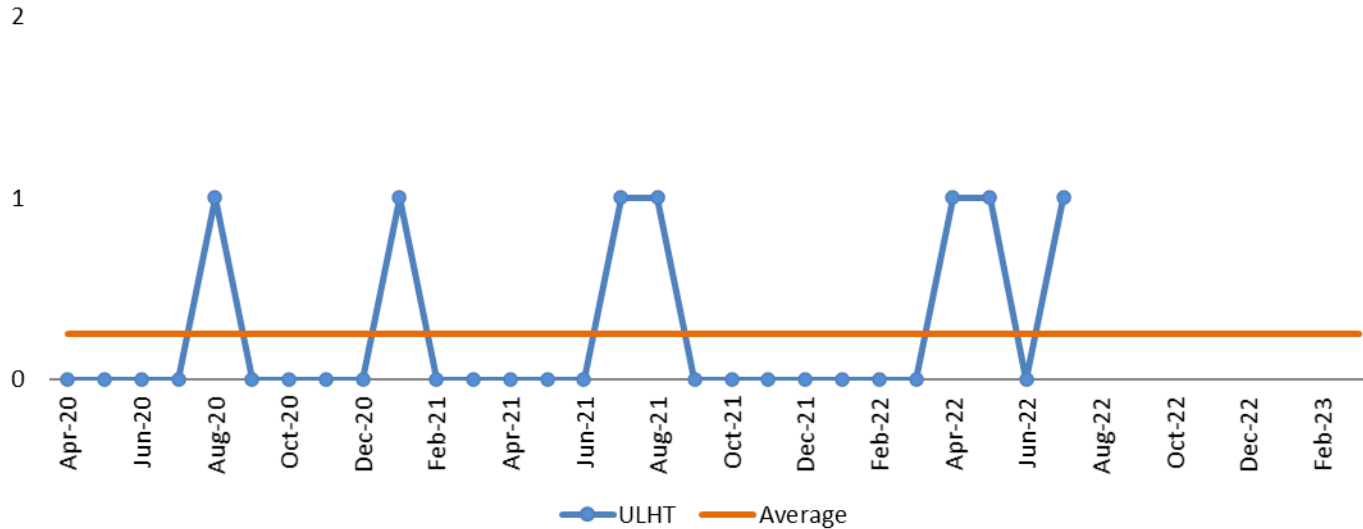
## CYP with an eating disorder (routine) starting treatment within four weeks (ICB)



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
22/23 Q1
Routine Referrals
76
Treated < 4 Weeks
37
ICB
48.7%
Trend



## Never Events (ULHT)



There has been a single never event reported in relation to Lincolnshire patients in July 2022. The Never Event was reported by ULHT, relating to wrong site surgery, reported on 21 July 2022.

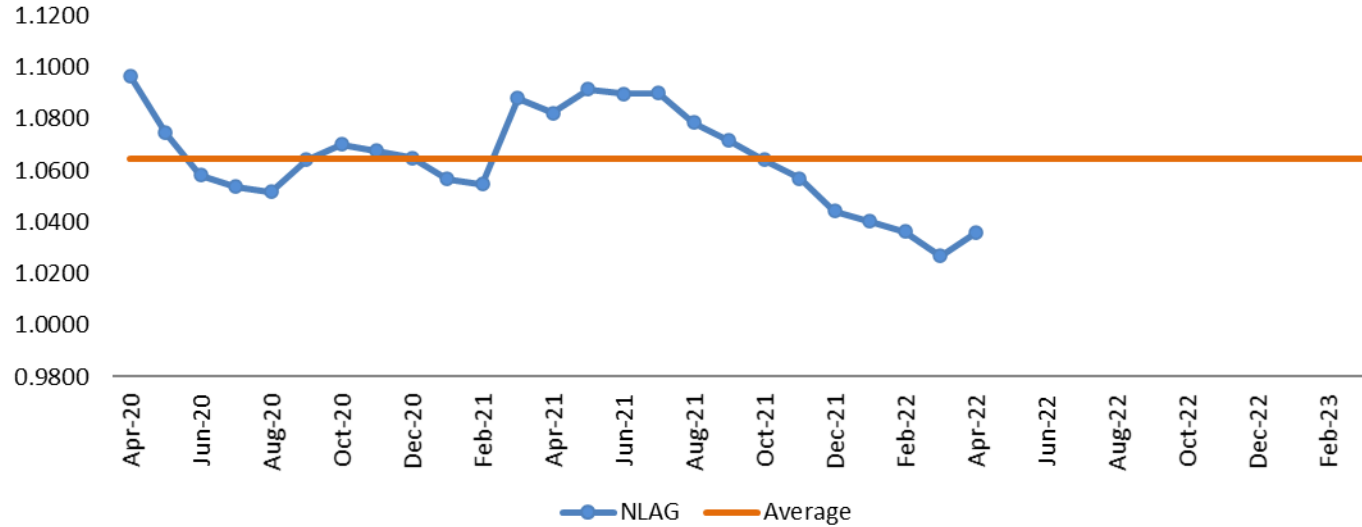
The table below indicates the never events reported between 1 April 2022 – 31 May 2022 by Trusts providing care to Lincolnshire patients. The table has been updated using information from NHS England publication illustrating Never Events Reported between 1 April 2022 – 31 May 2022 (published 14 July 2022).

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

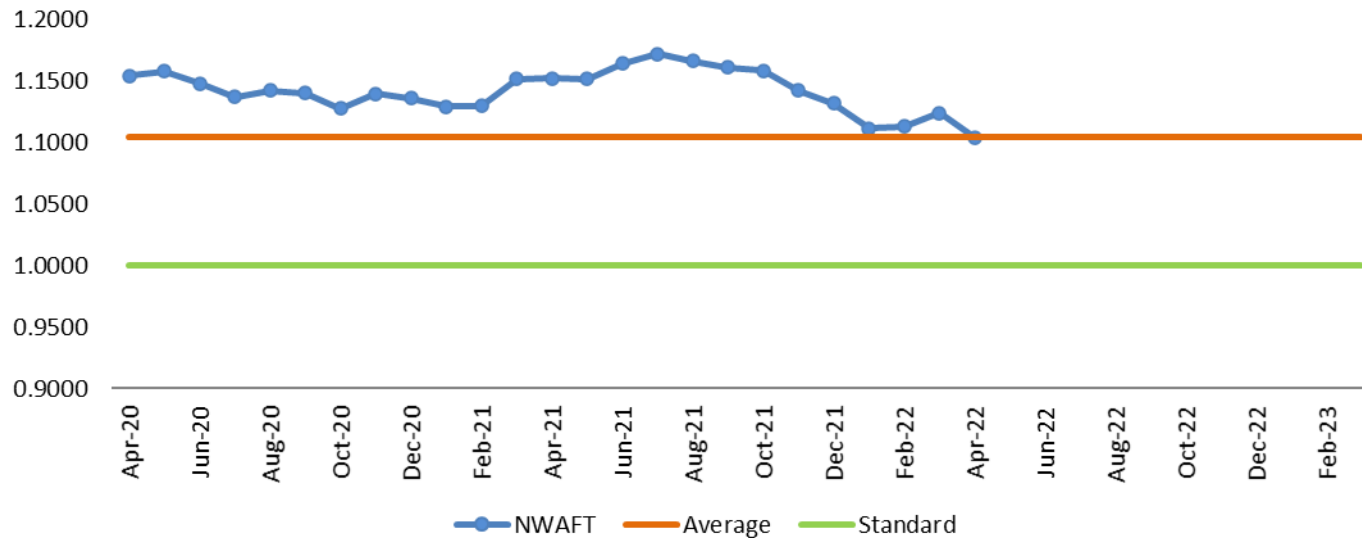
# Mortality (NWAFT)

Cause	Actions To Recover
<p>SHMI data (NHS Digital Feb 2021-Jan 2022) Aug 2022 Trust wide: 1.1239 (prev1.1113), higher than expected range PCH: 1.2052 (prev1.1860), higher than expected HH:0.9828 (prev0.9783) as expected</p> <p>HMSR (Aug 2022) Trust: 101.5, as expected PCH: 111.0 (prev111.7), statistically significant HH: 88.1 (prev87.6), below expected</p> <p>Assurance is required regarding NWAFT's clinical coding. NWAFT's zero comorbidity rate has increased from 42.99% to 45% in one year The current national average is 44.9%</p>	<ul style="list-style-type: none"> <li>• NWAFT have agreed to procure a 3rd party to undertake scrutiny on their Mortality workstream. Awaiting update.</li> <li>• 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.</li> <li>• 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.</li> <li>• Cambridgeshire and Peterborough ICB and Lincolnshire ICB are working in tandem to support NWAFT.</li> </ul>

## 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

Apr-22

### Neighbouring Trusts

ULHT:	1.0577
NLAG:	1.0358
NWAFT:	1.1042
NUH:	1.0084
QEH:	1.0410

### England

1.0013

### Trend

NLAG:



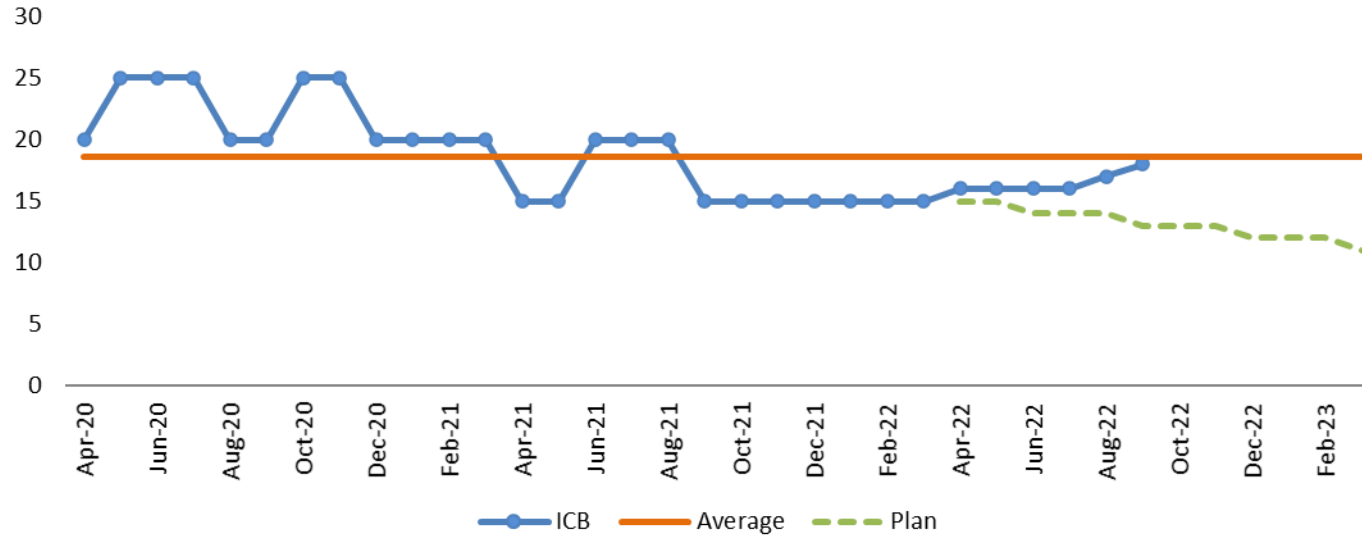
NWAFT:



# Learning Disability Inpatients & Annual Healthchecks

Cause	Actions To Recover
<p><b>LD Inpatients</b></p> <ul style="list-style-type: none"> <li>• There are currently 18 LD ICB Inpatients. This current figure is above the 22/23 Q2 target of 13</li> </ul> <p><b>LD Annual Healthchecks</b></p> <ul style="list-style-type: none"> <li>• Delivery from April to July is 551 Health Checks, 148 ahead of 21/22 but 12 behind plan for 22/23.</li> <li>• It is too early for a robust performance projection but current data indicates delivery of the 85% target by year end.</li> </ul>	<p><b>LD Inpatients</b></p> <ul style="list-style-type: none"> <li>• The issues and recovery actions outlined in the July Integrated Performance Report for learning disability inpatients and annual health checks still hold for September</li> </ul> <p><b>LD Annual Healthchecks</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• A funding bid to NHSE for £20k to support this catch up work has been successful (notification received 13 July). Currently engaging with PCNs and confirming funding allocation and process.</li> <li>• Engagement with practices indicates limited capacity to bring scheduled health checks forward in some cases.</li> <li>• Work on cancer screening underway with the LDHC Network.</li> <li>• NHSE regional team have noted positive progress YTD year compared to last year.</li> </ul>

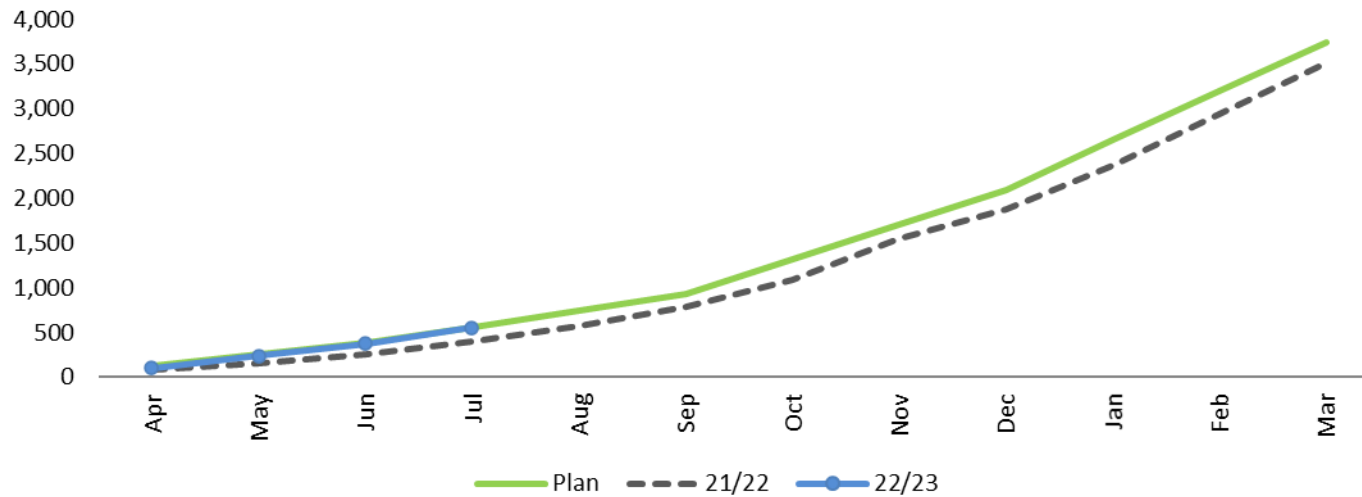
## Number of people with a learning disability receiving inpatient care (ICB)



Indicator
Number of people with a learning disability receiving inpatient care (ICB)
Plan
14
Period
Jul-22
ICB
16
Trend



## Learning Disability Annual Healthchecks (ICB)



Indicator
Cumulative Learning Disability Healthchecks (ICB)
Plan
563
Period
Jul-22
ICB
551
England
N/A
Trend



# Care Home Quality

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)
CQC rating	Outstanding	Good	Requires Improvement	Inadequate
August 2022				
No. of Homes: 276				
13 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	188 (5 homes less than last month)	55 (3 homes more than last month)	4 (2 more than last month)

## Update

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

Care Homes with high risk issues – under enhanced level of surveillance via CCG/LCC officers: x16 providers

### **There are 2 Suspensions in place by Health and Lincolnshire County Council:**

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

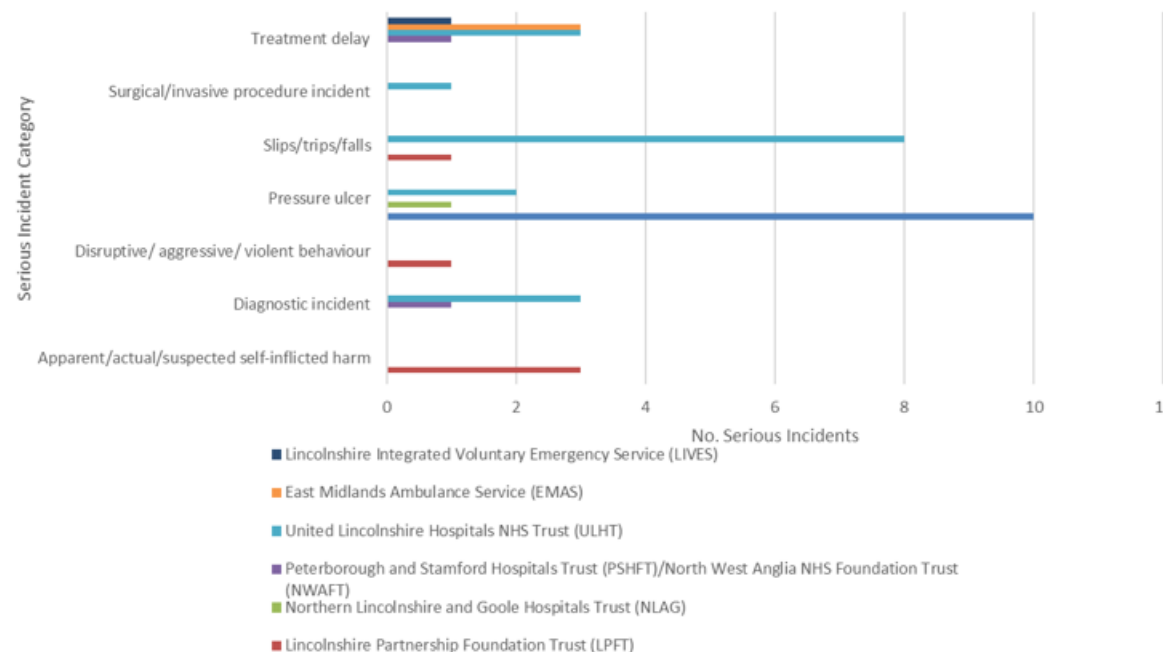
### **There has been a total of 14 Default Notices by Lincolnshire County Council:**

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

August 2022

# Serious Incidents

Serious Incidents Reported between 13 July 2022 - 9 August 2022



## Update

- There has been a total of 39 serious incidents reported between 13 July 2022 – 9 August 2022, this represents a decrease when compared to the last report (n=50), however, is more in keeping with previous reporting rates (n=35) and (n=42) respectively.
- There has been a decrease in the number of serious incidents reported by LCHS, recognising for the Trust there continues to be a focus on pressure ulcer reporting. A total of (n=10) serious incidents reported this month, compared to (n=21) last month.
- Consistent with last month (n=15), ULHT have reported (n=17) serious incidents between 13 July 2022 – 9 August 2022. The focus of reporting of serious incidents for this month has been slips/trips/falls (n=8) which is an increase when compared to last month. There have been (n=3) serious incidents reported, respectively, in relation to diagnostics and treatment delays; and (n=2) pressure ulcer incidents reported. In addition, there had been a single serious incident reported in relation to surgical/invasive procedures, which was categorised as a never event (wrong site surgery).
- LPFT reported a total of (n=5) serious incidents in the timeframe referenced, this figure remains relatively consistent. The focus of serious incident reporting for LPFT continues to be apparent/actual/suspected self-inflicted harm (n=3); with a single incident reported in relation to disruptive/aggressive/violent behaviour; and a single slip/trip/fall serious incident reported.

# 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.

## **September 2022 update**

- **Ockenden insight visit completed in June 2022, overall positive regarding the Trusts actions taken against 7 immediate and essential improvements actions (IEAs). ULHT have bench marked against the final Ockenden report 15 IEAs, identifying areas for further development and actions required.**

# Primary Care

Cause	Actions To Recover
<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>Lakeside CQC report was published on the 1st June with an overall Requires Improvement rating. CQC notice of intent has been withdrawn. The Primary Care team and Healthwatch Lincs are offering to support in developing the practice's PPG .</li> </ul> <p><b>Access</b></p> <ul style="list-style-type: none"> <li>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)</li> <li>Ongoing demand pressures and LTC recovery are impacting on patient access times</li> <li>Enhanced access data completeness is an ongoing issue</li> <li>Transfer of Enhanced Access contract arrangements to PCNs is on track.</li> </ul>	<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>ICB senior representatives continue to meet regularly with the Lakeside Practice Team to receive assurance on continued actions to address concerns and to support. LMC also supporting.</li> <li>ICB Primary Care and Quality teams continue to support practices in improving care quality and patient experience</li> </ul> <p><b>Access</b></p> <ul style="list-style-type: none"> <li>Review and monitor access activity</li> <li>Practice support available through Livi system and LMC</li> <li>Lantum available to support practice capacity and actively promoted to practices and PCNs</li> <li>GPAS monitoring practice pressures and reporting through to OPEL system: managed by the LMC. Discussing the options for more detailed information through GPAS with the LMC.</li> <li>Primary Care team supporting Enhanced Access reporting and following up with PCN.</li> </ul>

# 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

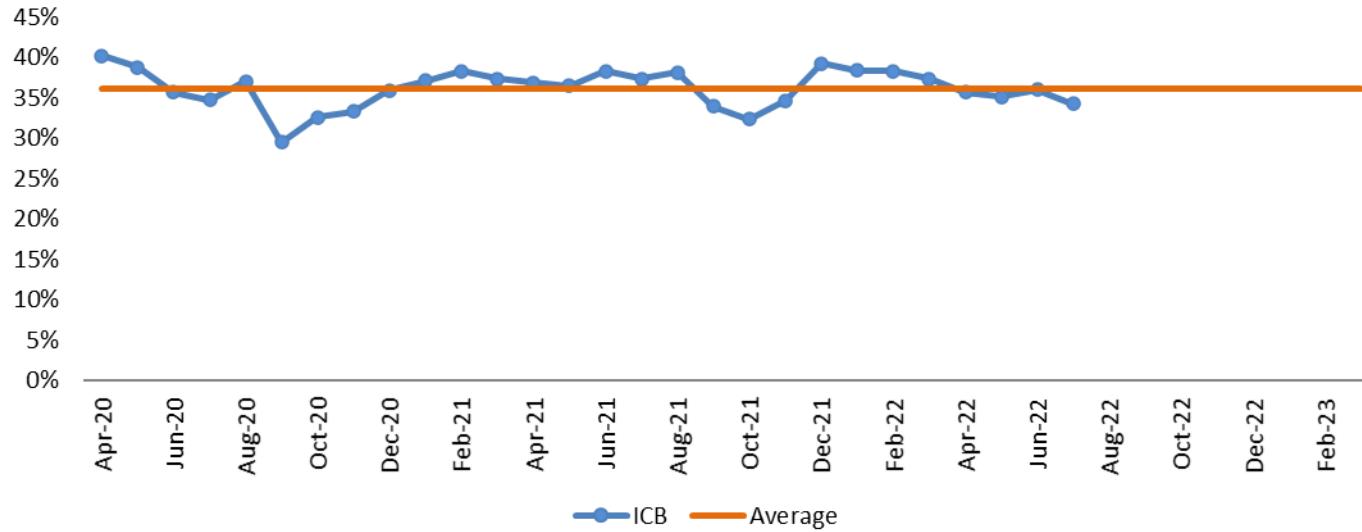
Practice	Publication Date	Locality	Overall Rating	Previous Rating
Hereward Medical Centre	18/08/2022	East	Good	Good

## Actions to recover

### Lakeside

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

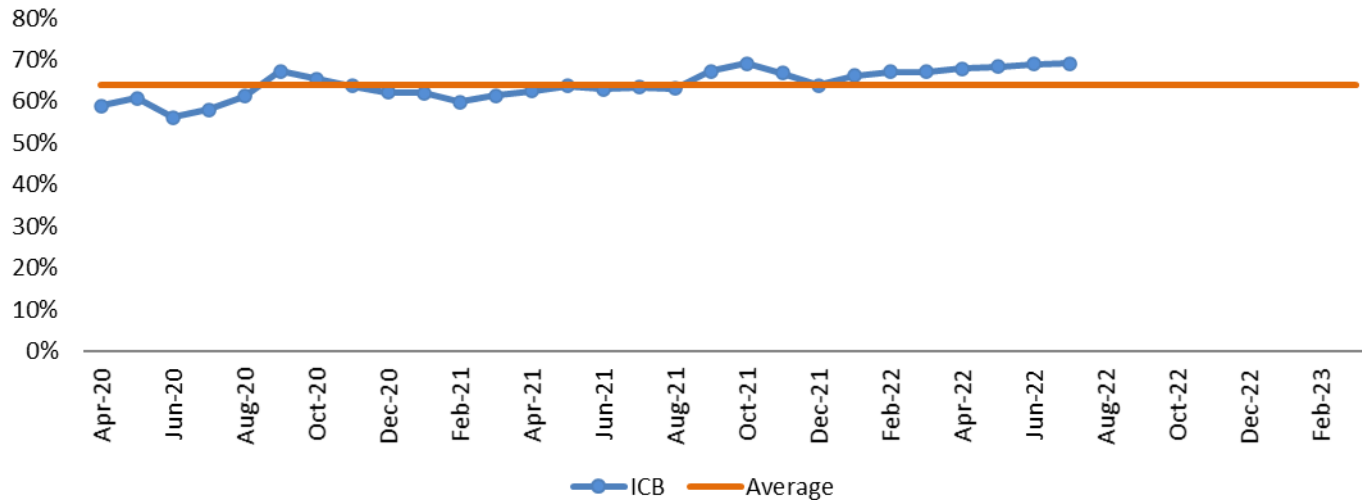
## GP Appointments- percentage seen by a GP



Indicator
GP Appointments- percentage seen by a GP
Period
Jul-22
20/21
34.7%
21/22
37.4%
22/23
34.3%
Trend



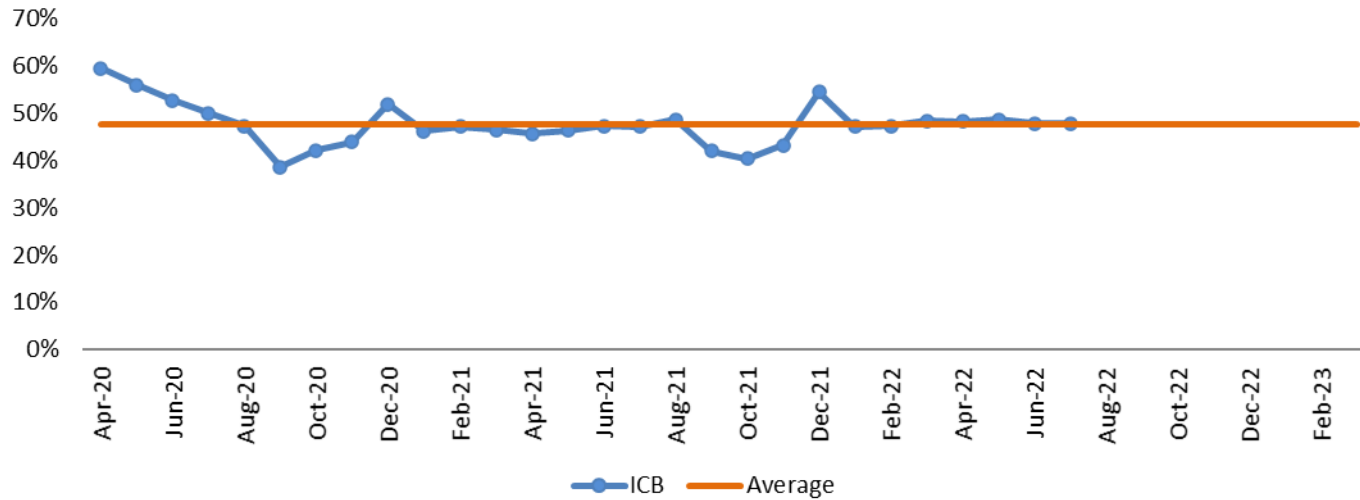
## GP Appointments Mode- percentage seen face to face



Indicator
GP Appointments Mode- percentage seen face to face
Period
Jul-22
20/21
58.0%
21/22
63.4%
22/23
69.1%
Trend



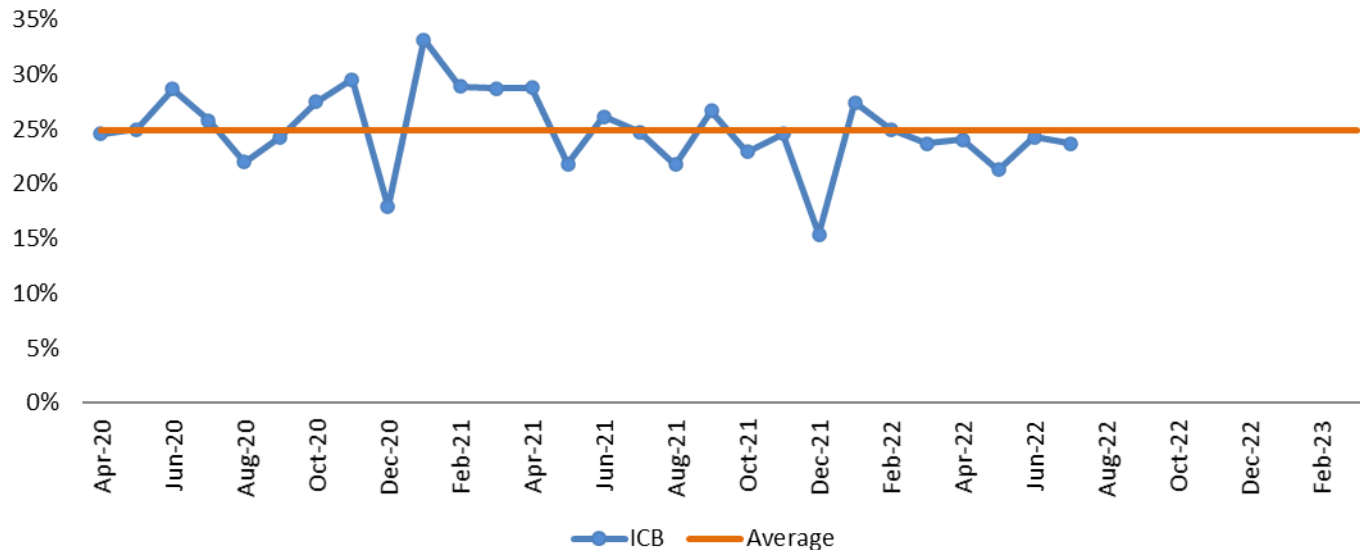
## GP Appointments- time from booking to appointment (Same Day)



Indicator
GP Appointments- time from booking to appointment (Same Day)
Period
Jul-22
20/21
50.0%
21/22
47.2%
22/23
47.8%
Trend



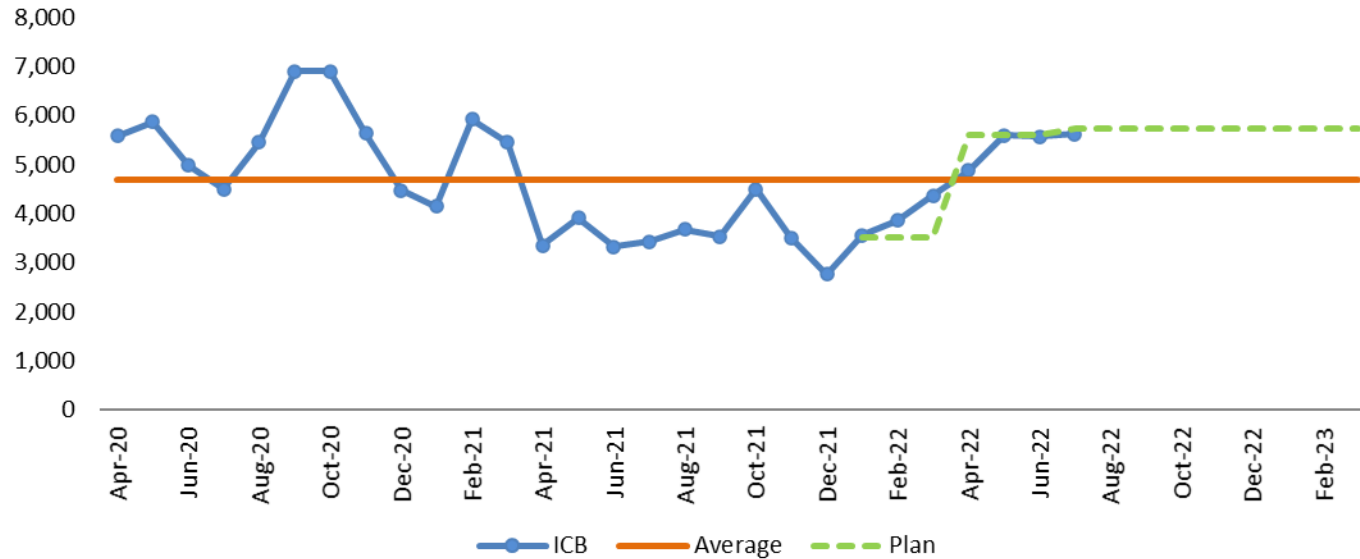
## GP Appointments- time from booking to appointment (1-6 Days)



Indicator
GP Appointments- time from booking to appointment (1-6 Days)
Period
Jul-22
20/21
25.8%
21/22
24.7%
22/23
23.7%
Trend



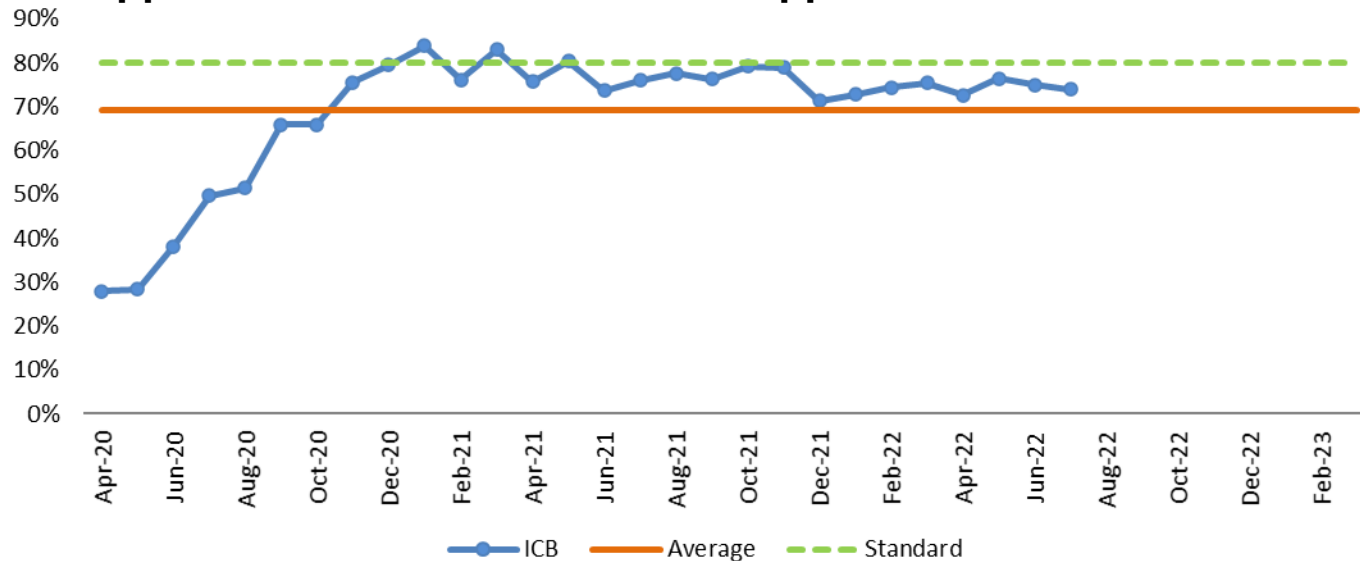
## GP Appointments-Extended Access Appointments Available



Indicator
The number of extended access appointments booked excluding did not attends (ICB)
Period
Jul-22
Plan
5723
22/23
5625
Trend



## GP Appointments-Extended Access Appointments Utilisation



Indicator
The percentage of available GP extended access appointments utilised (ICB)
Period
Jul-22
Standard
80.0%
22/23
73.9%
Trend



## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date:** 27<sup>th</sup> September 2022

**Location:** Bridge House, Sleaford

<b>Agenda Number:</b>	5 (i)
<b>Title of Report:</b>	Operational Resilience
<b>Purpose:</b>	To note Clair Raybould, Director for System Delivery
<b>Appendices:</b>	National guidance relating to increasing capacity and operational resilience ahead of winter Guidance for emergency departments

<b>1. Key Points for Discussion:</b>	To provide an update on national and local operational winter planning
<b>2. Recommendations</b>	To note the guidance and local operational winter planning.
<b>3. Executive Summary</b>	<p>All parts of the NHS continue to be under significant pressure and that is particularly noticeable across all Urgent and Emergency Care pathways from primary care through to acute services and is the picture replicated across the country.</p> <p>NHSE has issued the attached national guidance relating to increasing capacity and operational resilience in urgent and emergency care ahead of winter. The documents set out the core objectives and key actions for operational resilience.</p> <p>The Core Objectives are to:</p> <ul style="list-style-type: none"> <li>➤ Preparing for variants of COVID-19 and respiratory challenges</li> <li>➤ Increase capacity outside acute trusts</li> <li>➤ Increase resilience in NHS 111 and 999 services</li> <li>➤ Targeting category 2 response times and ambulance handover delays</li> <li>➤ Reduce overcrowding in A&amp;E departments and target the longest waits in ED</li> <li>➤ Reduce hospital occupancy</li> <li>➤ Ensure timely discharge</li> <li>➤ Provide better support for people at home</li> </ul> <p>There are six key metrics that will be used by NHSE and ICBs to monitor performance in each system through a new Board Assurance Framework, these are:</p> <ol style="list-style-type: none"> <li>1. 111 call abandonment</li> <li>2. Mean 999 call answering times</li> </ol>

3. Category 2 ambulance response times
4. Average hours lost to ambulance handovers per day
5. Adult general and acute type 1 bed occupancy adjusted for void beds
6. Percentage of beds occupied by patients who no longer meet criteria to reside

These have been developed to help local systems ensure there is effective oversight on local performance and will have elements tailored to each system.

The local system in Lincolnshire is working through this new guidance, developing the plans that need to be in place over winter and undertaking the first draft of the assurance framework.

Winter demand and capacity planning commenced in August with an initial bed plan and Mental Health plan submitted earlier than previous years. System operational executives have held a winter planning confirm and challenge session on planning so far for winter which will be supplemented by a Clinical session in October to enable robust development of a system first cut winter plan by early October. The plan will be shared with the Urgent & Emergency Partnership Board (UECPB) and will be the main agenda item for the October Service Delivery & Performance Committee.

The plan will remain iterative and be underpinned by the establishment of a System operational Centre allowing the system to adapt as winter unfolds based on monitoring of metrics, changes in assumptions and risks.

NHS England will be working with systems over the coming weeks to agree trajectories for the assurance framework and discuss plans for scenarios over and above the increased capacity already agreed.

<b>4. Management of Conflicts of Interest</b>
---

Not Applicable

<b>5. Risk and Assurance</b>
------------------------------

Will be covered in the assurance framework and plan

<b>6. Financial/Resource Implications</b>
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The system has had confirmation of allocation for demand and capacity schemes which will form part of the assurance framework.

<b>7. Legal, Policy and Regulatory Requirements</b>
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Not Applicable

<b>8. Health Inequalities implications</b>
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As detailed in the report.

<b>9. Equality and Diversity implications</b>
---

Not Applicable

<b>10. Patient and Public Involvement (including Communications and Engagement)</b>
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There will be a national and local communications plan for winter and resilience more generally

<b>11. Report previously presented at</b>
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Not applicable

<b>12. Sponsoring Director/Partner Member/Non-Executive Director</b>
--

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- To:
- Integrated Care Board Chief Executives and Chairs
  - NHS Foundation Trust and NHS Trust:
    - Chief Executives
    - Chairs

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**12 August 2022**

- cc.
- Regional Directors

Dear colleagues

### **Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter**

This week the NHS reached its first key ambition on recovering services, focusing on patients who had been waiting more than 104 weeks. We delivered this important milestone despite having to contend with further waves of COVID-19, including more than a quarter of our COVID-19 inpatients occurring since publishing the Elective Recovery Plan, an unprecedented heatwave, and other significant pressures. It shows once again that when we prioritise, invest, and innovate, the NHS can, acting as a national service, deliver for patients.

Urgent and Emergency Care is currently under significant pressure. Staff have faced one of their busiest summers ever with record numbers of A&E attendances and the most urgent ambulance call outs, all alongside another wave of COVID-19. Thanks to the professionalism and commitment of those staff, the NHS continues to provide care to over 100,000 urgent and emergency care patients each week. Despite their best efforts, these pressures have meant that there have been too many occasions when staff have not been able to provide timely access for our patients in the way they would have wanted.

Our immediate response has been to focus on ambulance performance, and the linked issue of speeding up discharge. We have provided extra funding to ambulance services, offered intensive support to those trusts most challenged by ambulance delays, and rolled out virtual wards across the country, enabling patients who would otherwise be in hospital to receive support at home.

And we have begun planning for the coming winter earlier than usual, recognising pressure on the NHS is likely to be substantial, particularly in UEC, making the most of the opportunity created by the formation of ICBs to maximise the benefits of system working.

In addition to maintaining progress on 2022/23 operational priorities and building on the significant successes in delivering our Elective Recovery plan, with a strong focus on 62 day cancer backlogs and elective long waits, today we are setting out the next steps in our plans to rapidly increase capacity and resilience ahead of winter, building on the operational plans we have worked on together.

## **Core objectives and key actions for operational resilience**

Our collective core objectives and actions are to:

- 1) **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
- 2) **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
- 3) **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
- 4) **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
- 5) **Reduce crowding in A&E departments and target the longest waits in ED**, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- 6) **Reduce hospital occupancy**, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
- 7) **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.
- 8) **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

This letter and the appendix sets out the important actions, developed in partnership with you, to help deliver these core objectives, as well as how NHS England will support you. Taking these actions should help manage pressure across the pathway, supporting improved flow for patients in emergency departments.

Clearly, expanding capacity is dependent on both sufficient workforce and workforce wellbeing. This is why it is important that the plans have been built from the bottom up, with ICBs responsible for developing plans that are based on realistic assumptions, including how many staff can be recruited and at what speed. We will fully fund the recent pay award nationally, avoiding the need to cut frontline services for winter.

Similarly, ICBs have been clear with us that much of the pressure on urgent and emergency care is driven by the current, significant, growing strain in social care. Too many patients are spending longer in hospital than they need to, creating pressure along the entire pathway. We will continue to work with the Government, and national local government partners, to help, as far as possible, address these issues. At a local level, the creation of ICSs offers an opportunity for all partners in a local system to work together to deliver local solutions. This includes making best use of the Better Care Fund, building on the work you are doing locally to map local demand and capacity.

### **Performance and accountability: A new approach to working together**

This plan is underpinned by a new approach to how organisations in the NHS work together – the Health and Care Act 2022 has enshrined Integrated Care Systems in law. Although this winter presents significant challenges, it is an opportunity to show how these new ways of working can make a real difference to patients and join up the entire urgent and emergency care pathway in ways we've been unable to do before. The plan empowers system leaders to do this in a number of critical areas, and where you can go further, please do so.

System working also means a new approach to accountability. ICBs are accountable for ensuring that their system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the populations they serve. ICBs are responsible for initial problem solving and intervention should providers fail, or be unable, to deliver their agreed role. Intervention support can be provided from NHS England regional teams as required, drawing on the expertise of our national level urgent and emergency care team as needed.

That line of accountability does mean that we will want to continue to work with you to stress test your plans and to 'check and challenge' progress in delivering them. We will expect that you work with us to report on local performance and collaboratively, but quickly, tackle problems where they occur.

On performance metrics, the overall objective remains the provision of safe and effective care. Until the adoption of the Clinically-led Review of Standards is agreed with the Government, current standards remain for emergency department performance and flow. Likewise, objectives set out in Planning Guidance, which includes reducing 12 hour waits and increased clinical input in 111, remain. These should continue to be used to understand flow through your emergency departments.

Working with ICBs we have identified the following six specific metrics, key to the provision of safe and effective urgent and emergency care, that NHS England and ICBs will use to monitor performance in each system through the [Board Assurance Framework](#):

- 111 call abandonment.
- Mean 999 call answering times.
- Category 2 ambulance response times.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute type 1 bed occupancy (adjusted for void beds).
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

We will work with you through the Assurance Framework to develop local performance trajectories to sit alongside these measures.

The work on elective care and the 100 day discharge challenge demonstrates the value of using an improvement approach based on data, easy to access best practice guidance, as well as senior clinical and executive peer review in spreading solutions focused on those facing the greatest challenges. We will launch new improvement offers to support ambulance handover and response times in the coming weeks.

To support ICBs, we will provide you with a Board Assurance Framework to monitor progress monthly against the combined System Capacity Plans, Actions and Good Practice basics and improvement priorities developed with colleagues over time. This is aimed at supporting and ensuring trusts continue to implement best practice. Each BAF will be unique to each ICS to reflect the specific capacity gaps that you have identified.

While these plans represent substantial work to increase capacity and improve operational resilience, clearly epidemiological modelling suggests reasonable worst-case scenarios for Covid-19 which would require a more significant set of actions. We will work with you to develop plans for these scenarios.

Thank you to you and your teams across the NHS for your continued hard work. While there is no doubt that we are going to experience challenges over the winter, when the NHS unites as it has over the past two and half years of the pandemic and works closely with wider partners, we know we can best serve patients, support our teams and maintain the momentum of the NHS's recovery from the pandemic.

Yours sincerely,



**Amanda Pritchard**  
NHS Chief Executive



**Julian Kelly**  
Chief Financial Officer  
NHS England



**Sir David Sloman**  
Chief Operating Officer  
NHS England

## **Appendix – Actions: Further details on increasing capacity and operational resilience in urgent and emergency care ahead of winter**

Each ICB plan has been discussed, and agreed, with the relevant NHS England region and a series of specific actions have been agreed between NHS England and each ICB in the following areas:

### **1. New variants of COVID-19 and respiratory challenges**

SPI-M scenarios for COVID-19, combined with scenarios for flu, suggest that even in optimistic scenarios, high numbers of beds may be needed for respiratory patients during winter. Resulting IPC requirements will make bed management complex, especially if bed occupancy remains high. We will do further work with you in the coming months on stress-testing planning for the operational response to realistic worst-case scenarios. We are working with local areas to:

- Deliver an integrated COVID-19 booster and flu vaccination programme to minimise hospital admissions from both viruses.
- Implement UKHSA's IPC guidance in a proportionate way and develop strategies to minimise the impact of 'void' beds.

### **2. Demand and capacity**

A lack of capacity across the NHS has an impact on all areas of the system. It is essential that ambulance and NHS 111 services have the necessary capacity in place and that access to primary care, community health services and mental health services for urgent patients is sufficient to ensure patients do not need to present to emergency services. We are working with local areas to:

- Open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand. This should create the equivalent of 7,000 additional general and acute beds, through a mix of new physical beds, scaling up virtual wards, and improvements in discharge and flow.
- Increase the number of NHS 111 call handlers to 4,800 and the number of NHS 999 call handlers to 2,500.
- Increase provision of High Intensity User services.
- Support good working relationships with the independent sector, building on the success so far, and facilitating patient choice.

In community care:

- Increase two-hour Urgent Community Response provision by maximising referrals from the ambulance service and other providers, aiming to maintain and improve the current standard of responding to 70% of call outs within two hours.
- Increase the number of virtual wards to create an additional 2,500 virtual beds.

In primary care:

- We will maximise recruitment of new staff in primary care across the winter, including care co-ordinators and social prescribing link workers.
- ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and

specific winter pressures (such as oximetry monitoring for COVID-19 patients) alongside the digital development of primary care.

In mental health, cancer, and elective care:

- Share mental health best practice between systems and work with the VCS and LA sector to alleviate capacity constraints.
- Releasing £10m of annual funding to support MH through the winter, in addition to continued planned growth in community and crisis provision.
- Maintain and increase elective capacity to eliminate waits of over 18 months, as per the Elective Recovery Plan, except for patients who choose to wait longer or require alternative plans due to clinical complexity.
- Reduce the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by March 2023.
- Ensure the preservation of the standard clinical pathway for CYP elective surgery, critically ill children, and emergency, general and specialist services.

### **3. Discharge**

While challenges are often seen at the 'front door', we know that their root cause is often in the ability to discharge patients from, and flow through, hospitals. There is a significant number of patients spending longer in hospital than they need to, often due to a lack of availability of social care. While the provision of social care falls outside of the NHS's remit, the health service must ensure patients not requiring onwards care are discharged as soon as they are ready and can access services they may need following a hospital stay. We are working with local areas to:

- Implement the 10 best practice interventions through the 100-day challenge.
- Encourage a shift towards home models of rehab for patients with less severe injuries or conditions.
- Maximise support available from the Seasonal Surge Support Programme, provided by VCS partners.

### **4. Ambulance service performance**

While ensuring there is enough capacity for ambulances to respond to the most urgent calls and take patients to hospital is essential, it is also important to focus on what can be done to reduce avoidable ambulance activity, through treating patients at the scene. We are working with local areas to:

- Implement a digital intelligent routing platform and live analysis of 999 calls.
- Agree and implement good practice principles for the rapid release of queuing ambulances in response to unmet category two demand.
- Work with the most challenged trusts on ambulance handover delays to develop solutions, including expanding post-ED capacity.
- Increase the utilisation of rapid response vehicles, supported by non-paramedic staff, to respond to lower acuity calls.
- Model optimal fleet requirements and implement in line with identified need.
- Implement the ambulance auxiliary service which creates national surge capacity to enhance the response and support for ambulance trusts.

- Deploy mental health professionals in 999 operation centres and clinical assessment services and deliver education and training to the workforce.
- Increase the use of specialist vehicles to support mental health patients.

## **5. NHS 111 performance**

The NHS 111 service can only work if it has sufficient clinical capacity to provide consultations if required and patients are able to be directed to the right service for their needs. We are working with local areas to:

- Improve call handling performance through the implementation of regional call management which will enable better integration between providers and ensure the entire NHS 111 capacity is used effectively.
- Continue pilot of national Paediatric Clinical Assessment Service and build on what we are learning.
- ICBs to update details of the 24/7 urgent mental health helplines for patients experiencing a mental health crisis, and ensure these services are promoted.

## **6. Preventing avoidable admissions**

A full range of urgent care services should be available to ensure patients can access the right care in the right place. The Directory of Services should be used by staff to direct patients to the most appropriate place, while same-day emergency care, frailty and 'hot' outpatient services should also be available for patients requiring urgent specialist treatment but not necessarily via an ED. We are working with local areas to:

- Increase number and breadth of services profiled on the Directory of Services to ensure only patients with an emergency need are directed to A&E.
- Develop and protect capacity for same-day emergency care services so that operational hours are profiled against demand and surgical availability.
- Review non-emergency patient transport services so that patients not requiring an overnight hospital stay can be taken home when ready.
- Improve the provision of the Acute Frailty service, including the delivery of thorough assessments from multidisciplinary teams.
- Implement out of hospital home-based pathways, including virtual wards, to improve flow by reducing hospital attendances. Reduce unnecessary attendances for patients with mild illness through revised [NHS @home](#) pathways that incorporate broader acute respiratory infections.

## **7. Workforce**

NHS staff have worked incredibly hard throughout the pandemic and both current and future pressures on the health services mean teams will remain stretched. The health and wellbeing of the workforce is crucial and interventions targeting recruitment and retention will be important in managing additional demand this winter. We are working with local areas to:

- Implement your recruitment and retention plans including staff sharing and bank arrangements.
- Utilise international support for UEC recovery, identifying shortages of key roles and skills and targeting recruitment as such.

- Implement the Wellbeing Practitioners' Pack.
- Develop roles for volunteers that reduce pressure on services and improve patient experience, such as community first responders and support in discharge.

### **8. Data and performance management**

Making the full use of data at a local, regional, and national level will help inform operational decision-making and improve the delivery of services. We are working with local areas to:

- Ensure timely and accurate submission to the Emergency Care Data Set.
- Encourage use of the A&E Forecasting Tool.

### **9. Communications**

We are undertaking the following actions to enable strong communications:

- Implement your winter communications strategy to support the public to minimise pressures on urgent and emergency services.
- Deliver the NHS 111 and GP Access strands of the Help Us Help You campaigns.

Classification: Official

Publication approval reference: B1449



Guidance for emergency departments

# Initial assessment: definitions and recommendations

August 2022

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# 1. Introduction

[The 2022/23 NHS planning guidance](#) specifies the need for more structured streaming arrangements between urgent treatment centres (UTCs) and emergency departments (EDs), and as such they must have robust processes that match patients with the service most suited to meet their clinical need; for example, a UTC (which may or may not be co-located with an ED) or same day emergency care (SDEC) service.

The rationale for changing the way in which we look at and understand the performance of UEC was set out in the [Interim report of the clinically led review of access standards \(March 2019\)](#) and subsequently in [Transformation of urgent care: models of care and measurement \(December 2020\)](#) makes it clear that UEC needs to identify the sickest patients early and their treatment begun as soon as possible after arrival. Urgent and emergency care (UEC) attendances continue to increase across England. Effective patient flow that supports early senior clinical decision-making is therefore imperative.

This guidance makes recommendations for models of initial assessment of patients arriving at EDs and provides standard definitions of the processes that classify as initial assessment: streaming, triage, and rapid assessment and treatment. It recognises that initial assessment and flow from the front door of a hospital are a crucial first step on a patient's journey. Decisions made at the first point of interaction can frame much of the subsequent process of care and are an essential component in managing risk and ensuring a high quality service.

It builds on and replaces [Clinical streaming in the accident and emergency department \(2017\)](#) and [Initial assessment of emergency department patients \(RCEM 2017\)](#), which recommended beginning initial assessment of patients presenting to ED within 15 minutes<sup>1</sup>. This document has been developed with the Royal College of Emergency Medicine (RCEM) after consultation with key stakeholders,<sup>2</sup> and agreed for England. RCEM will consult the other UK nations to achieve consistency wherever possible.

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<sup>1</sup> [SDDC Initial Assessment Feb2017.pdf \(rcem.ac.uk\)](#)

<sup>2</sup> NHS England and NHS Improvement, RCEM, Royal College of Nursing (RCN), Care Quality Commission, regional UEC clinical advisors, Society of Acute Medicine, emergency department clinicians across England.

'ED' in this document refers to the location where the initial patient assessment takes place. Assessment can be performed by a type 1 (ED) or type 3 (UTC) service. Hospitals may have a UTC at the front door which performs the streaming function.

The following are **not** within the scope of this document:

- initial assessment of patients presenting during a major incident
- initial assessment processes used by NHS111.

## 2. Patient flow into emergency departments

The core principle is that on arrival at hospital, patients are directed to a treatment area or service staffed with appropriate healthcare practitioners to manage their clinical needs.

### Patient arrival

Most patients who arrive at emergency departments (EDs) self-present (they are unheralded). Since the COVID-19 pandemic, hospitals have changed the way that patients access services due to increased infection prevention and control (IPC) measures, including rapid testing of patients for COVID-19. Consequently, a proportion of patients who attend ED may have had earlier contact with a clinician in another setting, such as NHS 111.

#### **Heralded patients**

These patients have contacted NHS 111 and been advised to go to hospital. NHS 111 books them into ED arrival slots. Providers should use the NHS [national standard for booking and referral](#) and should make the ED aware of the patient's attendance in advance of their arrival.

Patients who are conveyed by ambulance are also heralded.

#### **Ambulance handover**

Ambulances will pre-alert the ED if they are conveying a patient who needs to be received by a clinical team. These patients must be received by the appropriate team immediately on arrival.

Handover of non-pre-alerted patients from an ambulance crew to the ED should be completed following locally agreed processes within 15 minutes of arrival, as per [NHS ambulance services pre-alert criteria guidance](#). Responsibility for patient clinical assessment and treatment lies with the hospital from the point the ambulance arrives at the department. Ambulance clinicians need to return to their vehicle immediately after handover to prepare and make themselves available for patients needing an ambulance response in the community.

## Unheralded patients

These patients are not expected by the ED. They include patients who self-present with no previous contact with a clinician in another healthcare setting and those advised to attend ED by a clinician in 999, primary or community care.

## 3. Initial assessment

Patients should be assessed promptly by locally agreed processes within 15 minutes of arrival. However, patients who have a booked appointment via NHS 111 at a co-located UTC are not required to have a further assessment on arrival if they are seen within 30 minutes of their appointment time. An exception to this would be if the patient's clinical condition has deteriorated before arrival and in this case further clinical assessment would be of value.

Clinical governance of any assessment must be unambiguous. The service assessing and directing the patient should ensure joint governance arrangements are in place for clinical responsibility, until the patient is next assessed by a clinician.

Patients should be assessed according to two main factors:

- **chief complaint or suspected diagnosis:** the chief complaint is the primary problem the patient is presenting with, as initially assessed by a clinician
- **acuity:** acuity is a measure of the severity of the patient's condition and the urgency with which they need to be seen and assessed by a clinician qualified to do this through training and experience. Defined in the data dictionary.<sup>3</sup>

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<sup>3</sup> [EMERGENCY CARE ACUITY \(SNOMED CT\) \(datadictionary.nhs.uk\)](#)

In the Emergency Care Data Set (ECDS) acuity is assigned a score of 1 to 5. If an explicit (formal) triage system is not used, implicit triage that flows patients to resus (1), majors (3) or minors (4) is currently used.

**Table 1: Acuity coding in ECDS**

ECDS	A&E coding
1 Immediate emergency care	1 Resuscitation
2 Very urgent emergency care	3 Majors
3 Urgent emergency care	4 Minors
4 Standard emergency care	
5 Low acuity emergency care	

Initial assessment must add value to the patient’s journey and not cause inappropriate clinical duplication. Although initial assessment models may differ across the country and be based on one or more of the processes defined below. They should encompass the recommendations in Table 3 below.

The main objectives of initial assessment are to:

- identify patients with potentially life-threatening conditions and injuries to ensure those with the most time-critical conditions are prioritised
- accurately assess non-life-threatening conditions and injuries so that appropriate prioritisation occurs for these patients and they are seen by the right service within appropriate timeframes
- prevent ED crowding and support infection prevention and control (IPC)
- recognise potentially vulnerable patients and consider their immediate safeguarding concerns.

## Initial assessment recommendations

**Table 3: Recommendations**

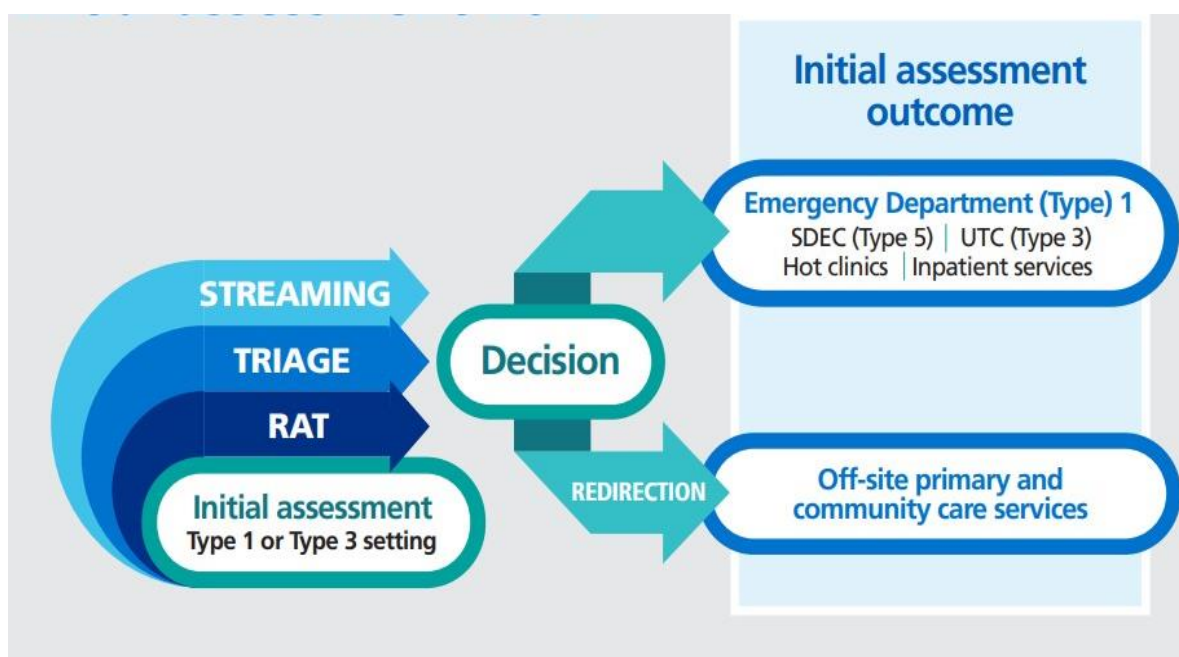
1	Identify patients with life-threatening conditions/injuries and ensure they are prioritised.
2	Identify patients with non-life-threatening conditions/injuries and ensure appropriate service allocation and prioritisation occurs.
3	Identify immediate clinical care needs (e.g. medication administration/diagnostics) and deliver care or enable prompt transfer to an area that can deliver care.
4	Identify potentially vulnerable patients including those with safeguarding concerns, learning disabilities, acute mental health illness and high risk of absconding.
5	Initial assessment should begin at soon as possible after a patient arrives.
6	Patients should be made aware of who is responsible for their care.
7	Initial assessment processes should be resourced to meet variation in demand.
8	There must be clear signage and processes to ensure patients know where they can access care.
9	When patients are advised to attend ED by other providers, the initial assessment process must account for this.
10	Where clinicians from other providers work within an initial assessment system, service development and governance structures should be shared.
11	Initial assessment areas must facilitate confidential conversations, enable access to patients with disabilities and their careers, and maintain patient dignity.
12	Staff should have support to assess patients who do not speak or understand English.
13	Initial assessment processes must support IPC measures, including minimising crowding in ED.

## 4. Clarification of definitions of activity that constitutes initial assessment

The terminology surrounding patient flow – pre-hospital and from the ED front door – is inconsistent, with terms such as streaming, assessment and triage used interchangeably. Since national implementation of streaming models in EDs in 2017/18, providers have said clearer definitions of initial assessment would be helpful.

On arrival at an ED, patients undergo an initial clinical assessment. This includes one or more of the processes described in Table 2. While navigation, redirection and referral are also defined and described to clarify terminology around flow, they are not classed as part of the initial assessment but could be an output.

**Figure 1: Initial assessment flow**



**Table 2: Definitions of initial assessment and context in which terms should be used**

Definition	Context
<p><b>Streaming:</b> a clinical activity to direct patients to the most appropriate service based on their presenting symptoms, chief complaint and acuity.</p>	<p>Streaming manages queues and matches patients' needs to the practitioner and area with the right clinical skills and diagnostic and treatment capabilities at the earliest opportunity.</p> <p>Streaming of patients is carried out within an ED (type 1) or a co-located UTC (type 3) and is likely to be the first clinical activity the patient experiences when arriving. It focuses on determining who will see the patient next, and results in a transfer of care.</p> <p>It is based on a clinical assessment that typically involves taking a brief medical history and may include performing basic observations. Some sites may include other measures such as NEWS (National Early Warning Score) or PEWS (Paediatric Early Warning Score), basic first aid measures, simple analgesia and simple tests. It is not appropriate to perform complex investigations at this point in the patient journey.</p> <p>Streaming should be done only by clinicians who are registered and trained in local guidelines and bound by local clinical governance. Patients may also be asked to use digital streaming tools (digital enablers) and where they are staff should be available to support them to do so if required; the clinical governance and accountability remain with the clinical service.</p> <p>Streaming is the first clinical activity the patient is likely to experience when arriving at the ED. The streaming activity should be brief, to avoid queues developing, and completed as soon as possible. However, the overall system must incorporate safeguards to ensure the further assessment of those patients who require this</p> <p>Streaming environments must be conducive to a patient's needs, with sufficient privacy to allow the exchange of confidential information. They should be situated close to clinicians who can provide support if needed, and as close to the main entrance and waiting room as possible.</p> <p>Outcomes of streaming are likely to be varied and can include:</p>

	<ul style="list-style-type: none"> <li>• UTC (if present on-site)</li> <li>• ED clinical assessment (resuscitation room, majors, minors)</li> <li>• streaming to another service such as SDEC, or a specialty assessment unit (medial, surgical, gynaecology, children's, etc)</li> <li>• redirection off-site.</li> </ul> <p>Streaming explicitly assumes protocols are in place that allow patients to be immediately transferred to the ED if clinically required and appropriate.</p> <p>Streaming allows rapid referral into services such as SDEC but pre-hospital referral to services such as SDEC is recommended at an integrated care system (ICS) level, to avoid presentation at the ED where appropriate. Patients arriving by ambulance may be suitable for streaming and there should be joint working and governance between ED, the ambulance service and any streaming provider.</p>
<p><b>Triage:</b> the clinical process to prioritise patients, completed before a full assessment to support effective management of demand and flow, identifying time critical requirements for patients.</p>	<p>Triage is part of the process to prioritise patient treatment so that the most acutely unwell patients are seen first. Triage may be done in isolation from streaming or completed after a patient has been initially streamed on arrival. This process and model of care will depend on capacity and demand. When EDs are under pressure, triage may be used to help clinicians identify the order in which patients should be seen, but it can also be part of normal business to support the flow of patients within the ED.</p> <p>Triage is a meaningful face-to-face clinical assessment which may include observations and the use of triaging tools to support decision-making. It typically takes longer than streaming. The outcome is a priority assigned to the patient, thus helping manage workload and ensuring the sickest patients are seen first.</p> <p>Triage should be performed by a clinician who is trained and competent in using the specific triage system being applied. Its correct use ensures robust and reproducible assessment. The triage process should start as soon as possible after the patient arrives in the department, and if the patient has not already been streamed will also be the patient's initial assessment. Sufficient resources need to be</p>

	<p>allocated to triage to cope with variations in demand (both in numbers and time taken to complete triage), not average demand.</p> <p>Triage should be performed in an environment that is sufficiently private for exchange of confidential information but not isolated from the department.</p> <p>Several validated triage systems are in use across England, such as the Manchester Triage System, Canadian Triage and Acuity Scale and the Emergency Severity Index.</p>
<p><b>RAT:</b> rapid assessment and treatment is the initiation of investigations and treatment as determined by a team including senior decision-makers.</p>	<p>RAT is the most complex form of initial assessment and incorporates both streaming and triage. It is commonly but not exclusively used for the most unwell patients arriving to the ED.</p> <p>A RAT process requires a team that includes a senior decision-making clinician, nursing, and support staff. Clinicians are usually senior doctors such as consultants, middle grades or advanced clinical practitioners who can make decisions about care, order investigations and prescribe early treatments.</p> <p>It takes longer than streaming or triage (often 20 to 30 minutes, depending on the patient) and therefore, if insufficiently resourced, could create a queue to access it. However, it can improve the overall emergency care episode by initiating investigations and treatments early.</p>
<p><b>Note on digital enablers:</b> External providers and NHS England and NHS Improvement have developed digital tools across England to support the initial assessment process and they are becoming a key part of the initial assessment process. More tools are emerging and being implemented to help reduce overcrowding in waiting rooms and to offer patients the ability to self-triage as they enter a type 1 or type 3 site. These tools are clinically designed and governed by the site where they are used.</p>	

## Definitions of activity that is associated with flow and may be an outcome of initial assessment (but is not part of the initial assessment)

<p><b>Redirection:</b> patients may be redirected to an appropriate service after streaming or triage contact with a clinician or digital clinical tool. Redirection is a choice offered to patients with the full awareness that there is no transfer or formal handover of care.</p>	<p>Redirection involves signposting the patient to services that are suitable for their care needs after a clinician or digital tool has streamed or triaged them. It is different from streaming, navigation, and triage as it involves directing patients to off-site care.</p> <p>The patient should be able to access the services offered within an appropriate timescale. This is not a direct transfer of care as it is for the patient to decide if they should act on. The responsibility to utilise the advice lies with the patient, and there is not a direct transfer of care.</p> <p>Technical streaming tools used in EDs may assist in this process. Redirection options are agreed by the hospital on implementing the digital enablers. Examples are community pharmacies, dental services, or other specialist services in primary and community care.</p>
<p><b>Referral:</b> occurs when a patient has been assessed by an appropriately qualified practitioner in an emergency care facility and the decision made to refer them to another specialty for further care. In this case, a full ECDS ED episode has occurred.</p>	<p>To differentiate streaming from referral, it is important to understand that referral happens <b>after</b> a patient has been assessed by an appropriately qualified practitioner in an emergency care facility and the decision made to refer them to another specialty for further care. The ECDS ED episode has been completed.</p> <p>The clinical governance of this process is subject to local agreements; that is, it may be a negotiated or non-negotiated transfer of care. In the case of streaming there is not a full ECDS ED episode for the attendance, just an ECDS streaming episode. The clinical governance of this process is subject to local agreements: i.e. may be a negotiated or non-negotiated transfer of care.</p>
<p><b>Navigation:</b> a process to direct patients to services that may be suitable for their care needs. It is not based on clinical judgement or assessment.</p>	<p>Navigation typically happens before the patient comes under the responsibility of the ED and is not a counted activity in the patient's journey. This activity, at an early point of a patient's experience, may not involve a clinician and therefore is not based on clinical judgement. Navigation should not be confused with redirection, which is conducted by a clinician.</p> <p>Positive or adverse outcomes as a consequence of navigation cannot be recorded. This has clinical governance issues, specifically an absence of accountability or ability to recognise good practice. This process lacks an ability to be counted.</p>

## 5. Counting and coding

Initial assessment activity should be recorded using the Emergency Care Data Set v3 regardless of whether the streaming episode occurs in a type 1 or 3 ED. Consistent data supports management of demand and capacity, enables comparisons between sites and supports improved processes for patients. Streaming does not currently attract a national tariff under payment by result; however, local arrangements may apply.

- To record an initial assessment episode in ECDS these fields need to be completed: arrival mode,
- attendance source
- date/time of attendance
- date/time of initial assessment
- chief complaint
- acuity, including NEWS-2 score if relevant, injuries fields if relevant.

If the patient is streamed to another service (eg SDEC or UTC), the episode would include discharge status, discharge destination and, if relevant, safeguarding should also be recorded.

Treatments, investigations, or diagnosis would be necessary.

Providers should refer to the most up-to-date technical standards in the data dictionary for the clock start and stop times for any patient's journey. Policy guidance should be followed when recording the patient journey on ECDS.

It is critical that patient registration is the first step in any patient journey, so that ECDS can then accurately record all episodes of care whether the outcome of initial assessment is for the patient to remain in the ED, be streamed to a UTC or an SDEC, or to flow into another part of the hospital or offsite.

Example	Streamed to co-located UTC	Streamed to co-located SDEC
Acuity	4 or 5	3, 4 or 5
Chief complaint	From the standard ECDS list	From the standard ECDS list
Discharge status	Streamed to primary care	Streamed to ambulatory emergency care*

\* Ambulatory emergency care is now referred to as SDEC, but this change has still to be made in some systems. [NHSI SDEC](#).

[The NHS UEC Daily SitRep](#) uses the same definitions for streaming and acuity, and submissions to this collection should be consistent with those made to ECDS.

## 6. Training in initial assessment

Staff undertaking initial assessment should be registered healthcare professionals who are competent in UEC and have received appropriate training.<sup>4</sup> They will need to demonstrate well-developed interpersonal skills so they can communicate effectively with patients and their families in what is often a stressful situation. Individual departments should have an agreed and documented auditable training process for staff that includes a competency framework.

Experienced reception staff have always had a role in identifying extremely unwell patients presenting to an ED or UTC and will often alert a clinical colleague if they are concerned about a patient who has yet to have a formal clinical assessment. However, their role must be viewed as an adjunct to safety mechanisms in place and never a replacement for a timely initial assessment by a trained registered clinician.

When digital tools are used to support initial assessment, staff trained in using them should be available to support their use by patient using the tools.

<sup>4</sup> [RCN recommends the National Curriculum and Competency Framework for Emergency Nursing level 1 and 2.](#)

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## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date: 27 September 2022**

**Location: Bridge House, Sleaford**

<b>Agenda Number:</b>	6 (i)
<b>Title of Report:</b>	Financial Management Report August 2022 (Month 5)
<b>Purpose:</b>	To consider Rebecca McCauley, Senior Finance Business Partner
<b>Appendices:</b>	Appendices – Financial Tables

<b>1. Key Points for Discussion:</b>	This is a standing report to Board setting out the financial position of the Lincolnshire Healthcare NHS System and the Lincolnshire ICB as at 31 <sup>st</sup> August 2022.
<b>2. Recommendations</b>	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.
<b>3. Executive Summary</b>	<p>The report represents the closing reported position of the Lincolnshire CCG and reports the financial position of the recently formed Lincolnshire ICB based on information known on 31<sup>st</sup> August 2022.</p> <p>The Lincolnshire Integrated Care System planned to deliver a £1.5m deficit position by 31<sup>st</sup> August 2022 (Month 5). At Month 5 the system reported a £8.8m adverse variance to the plan by delivering £10.3m deficit. This is the position after accounting for an anticipated reimbursement of £1.3m for Outside of Envelope items relating to COVID-19 expenditure incurred (it is expected that this will be reimbursed to the ICB in Month 6).</p> <p>The transition from an CCG to an ICB meant that any underspend or overspend is novated between the organisations therefore the £7m underspend relating to the CCG in Q1 has been novated to the ICB. This novation is included in the month 5 numbers and provides a cumulative position for the CCG/ICB.</p> <p>The system has forecast to deliver a breakeven position for the full year, which is in line with the NHS statutory duty. Delivery of a breakeven position is however predicated on £68.3m efficiency schemes which equates to 5.5% of the system allocation and of which £19.9m is either unidentified or has high risk of non-delivery.</p> <p>On 31<sup>st</sup> August 2022 the system reported £57.3m of identified risks, of which the £19.9m unidentified efficiency is included. Only £30.0m is mitigated, leaving £27.3m unidentified. Risks are continuing to crystallise such as delays in achieving costs savings, costs of managing Covid-19, high beds occupancy and continuation of agency staff cost pressures.</p>

Lincolnshire ICS Surplus (+) / Deficit (-)	Year to Date			Forecast Outturn		
	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
NHS Lincolnshire Integrated Care Board (and former CCG)	-2.98	-2.97	0.01	0.00	-3.25	-3.25
Lincolnshire Provider Collaborative	1.50	-7.30	-8.80	0.00	3.25	3.30
<b>Total</b>	<b>-1.48</b>	<b>-10.27</b>	<b>-8.79</b>	<b>0.00</b>	<b>0.00</b>	<b>0.05</b>

### **Revenue Position – Key Points**

On 31 August 2022 the Lincolnshire system reported a £10.3m deficit against allocations and income. Against a £1.5m planned year to date deficit this represented a £8.8m adverse variance against plan. This is after the assumed reimbursement of Covid-19 outside of envelope expenditure of £1.3m.

The full year forecast positions for the ICS are all in line with the plans: The Lincolnshire ICB forecasts to deliver a £3.2m deficit for the full year (inclusive of the Lincolnshire CCG position for Quarter 1) which is offset in full by a surplus of £3.3m across the Lincolnshire NHS Provider Collaborative.

The £8.8m adverse variance reported at Month 5 relative to allocation and income was attributable to the Lincolnshire Provider Collaborative. Principal reasons for the overspend are:

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

Agency and bank spend continues to be high. If the year-to-date costs at Month 5 are straight-lined the year-to-date agency costs across the system would equate to a spend of £60.5m for the full year against a £27m cap. This is included within the risk position noted above.

### **Efficiencies**

The Lincolnshire system reported year to date efficiencies of £13.5m at 31<sup>st</sup> August 2022 against a plan of £15.8m therefore reporting a £2.3m adverse variance to plan. The forecast for the end of the year is that this shortfall is almost all recovered to leave a £0.3m deficit in efficiencies across the whole system therefore a £63.4m full year forecast against a £63.8m plan.

It should be noted that the current full year forecast is subject to system risks which are detailed below with the main risk being £19.9m unidentified system efficiencies. The most likely means to close at least part of the shortfall is through the System Improvement Plan. Three programmes are in phase 1:

- Care Closer to Home (CC2H)
- MSK
- Prescribing Initiatives

The sprint phase for the above having been completed in October 2021.

There is agreement that Frailty and Same Day Emergency Care represent the first of the Phase 2 initiatives; these have not been through a sprint phase evaluation, so benefits realization have yet to be agreed. However, these will be substantially piloted through the winter plans that are now being put in place.

It should be noted that c.60% of the projected efficiencies are deemed as non-recurrent and will not be expected to deliver savings beyond 2022-23.

## **Risks and Mitigations**

There are substantial risks to be managed if the system is to deliver a breakeven position. Most notable is the £19.9m unidentified savings target. This was part of the system financial plan and still requires the development of schemes to deliver this saving as discussed above.

The position reported at Month 5 identified a £57.3m system financial risk with potential mitigation of £30.0m but this still means that without further action the system could significantly fail to meet its financial target, by £27.3m.

As well as unidentified savings there are emerging cost pressures throughout the system. These have started to crystallise to create a year-to-date overspend due to delays in achieving savings, agency staff cost pressures and additional costs from managing COVID-19.

In addition, the system faces additional risk of £22.7m which is dependent on the two-year performance (2022/23 – 2023/24) of the ICB in delivering a balanced financial position; failure to do so would trigger the imposition of cumulative legacy CCG deficit for repayment.

## **Actions**

The considerable level of unmitigated risk will in some case translate into an impact on the financial position within subsequent months in the absence of further mitigation. This will create an adverse variance to plan and threaten the systems intention to deliver a breakeven position by the 2022/23 financial year-end. This may also have consequences relating to the imposition of cumulative legacy Lincolnshire CCG £22.7m deficit for repayment.

The following actions are underway:

1. Continuation of the investment panel and a double lock on organisational spend to control system expenditure and conduct a system level review of investments using its principles.
2. Greater focus on controls to reduce system bank and agency spend, focusing on increased use of frameworks and price cap compliance
3. 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. A commitment to take a longer-term view of the financial and efficiency position by creating an 18/24 month forecast.
5. Strive towards ensuring an in-month breakeven position by the end of March 2023.
6. Ensure accelerated processes for implementation and transformation are in place.
7. An internal audit review of system financial governance across the system.

### **4. Management of Conflicts of Interest**

None to be noted.

### **5. Risk and Assurance**

As noted within the paper.

### **6. Financial/Resource Implications**

As noted within the paper.

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

None

### **8. Health Inequalities implications**

None

<b>9.</b>	<b>Equality and Diversity implications</b>
	None
<b>10.</b>	<b>Patient and Public Involvement (including Communications and Engagement)</b>
	None
<b>11.</b>	<b>Report previously presented at</b>
	Not Applicable
<b>12.</b>	<b>Sponsoring Director/Partner Member/Non-Executive Director</b>
	Matt Gaunt, Director of Finance, <a href="mailto:m.gaunt@nhs.net">m.gaunt@nhs.net</a>

## Appendices

Table 1 - System Income and Expenditure Summary

Lincolnshire ICS Position	Year to Date			Forecast Outturn		
	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
<b>Income</b>						
ICB & CCG Allocation	254.4	254.4	0.0	1,157.8	1,157.8	0.0
Provider Patient Care Services	242.9	245.2	2.3	323.2	322.9	-0.3
Provider Non-Patient Care Services	20.2	24.1	4.0	49.5	52.8	3.3
Top-Up Funding	0.2	0.3	0.1	0.8	0.4	-0.3
<b>Total Income</b>	<b>517.7</b>	<b>524.1</b>	<b>6.3</b>	<b>1,531.1</b>	<b>1,533.9</b>	<b>2.8</b>
<b>Expenditure</b>						
Provider Staff	258.0	271.8	-13.8	628.3	631.3	-3.0
Provider Drugs & Supplies	66.3	68.1	-1.8	154.2	154.5	-0.3
Other Provider Non-Pay	55.9	55.6	0.3	141.4	141.7	-0.3
Primary Care Services (Incl. Prescribing)	131.5	127.1	4.4	317.6	317.3	0.3
Continuing Healthcare	27.0	20.9	6.1	62.7	54.0	8.7
Community Health Services (Excl. LCHS)	18.0	18.8	-0.8	46.7	48.4	-1.7
Mental Health Services (Excl. LPFT)	30.9	25.6	5.3	79.9	70.4	9.6
Acute Services (Excl. ULHT)	117.2	117.0	0.2	287.1	288.4	-1.3
Other Commissioning Spend	3.3	16.0	-12.7	2.6	15.6	-13.0
CCG - Technical Adjustment (planned deficit)	-3.0	0.0	-3.0	-3.2	0.0	-3.2
<b>Total Expenditure</b>	<b>708.1</b>	<b>720.9</b>	<b>-12.8</b>	<b>1,720.6</b>	<b>1,721.6</b>	<b>-1.1</b>
<b>Operating Surplus/Deficit</b>	<b>-190.4</b>	<b>-196.8</b>	<b>-6.5</b>	<b>-189.4</b>	<b>-187.7</b>	<b>1.7</b>
Less Non-Operating Items/Technical Adjustments	188.9	186.6	-2.3	189.4	187.8	-1.6
<b>Net Surplus/Deficit Position</b>	<b>-1.5</b>	<b>-10.3</b>	<b>-8.8</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Table 2 – System Income Summary

System Income Breakdown	Year to Date			Forecast Outturn		
	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
ICB & CCG Allocation (Excl. payments to 3 Local Provi	335.7	335.7	0.0	804.1	804.1	0.0
<b>Provider Patient Care Services</b>						
Lincolnshire ICB & CCG	305.5	305.5	0.0	740.4	740.4	0.0
NHSE Commissioned Services	39.4	40.7	1.3	94.6	94.8	0.1
CCG (Non-Lincs CCG)	5.3	6.2	0.9	9.7	9.6	-0.1
Other NHS Trusts	2.0	2.1	0.1	4.6	5.1	0.5
Local Authorities	11.2	11.5	0.3	27.0	27.6	0.6
Other NHS Bodies	0.3	0.1	-0.2	0.7	0.1	-0.6
Non-NHS Bodies	1.3	1.2	-0.1	3.1	2.3	-0.8
<b>Provider Non-Patient Care Services</b>						
Research & Development	0.7	0.9	0.2	1.8	2.0	0.2
Education & Training	10.1	11.0	0.9	24.5	26.6	2.0
Non-patient care services to other WGA bodies	2.7	4.7	2.0	6.6	10.1	3.5
Non-patient care services to other Non WGA bodies	0.9	1.0	0.1	2.0	2.3	0.3
PSF/FRF/Top-up Funding	0.2	0.3	0.1	0.8	0.4	-0.3
Income in respect of employee benefits	2.2	2.4	0.2	5.2	5.6	0.4
Rental Income	0.5	0.6	0.0	1.3	1.3	0.0
Other	3.0	3.5	0.5	8.1	5.1	-3.0
<b>Total Income</b>	<b>721.1</b>	<b>727.4</b>	<b>6.3</b>	<b>1,734.5</b>	<b>1,737.2</b>	<b>2.8</b>

Table 3 – System Expenditure Summary

System Expenditure Breakdown	Year to Date			Forecast Outturn		
	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
<b>Provider Expenditure</b>						
Staff	258.0	271.8	-13.8	628.3	631.3	-3.0
Clinical Supplies	33.5	32.4	1.1	75.8	75.2	0.6
Non-Clinical Supplies	6.2	7.4	-1.3	14.6	15.3	-0.7
Drugs	26.6	28.2	-1.6	63.8	64.0	-0.2
Establishment	0.0	0.0	0.0	0.0	0.0	0.0
Premises	0.0	0.2	-0.1	0.1	0.3	-0.2
Transport	3.4	3.6	-0.2	7.9	7.6	0.3
Depreciation & Amortisation	16.3	14.7	1.7	40.0	40.7	-0.7
Clinical Negligence	0.0	0.0	0.0	5.9	5.9	0.0
Education & Training	10.3	10.6	-0.3	24.6	24.6	-0.0
Leases	0.0	0.1	-0.1	0.0	0.1	-0.1
Other	25.8	26.5	-0.7	62.9	62.4	0.5
<b>Total Provider Expenditure</b>	<b>380.2</b>	<b>395.5</b>	<b>-15.4</b>	<b>924.0</b>	<b>927.5</b>	<b>-3.6</b>
<b>ICB and CCG Expenditure</b>						
Acute Services (Excl System Providers)	117.2	117.0	0.2	287.1	288.4	-1.3
Community Health Services	18.0	18.8	-0.8	46.7	48.4	-1.7
Mental Health Services	30.9	25.6	5.3	79.9	70.4	9.6
Continuing Health Care	27.0	20.9	6.1	62.7	54.0	8.7
Primary Care Co-Commissioning (Incl. PCN)	58.3	56.3	2.0	35.9	33.1	2.8
Other Primary Care Services (Incl. Prescribing)	73.2	70.7	2.4	281.7	284.3	-2.5
Other Commissioned Services	-2.7	10.6	-13.3	-12.1	1.7	-13.8
ICB & CCG Corporate Costs	5.9	5.4	0.5	14.7	13.9	0.8
ICB - Technical Adjustment (planned deficit)	-3.0	0.0	-3.0	-3.2	0.0	-3.2
<b>Total ICB &amp; CCG Expenditure</b>	<b>327.9</b>	<b>325.4</b>	<b>2.5</b>	<b>796.6</b>	<b>794.1</b>	<b>2.5</b>
<b>Total System Expenditure</b>	<b>708.1</b>	<b>720.9</b>	<b>-12.8</b>	<b>1,720.6</b>	<b>1,721.6</b>	<b>-1.1</b>

Table 4 – ICB Financial Summary

The table below represents the ICB position since its establishment for the 2 months from 1<sup>st</sup> July 2022 to 31<sup>st</sup> August 2022. This excludes the CCG position for the 3 months from 1<sup>st</sup> April 2022 to 30<sup>th</sup> June 2022.

Lincolnshire ICB Position (from Month 5)	Year to Date			Forecast Outturn		
	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
<b>Allocations</b>						
<b>Total Allocations</b>	<b>254.4</b>	<b>254.4</b>	<b>0.0</b>	<b>1,157.8</b>	<b>1,157.8</b>	<b>0.0</b>
<b>Expenditure</b>						
Acute Services	134.4	135.0	-0.6	608.7	610.9	-2.2
Community Health Services	25.4	26.0	-0.6	117.6	119.1	-1.5
Mental Health Services	29.1	27.6	1.6	141.3	135.5	5.8
Continuing Care Services	11.1	8.0	3.2	46.8	41.0	5.8
Primary Care Services	23.3	23.5	-0.2	2.4	1.7	0.6
Primary Care Co-Commissioning	29.7	30.1	-0.4	240.3	245.7	-5.3
Other Programme Services	-5.1	6.6	-11.7	-14.5	-2.3	-12.2
Running Costs	2.4	2.0	0.4	11.4	10.7	0.8
<b>Total Expenditure</b>	<b>250.4</b>	<b>258.7</b>	<b>-8.3</b>	<b>1,154.0</b>	<b>1,162.3</b>	<b>-8.3</b>
<b>Operating Surplus/Deficit</b>	<b>4.0</b>	<b>-4.2</b>	<b>8.3</b>	<b>3.8</b>	<b>-4.5</b>	<b>8.3</b>
Adjustment to position for ICB	0.0	1.3	1.3	0.0	1.3	1.3
<b>Net Surplus/Deficit Position</b>	<b>4.0</b>	<b>-3.0</b>	<b>-7.0</b>	<b>3.8</b>	<b>-3.2</b>	<b>-7.0</b>
<b>Lincolnshire CCG (to Month 3)</b>						
<b>Total Allocations</b>	<b>376.0</b>	<b>376.0</b>	<b>0.0</b>	<b>376.0</b>	<b>376.0</b>	<b>0.0</b>
<b>Expenditure</b>	<b>383.0</b>	<b>376.0</b>	<b>7.0</b>	<b>383.0</b>	<b>376.0</b>	<b>7.0</b>
<b>Operating Surplus/Deficit</b>	<b>-7.0</b>	<b>0.0</b>	<b>7.0</b>	<b>-7.0</b>	<b>0.0</b>	<b>7.0</b>
<b>Net Surplus/Deficit Position</b>	<b>-3.0</b>	<b>-3.0</b>	<b>0.0</b>	<b>-3.2</b>	<b>-3.2</b>	<b>-0.0</b>

Table 5 – Efficiencies

ICS Efficiencies	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m	FOT £m	FOT Variance £m
NHS Integrated Care Board	1.7	2.5	0.9	26.2	26.2	0.0
Lincolnshire NHS Provider Collaborative	14.1	10.9	-3.2	42.1	41.8	-0.3
Commissioning Efficiencies impact on Providers	0.0	0.0	0.0	-4.5	-4.5	0.0
<b>Total ICS Efficiencies</b>	<b>15.8</b>	<b>13.5</b>	<b>-2.3</b>	<b>63.8</b>	<b>63.4</b>	<b>-0.3</b>

Recurrent / Non-Recurrent Split:						
Recurrent	10.6	5.4	-5.1	51.2	28.1	-23.2
Non-recurrent	5.2	8.0	2.8	12.5	35.4	22.8
<b>Total ICS Efficiencies</b>	<b>15.8</b>	<b>13.5</b>	<b>-2.3</b>	<b>63.8</b>	<b>63.4</b>	<b>-0.3</b>

Table 6 – Risks and Mitigations

Org / System Wide	Description of risk	Likelihood	Potential Financial Impact before mitigations £m
System Wide	Delivery of waste Efficiency schemes	High	-19.9
United Lincolnshire Hospitals NHS Trust	Delivery of waste Efficiency schemes	High	-12.2
United Lincolnshire Hospitals NHS Trust	COVID-19 costs	High	-7.7
System Wide	Reductions in agency spend via escalation bed closures	High	-5.2
System Wide	Risk of the return of the funding received to address the elective backlog.	Medium	-9.6
United Lincolnshire Hospitals NHS Trust	Continued increase in inflation levels	Medium	-2.1
Lincolnshire ICB	Demand pressures in Ambulance services	Medium	-0.6
<b>Grand Total</b>			<b>-57.3</b>

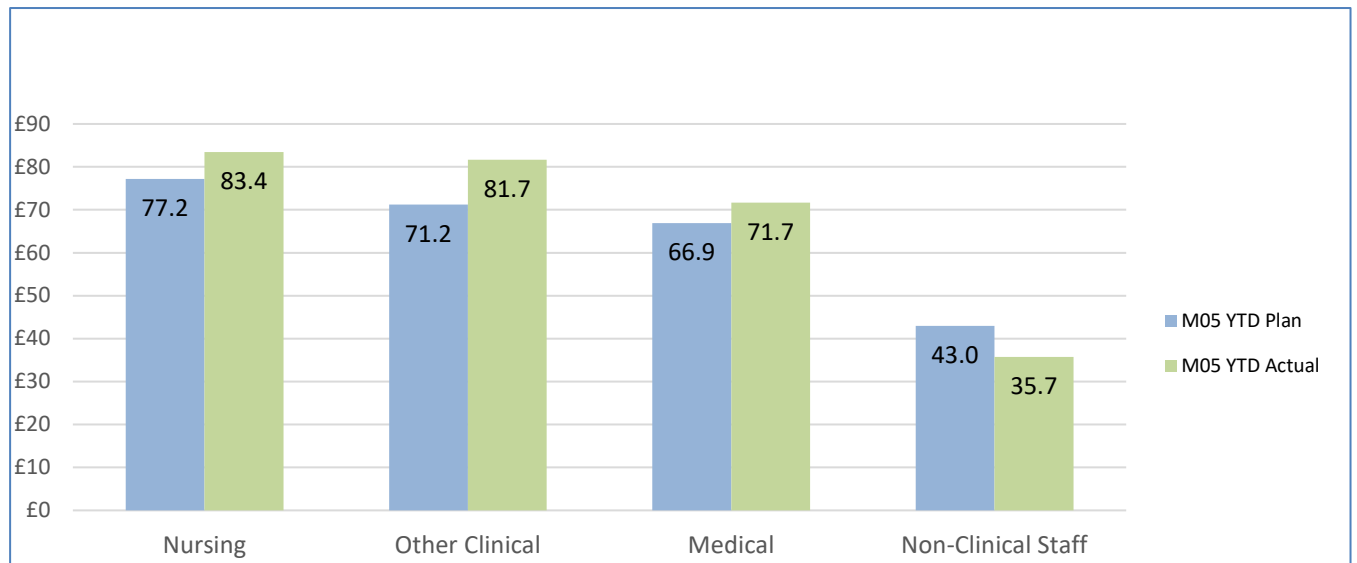
  

Mitigations			
Lincolnshire ICB	Revenue underspends		10.7
System Wide	System mitigations		19.3
<b>Total Mitigations</b>			<b>30.00</b>

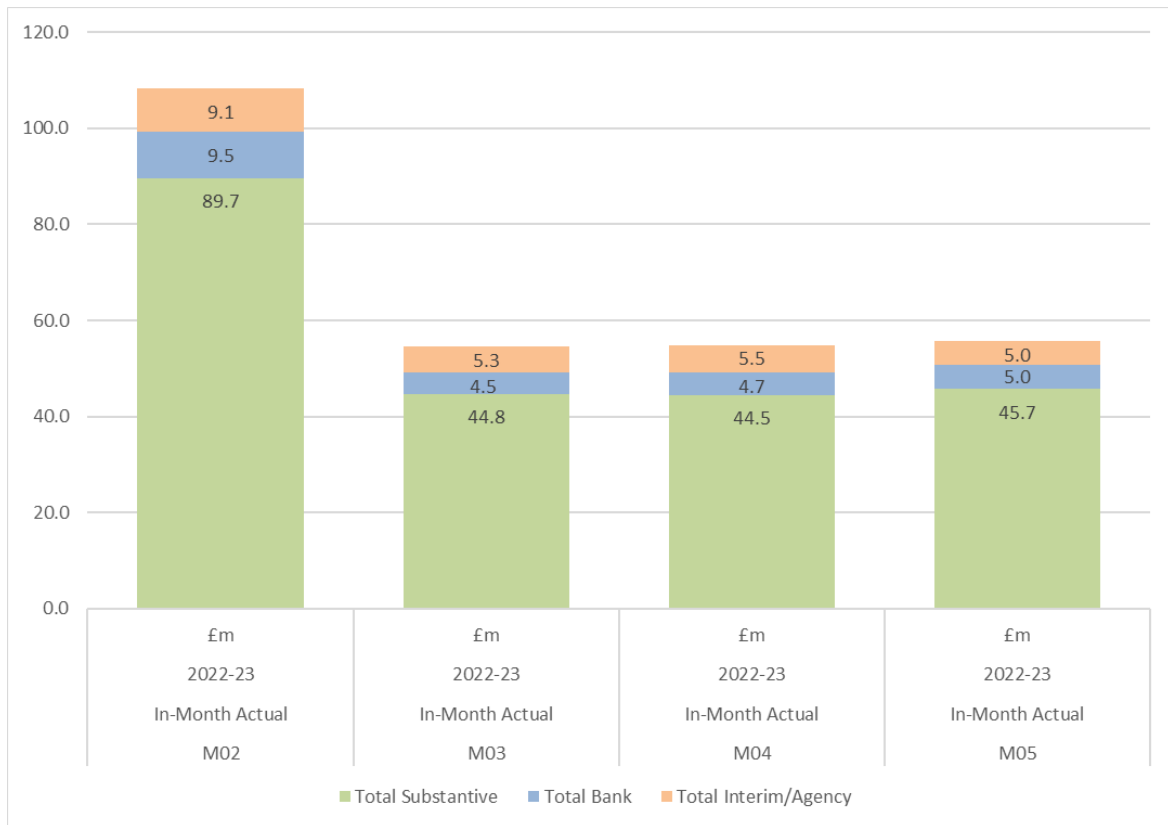
  

<b>Total Net System Financial Risk</b>	<b>-27.30</b>
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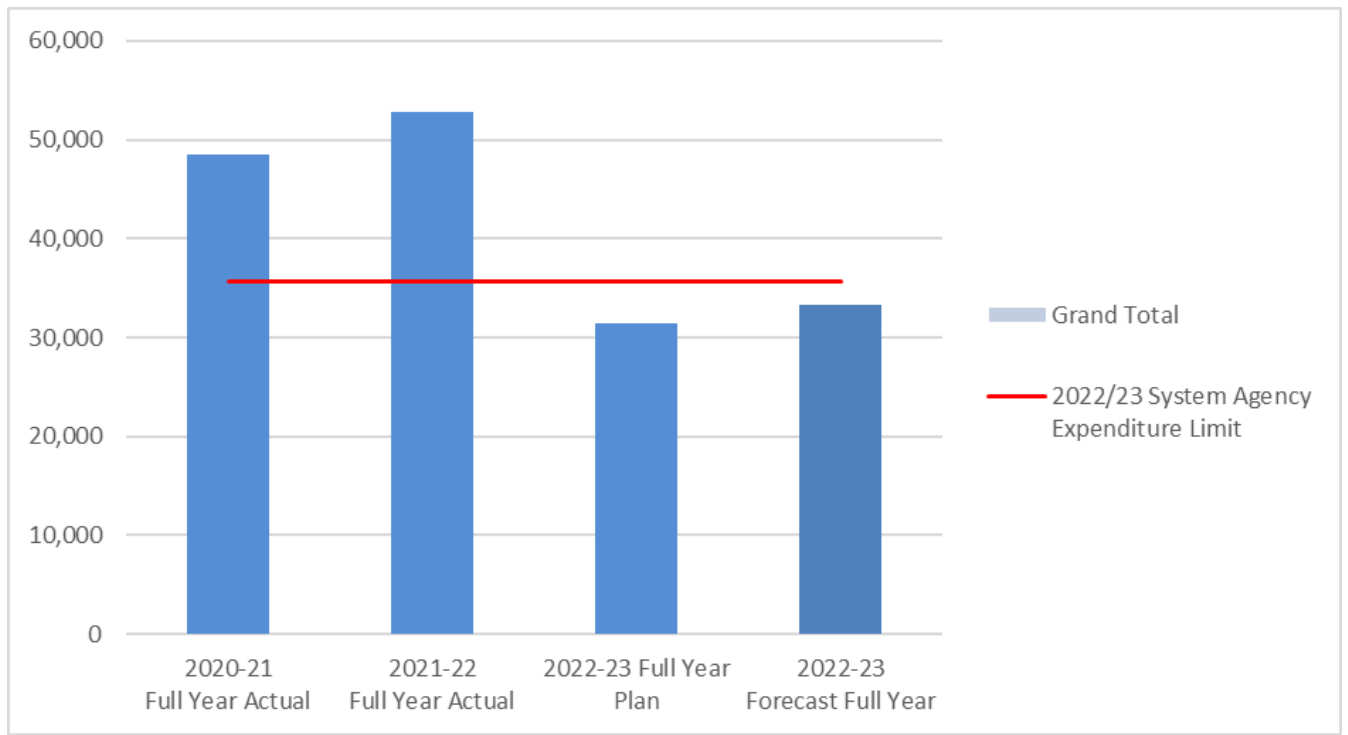
Chart 1 – Provider Staff Costs (£m)



**Chart 2 – Provider Staff Costs (£m)**



**Chart 3 – Agency Expenditure against System Agency Expenditure Limits**



## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date: 27<sup>th</sup> September 2022**

**Location: Bridge House, Sleaford**

<b>Agenda Number:</b>	7 (i)
<b>Title of Report:</b>	Cost of Living Challenge
<b>Purpose:</b>	To note Sarah-Jane Mills, Director of Primary Care, Communities and Social Value
<b>Appendices:</b>	1 – Lincolnshire Integrated Care System Cost of Living Challenge

<b>1. Key Points for Discussion:</b>	<p>The rising costs of fuel, food and other essentials are combining with existing disadvantage and vulnerability in our communities to put many households at greater risk of both immediate hardship and reduced opportunity and wellbeing. It is also placing the most vulnerable within our health and care system at significant risk.</p> <p>The Integrated Care System has commissioned a task force via the Better Lives Lincolnshire Leadership Team to develop strategic priorities and a communication strategy to enable a co-ordinated response to the challenge.</p> <p>This report provides an overview of the proposed actions for consideration by members of the ICB.</p>
<b>2. Recommendations</b>	<p>The ICB note the establishment of the task force by the ICS and confirm support for the actions outlined.</p>
<b>3. Executive Summary</b>	<p>The rising costs of fuel, food and other essentials are combining with existing disadvantage and vulnerability in our communities to put many households at greater risk of both immediate hardship and reduced opportunity and wellbeing. It is also placing the most vulnerable within our health and care system at significant risk.</p>

The Integrated Care System has commissioned a task force via the Better Lives Lincolnshire Leadership Team (BLLLT) to develop strategic priorities and a communication strategy to enable a co-ordinated response to the challenge.

A task force led by District council and Lincolnshire Voluntary Engagement Team (LVET) will be established for three months to facilitate the development of a single plan for the ICS that will enable a co-ordinated response to the cost-of-living challenge.

The Director of Primary Care, Communities and Social Value will be a member of the task force and will link with colleagues within the ICB and wider NHS to ensure they have full sight of the work plan and any actions.

The attached briefing provides an overview of the proposed framework as agreed at the inaugural meeting.

#### **4. Management of Conflicts of Interest**

Not applicable

#### **5. Risk and Assurance**

Not applicable

#### **6. Financial/Resource Implications**

The aim of the task force is to ensure that people are sign posted to support. There is no intention for the ICB will provide additional funding to individuals affected by the cost of living challenge.

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

Not applicable

#### **8. Health Inequalities implications**

The cost of living challenge is likely to impact the most disadvantaged and vulnerable across the Lincolnshire community. The Task force has identified the need to establish strong links with agencies supporting individuals who are likely to be affected by health inequalities.

#### **9. Equality and Diversity implications**

Not applicable

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

A key objective for the ICB will be to facilitate the communication of the work of the Task force and to develop a communication plan that ensures that patients and staff are able to access information.

#### **11. Report previously presented at**

Not applicable

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

Sarah-Jane Mills, Director of Primary Care, Communities and Social Value  
[Sarah-Jane.Mills1@nhs.net](mailto:Sarah-Jane.Mills1@nhs.net) Mob: 07870 898428



### **Lincolnshire Integrated Care System response to the Cost of Living Challenge**

The rising costs of fuel, food and other essentials are combining with existing disadvantage and vulnerability in our communities to put many households at greater risk of both immediate hardship and reduced opportunity and wellbeing. It is also placing the most vulnerable within our health and care system at significant risk. This at a time where there is expected to be a spike in Covid and Influenza infections. In declaring the cost of living situation as an emergency the ICS will set out measures to support residents and employees.

Working in partnership with Lincolnshire County Councils the ICB with its anchor institutions, health and care providers, police and fire, faith and community groups, charities, local business, clubs, staff and the public to maximise knowledge, identification of risk and vulnerability, capacity for targeted support, signposting to meet the needs of residents impacted at this time.

Core objectives :

- To co-ordinate
- To communicate
- To act
- To Influence

#### **Roles and responsibilities:**

The ICS will commission a Task Force via Better Lives Lincolnshire Leadership Team (BLLLT) and directly linked to develop strategic priorities and a communications strategy to enable a response to the emergency:

- Engaging and embedding the focus and response capacity in our workforce and partners
- Effective signposting and access to services
- Tackling food and fuel poverty
- Improving access to financial information and support
- Balancing direct delivery, partnership working and influencing work
- Wellbeing for residents and staff and commissioning direct support
- Health & Care Staff Health & Wellbeing Strategy

#### **At District/PCN**

Community engagement on developing the local plan for 22/23

Applied prioritisation of resources to support the most vulnerable, needs assessment  
Supporting mobilisation of community assets, community groups and volunteering  
Coordination of access to food/meal support, emergency grants, helpline  
Within gift direct support for residents and staff eg; free bus travel, vouchers, rebates  
Housing retrofit innovation and advice  
Employment advice and access to vacancies  
Connected professional relationships and agile signposting  
Access to the right service to meet the primary need  
Social prescribing  
Partnership working with faith and local groups  
Warm and friendly places  
Food banks, social supermarkets, financial advice  
Staff health & wellbeing hubs

### **At individual Leader, Professional and Staff – making every contact count...**

'How are you today' – a universal approach to connecting with others

Three key questions – *To Be Agreed*

- Have you had a hot meal today ?
- Have you spoken with anyone other than me today ?
- Are you worried about your children or loved ones ?

### **Actions:**

Agree multi-agency partnership approach led by a Task Force

Task force Led by District Council and LVET

To develop a comprehensive communications plan

District/PCN community engagement planning events

Anchor institutions involvement via Task Force and LRF

Staff engagement bringing key questions to life in practice

## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date: 27<sup>th</sup> September 2022**

**Location: Bridge House**

<b>Agenda Number:</b>	8 (i)
<b>Title of Report:</b>	Memorandum of Understanding Lincolnshire Integrated Care Board and NHS England
<b>Purpose:</b>	To note Peter Burnett – Director of Strategic Planning, Integration and Partnerships
<b>Appendices:</b>	220921 Lincolnshire ICB and NHSE Memorandum of Understanding Final V5

<b>1.</b>	<b>Key Points for Discussion:</b>
<p>The purpose of the report is to outline to the ICB Board the key features outlined in the Memorandum of Understanding (MOU) between NHS England (NHSE) and NHS Lincolnshire ICB.</p> <p>The MOU was developed in partnership with NHSE, it was presented to the Lincolnshire Leaders Group (LLG) in August and submitted to the Regional Executive Team for final approval.</p> <p>NHSE have subsequently approved the MOU and it has been signed by John Turner, ICB Chief Executive.</p>	
<b>2.</b>	<b>Recommendations</b>
<p>The NHS Lincolnshire ICB Board is requested to note</p> <ul style="list-style-type: none"> <li>• The note the agreed Memorandum of Understanding Lincolnshire Integrated Care Board and NHS England</li> </ul>	
<b>3.</b>	<b>Executive Summary</b>
<p>As Integrated Care Boards (ICBs) became statutory bodies from July 2022, NHS England regions and ICBs were required to refresh the arrangements supporting their relationships, developing how they will underpin their working arrangements in the first year.</p> <p>To support this, every ICB has been required to work with NHSE through their regional team to agree a MOU that sets out:</p> <ul style="list-style-type: none"> <li>• The principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services</li> </ul>	

- The delivery and governance arrangements across the ICB and its partner organisations
- How NHSE, ICBs and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks and support needs
- How the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

The MOU sets out the future ways of working taking account of the system architecture in Lincolnshire and outlines the approach to governance and oversight and roles and responsibilities regarding performance improvement.

The fundamental difference from the previous arrangements that were in place with NHS Systems pre-July 2022, is the ICB will be the first port of call in most circumstances from NHSE. Therefore, if NHSE have concerns with individual providers or service delivery the regional team will contact the ICB and request them to ensure they are resolved.

NHSE will also delegate duties for provider oversight and performance improvement to ICB's. The arrangements for Joint Committees with NHS Providers in Lincolnshire which were put in place when establishing the ICB will ensure this duty will be delivered. NHS Lincolnshire ICB will consult with the NHS England regional team about any areas of concern identified, specific support requirements and, where necessary, issues requiring formal intervention by NHS England. The ICB will coordinate the agreed NHS support interventions within the system.

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

<b>4.</b>	<b>Management of Conflicts of Interest</b>
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Not applicable in relation to this paper.

<b>5.</b>	<b>Risk and Assurance</b>
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Not applicable in relation to this paper.

<b>5.</b>	<b>Financial/Resource Implications</b>
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Not applicable in relation to this paper.

<b>6.</b>	<b>Legal, Policy and Regulatory Requirements</b>
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Not applicable in relation to this paper.

<b>7.</b>	<b>Health Inequalities implications</b>
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Not applicable in relation to this paper.

<b>8.</b>	<b>Equality and Diversity implications</b>
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Not applicable in relation to this paper.

<b>9.</b>	<b>Patient and Public Involvement (including Communications and Engagement)</b>
Not applicable in relation to this paper	
<b>11.</b>	<b>Report previously presented at:</b>
Not applicable	
<b>12.</b>	<b>Sponsoring Director/Partner Member/Non-Executive Director</b>
John Turner NHS Lincolnshire ICB, Chief Executive	

Classification: Official

Publications approval reference: xxxxxx



# Memorandum of Understanding Lincolnshire Integrated Care Board and NHS England

*September 2022*

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## Executive Summary

The purpose of this draft Memorandum of Understanding (MOU) is to describe the principles and collaborative ways of working that underpin how NHS Lincolnshire Integrated Care Board (ICB) and NHS England (NHSE) will work together to achieve high quality, equitable health and care services. As partners, we are committed to deliver the best for our people and our patients. The journey from Clinical Commissioning Groups to ICBs means ICBs have new statutory responsibilities and accountabilities. To deliver during this transition year, the ICB will lead the ICS, working with NHSE in its regulatory and supporting capacity, to drive delivery, transformation and performance.

There are a number of critical performance challenges which need immediate attention in 2022/23, such as urgent and emergency care, elective recovery and cancer plus key developments such as the primary care oversight framework. There will be a dedicated focus on improvement in line with the NHS Oversight Framework and planning trajectories for 2022/23. Whilst there is a focus on improving performance, quality and safety, the ICB expects to sustain areas of good delivery and work towards and improved NHS Oversight Framework rating. The MOU describes governance and delivery arrangements which includes place-based arrangements that are developing at pace. This will enable the Integrated Care System (ICS) to realise its ambition of subsidiarity with decisions taken as locally as possible.

This MOU signals a new and collaborative way of working that will provide effective support and challenge to the ICB, underpinned by joint values. The ICB, its partners and NHSE are fully committed to making this work. As such, this remains the foundation for the future ways of working and will be a live document that will be refreshed regularly.

## Introduction

Integrated Care Systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

The four key aims of an ICS are to:

- improve quality of services and 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.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people.
- supporting people to stay well and independent.
- acting sooner to help those with preventable conditions.
- supporting those with long-term conditions or mental health issues.
- caring for those with multiple needs as populations age.
- getting the best from collective resources so people get care as quickly as possible.

ICSs are led by both an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB). The ICP is a statutory committee bringing together all system partners to produce the ICSs integrated care strategy. The focus of this Memorandum of Understanding (MOU) is with the ICB as the statutory body with responsibility for NHS functions and budgets.

### Purpose of this agreement

This MOU is between the NHS Lincolnshire ICB, and NHS England Midlands region, on behalf of NHS England. It is effective as of September 2022. It sets out:

- the principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services
- the delivery and governance arrangements across the ICB and its partner organisations
- how NHSE, ICBs and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks and support needs
- how the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

This MOU is not a legally binding agreement, and it does not change the statutory roles and responsibilities or functions of either party. NHSE will continue to exercise its statutory role and powers in relation to regulatory action under legislation, including to address individual organisational issues in line with the principles set out in this MOU. The accountabilities of individual NHS organisations also remain unchanged.

In particular, it is noted that:

- this MoU does not delegate functions from NHSE to the ICB or vice versa
- NHSE's oversight delegated functions will take place in accordance with the delegation agreement.
- the MoU does not mean that functions are being exercised jointly by NHSE and the ICB within the meaning of section 65Z5 of the NHS Act 2006 (joint working and delegation arrangements) and
- references to meetings held jointly do not mean that a joint committee has been set up between NHSE and the ICB.

It is acknowledged that the MOU represents a new way of working and there will be a period of transition and bedding in required, and an associated regular review process.

## Ways of working

### Midlands Leadership Behaviours to support 'Whole System' working in the Midlands

To deliver the best for our people and our patients, we are committed to the following leadership behaviours across the Midlands.



### Rules of engagement to support 'Whole System' working in the Midlands

The following principles will inform how the ICB and NHSE will work together:

1. **First among equals whilst respecting the respective responsibilities and accountabilities.** Ways of working will be non-hierarchical and jointly owned whilst respecting that statutory roles and responsibilities of different parts of the system will still need to be carried out. Despite respective NHSE/ICB roles there are common challenges that affect us all which will require collaborative leadership to resolve.
2. **No decision about me without me.** Structures for regional decisions relating to development and improvement will include systems as part of a whole system approach. This is to ensure that decisions around regional support are informed by the knowledge, skills and experience of those leading and delivering the strategic change/operational improvement.

3. **No surprises.** Arrangements will be transitional and will need to evolve as together we build confidence and trust. Early notice of information and concerns, be open and willing to share intelligence using agreed data sources to avoid different views.
4. **No bypassing.** There will be agreed, channels of communication between the organisations, the ICB and NHSE ensuring that duplication is minimised and that the region and system role is not undermined. There should be no bypassing system or regional leadership. NHSE's primary relationship will be with national directorates and ICBs whereas ICB primary relationships will be with place, organisations and local government.
5. **ICB Oversight will be NHSE-led with oversight of NHS organisations led by the ICB - where we need to deviate from this it will be with ICB involvement.** ICBs are accountable for the oversight of NHS performance whilst NHSE remains statutorily responsible. NHSE will work with and through ICBs to discharge this function however where there is a need to respond quickly to unexpected issues or where formal regulatory action is required this will be responsibility of NHSE. In all cases NHSE decisions will include the involvement of the ICB and good relationships and communication should ensure that NHSE is sighted on local issues.
6. **Midlands and NHSE ways of working will be clearly outlined to clarify responsibilities and to avoid undermining or duplicating the role of an ICB.** Jointly agreed arrangements will be set out for Midlands System Leadership. Individual ICB/NHSE ways of working will be outlined in MOUs which are to confirm roles and responsibilities for any NHSE functions discharged or delegated by NHSE and reviewed/updated regularly as arrangements evolve. These will articulate the 'step in rights for NHSE' where required.
7. **Continue to address unwarranted variation whilst upholding the principle of subsidiarity and local flexibility.** Some things will need to be done once for consistency and or where there are benefits to economies of scale. The overriding principle however should be one of decisions being taken as locally as possible to ensure we are meeting the need of populations served.
8. **Together we will strive for excellence and harness the talent we have to improve health and care outcomes, quality and access to care and reduce health inequalities.** Where things go well, we will lock in the learning and strive to do better. When things go wrong, we will seek to understand why and learn from our mistakes.
9. **Collaboration.** All ICBs are expected to work together and with NHSE to support effective and timely delivery of care to patients and communities, and performance improvement against regional priorities. We recognise that collaborating and supporting beyond system or organisational boundaries can create additional challenges and risks locally and we will work together to quickly resolve any barriers and ensure that the positive impact of effective collaborative behaviour is duly recognised and celebrated.

## System priorities and deliverables

### Lincolnshire Integrated Care System development priorities

The NHS leadership team, alongside our ICS partners, is committed to recover from the COVID pandemic, deliver key transformation programmes and improving the efficiency and productivity of services through stronger integration and focus on population health outcomes and reduction in health inequalities.

The Lincolnshire system has a proven track-record of partnership working across organisational boundaries, which will be further developed and include local statutory and non-statutory organisations, including East Midlands Ambulance Service NHS Trust. The expectation is that this collaborative approach will continue to strengthen as the ICS matures.

Our five key deliverables for 2022/23 are as follows:

1. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards
2. Reduce the pressures on urgent and emergency care by building community care capacity – keeping patients safe and offering the right care, at the right time, in the right setting
3. Service-specific transformation:
  - a. Local Maternity & Neonatal System: three priorities of pandemic recovery; Ockendon actions and maternity transformation
  - b. Mental health service transformation
  - c. Learning disabilities and autism service transformation
  - d. Musculoskeletal services
  - e. Medicines optimisation
4. Using our collective resources more effectively and equitably to deliver agreed financial plans
  - a. Focus on population health outcomes
  - b. improving the stability of our workforce including developing new roles and reducing the usage of agency staff
  - c. Accelerating our adoption of digital technologies
5. Delivering the national ambition on integrated care
  - a. Development of a five-year Integrated Care Strategy
  - b. Developing a five-year plan ICB plan, which responds to the Integrated Care strategy
  - c. Provider Collaborative: Continued development of the Lincolnshire Health & Care Collaborative and Mental Health, Learning Disability and Autism (MHLDA) Alliance

## Recovery Support Programme

The Lincolnshire system is actively working to satisfy the exit criteria and successfully transition from NOF4 to NOF3. This is dependent on the delivery of the system-approved Strategic Delivery Plan (SDP) and specifically, the clinical transformation (being driven by the Provider Collaboratives) and the financial plan.

In terms of Regional/National assurance processes, it has been agreed to use membership of existing Lincolnshire System governance processes, as far as practical, to gain collective assurance rather than setting up new vehicles specifically:

1. Lincolnshire Health and Care Provider Collaborative Executive Delivery Board (responsible for driving system transformation programme)
2. Lincolnshire NHS Leaders Group (fulfilling the function of System Improvement Board)
3. Lincolnshire Quarterly System Review Meeting

## Our joint commitment to three key priority areas for 2022/23

### 1. **Delivering a Greener NHS:**

As a Midlands team we are committed to address the climate emergency, which is also a health emergency. Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated.

All ICS's and Providers have Green Plans in place, and NHSE will provide appropriate expertise, investment and focus to enable us to deliver as a region. Sustainability should be implicit in all considerations and decisions made and geared towards delivery of the NHS's net zero targets.

### 2. **Reducing health inequalities:**

We will work together to support tackling Health Inequalities in outcomes, experience and access.

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individual that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

There are unfair and avoidable differences in access to and experience of NHS services by different population groups. Additionally, there are healthcare inequities that could be addressed through the provision of needs based, person centred services and systems.

The Health and Care Act 2022 introduces a range of obligations on NHS bodies in relation to action on health inequalities. These new obligations are summarised in Annex A.

### 3. Supporting our People:

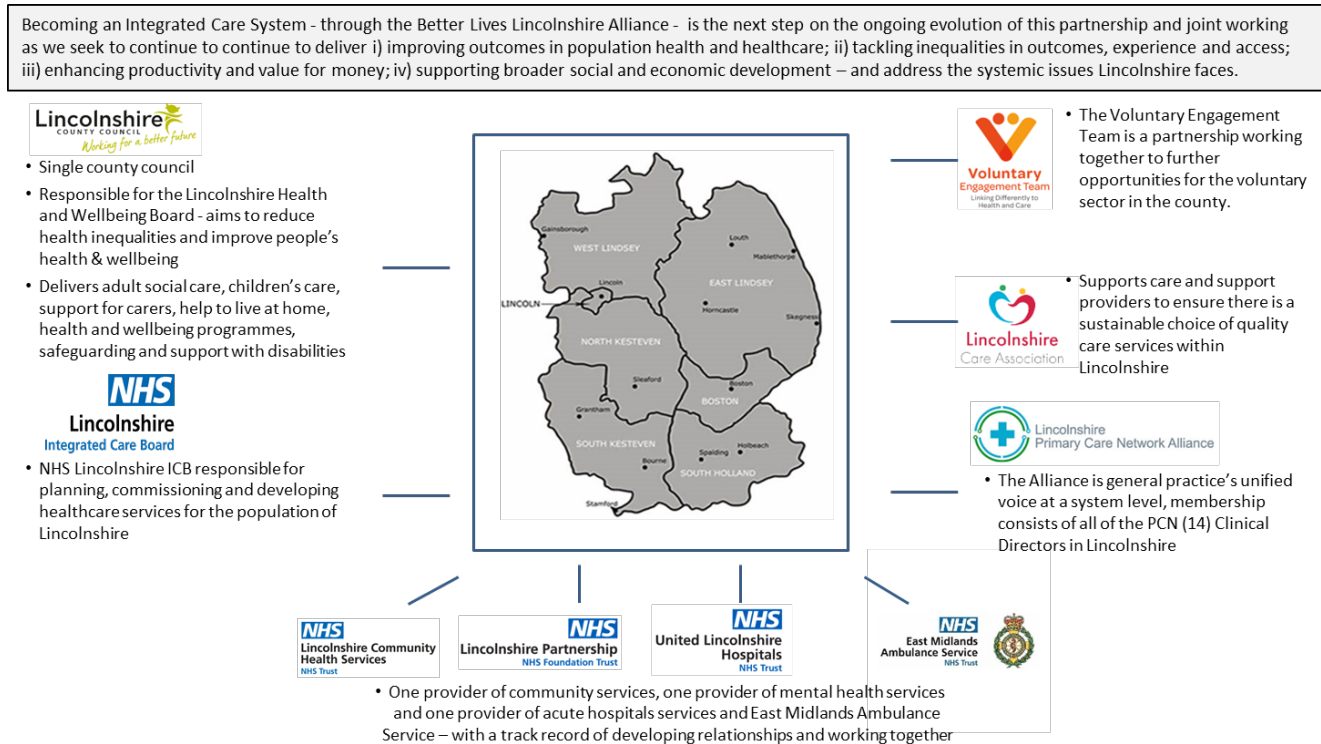
Staff are at the centre of our collective ambition for greater integration and better care and ICBs have a central role to play in delivering the vision for our 'one workforce'. As NHS leaders and organisations we will work together to deliver 10 outcomes-based functions with our partners in the ICB to make the local area a better place to live and work for their people and we will work together and through the local People Board to meet the following core objectives:

1. Supporting the health and wellbeing of all staff
2. Growing the workforce for the future and enabling adequate workforce supply
3. Supporting inclusion and belonging for all, and creating a great experience for staff
4. Valuing and supporting leadership at all levels, and lifelong learning
5. Leading workforce transformation and new ways of working
6. Educating, training and developing people, and managing talent
7. Driving and supporting broader social and economic development
8. Transforming people services and supporting the people profession
9. Leading coordinated workforce planning using analysis and intelligence
10. Supporting system design and development, to include elective care, cancer, workforce.

## ICS arrangements

The Lincolnshire ICS is a 'one place system' due to all partners being conterminous.

The partners in the ICS are as follows:

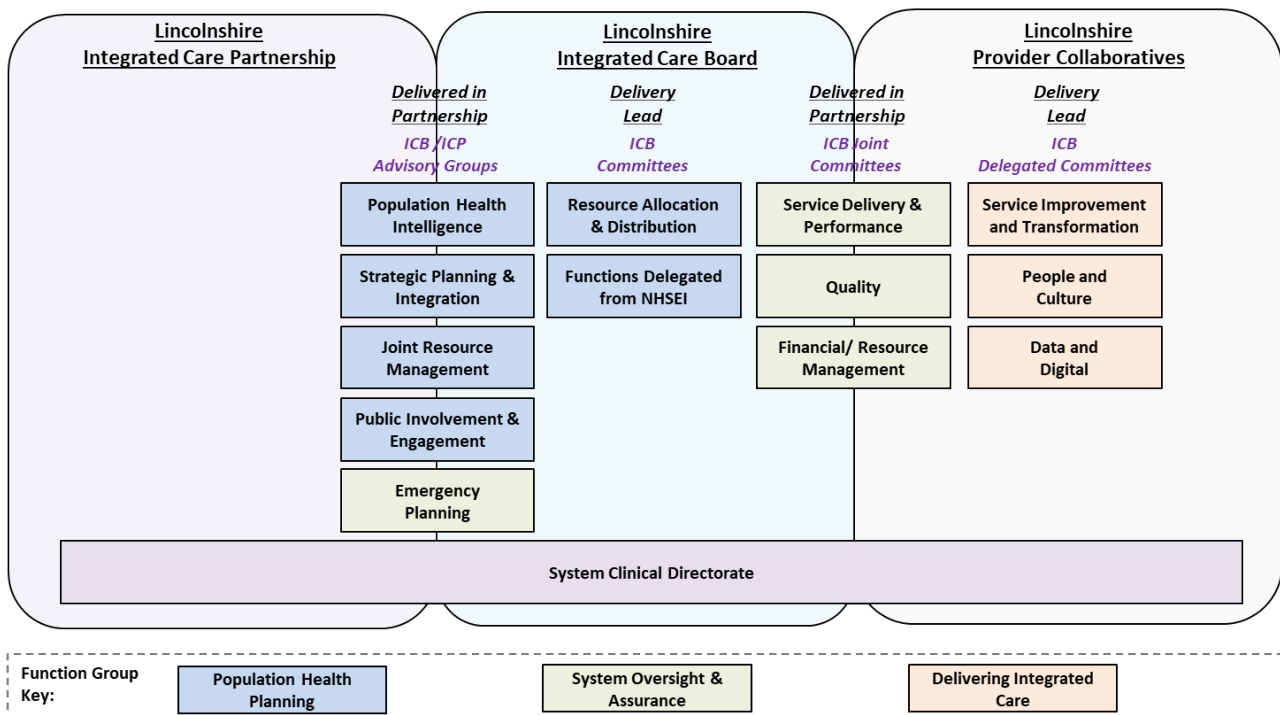


## ICB Function Map

Discussions with and feedback from stakeholders has identified the following principles for informing and shaping how the Lincolnshire ICB's functions should be delivered:

1. The ICB will be a slim organisation focussed on outcome gain improvement, strategic planning, agreeing system priorities and resource allocation – transformation, service redesign and pathway improvement will be the accountability of provider organisations (delivered through the provider collaborative).
2. The ICB will bring a greater emphasis on collaboration and driving a shared purpose, including the establishment of oversight mechanisms to provide system assurance, and avoid being drawn into the operational detail – accountability for whole system delivery and performance will sit between all partners.
3. ICB arrangements will be proportionate to facilitate transparent decision-making and empower decision making at the point of maximum positive impact to achieve the best outcomes for patients - to enable this statutory partner organisations will need to align their decision-making arrangements.
4. To drive the integration of health and care provision and ensure the NHS plays a full part in the wider social and economic development and environmental sustainability, the ICB will work in partnership with the Local Authority.
5. Support functions need to be the responsibility of the organisation they are trying to support. i.e. digital integration is to support front line staff, people board focused on workforce development of providers.

### ICB Function Map



## Provider Collaboratives

The collaboration is delivered through two principal local Provider Collaboratives which are as follows:

### Lincolnshire Mental Health, Learning Disability and Autism Alliance

In 2022 the following partners have met and agreed to form a strategic alliance partnership for Mental health, learning disability and autism in Lincolnshire. This is a developmental process and the Partners involved in this process to date are:

- NHS Lincolnshire ICB
- Lincolnshire County Council (adult social care, children's commissioning and Public Health)
- Lincolnshire Partnership NHS Foundation Trust
- Voluntary Sector Representation
- GP Primary Care Representation

The key vision of the alliance is to enable people with mental illness, learning disabilities and/or autism to live independent, safe and fulfilled lives in their local communities.

### Lincolnshire Health and Care Collaborative (Provider Alliance)

The Lincolnshire Health and Care Collaborative (Provider Alliance) has been formally established with effect from October 2021. This is a multi-agency Collaborative and the partners are currently the United Lincolnshire Hospitals Trust (ULHT), Lincolnshire Partnership Foundation Trust (LPFT), Lincolnshire Community Health Services (LCHS), the Lincolnshire Primary Care Alliance, the Lincolnshire Care Association, the Lincolnshire Voluntary Executive Team (VET) and Lincolnshire County Council.

A LHCC Delivery Board has been established composed of CEOs/Executive Leads from Collaborative members. It functions as the Provider Collaborative Leadership Board. It has agreed terms of reference.

As the Lincolnshire Integrated Care System (ICS) is currently in the NHS Oversight Framework 4 (NOF4), a primary focus of the LHCC will be delivering service redesign and transformation and improving system sustainability. There is currently a System Delivery Plan (SDP) which outlines an initial 'wave' of improvements. Achieving the objectives set out in the SDP is essential to meet the exit criteria of NOF4, and it is for this reason that LHCC is looking to implement a revised programme architecture to drive transformation and improve financial and operational sustainability.

#### Collaboration across ICBs:

- In order for an ICB to effectively discharge its functions, it will need to collaborate with other ICBs both within the region and across regional boundaries.
- NHSE/ICB ways of working will need to evolve to take account of collaborations and agreed governance including the emerging offices of the East/West Midland ICBs. This MOU will be updated to take account of those arrangements when they are clear both in terms of the governance and the activity.
- For some commissioning activity, the preference is to collaborate across East and West Midlands footprint. During 2022/23 we plan to develop the existing East and West Collaborative Commissioning Boards into formal committees / decision making bodies. This work is being led by NHSE Commissioning Directorate and the Chief Executives from the eleven Midlands ICBs.
- Some commissioning functions will be retained by NHSE and these responsibilities will also be recognised within the developing collaborative arrangements noted above.
- The ICBs have formally been delegated responsibility for Primary Medical services. NHSE will operate the support services GMAST under a separate MOU arrangement until all the other Primary Care Services - Pharmacy, Optometry and Dental are formally delegated in April 23.
- NHSE will need to engage directly with providers on specialised and directly commissioned contract arrangements and procurements, but the ICB(s) will be involved as appropriate.
- NHSE Specialised Commissioners have a relationship with mental health provider collaboratives through the NHS Standard form contract, retaining strategic commissioning and oversight and assurance functions. Multi-ICB involvement and oversight will be on an East/West Midlands basis through collaboration and agreed governance as above.
- Responsibility for complaints will be delegated to ICBs at the same time as functions are delegated but the regional complaints functions will continue to transact pending confirmation of national policy and local implementation.
- Mutual aid arrangements to support the region to meet its elective recovery plans will continue during 2022/23. Where mutual aid is provided between providers and systems, NHSE will recognise and support where an ICB has provided this capacity, including taking into account any consequential impact on the local delivery of financial and operational performance targets.

#### Single point of contact:

- The Regional Operations Centre (ROC) will become the single source of access in and out of the NHSE Midlands region for formal and / or routine communications, cascades, commissions and data requests from Regional and National teams. There will be a transitional period to confirm the scope of what is covered by the ROC and embed the new arrangements.
- The ROC will also assume a point of regional escalation and de-escalation, ensuring the appropriate records management and governance are in place for events such as critical incidents. The ROC will hold a position which considers data at a holistic pan regional level, drawing conclusions and raising alerts where links to delivery are recognised.
- SPOC address is [licb.spoc@nhs.net](mailto:licb.spoc@nhs.net)

## Governance and oversight

Corporate governance is the means by which the Board of the ICB lead and direct the organisation, to enable effective decision-making.

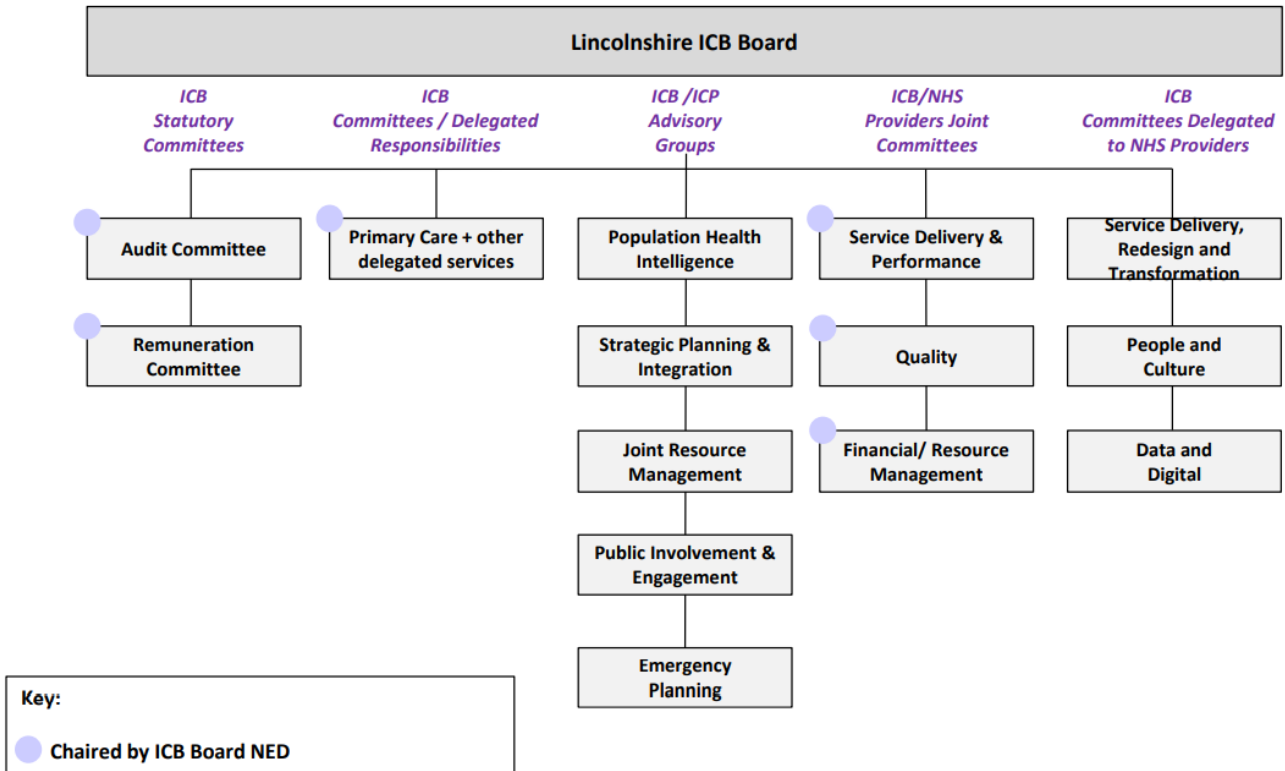
The Board will ensure that it complies with the full range of regulations and legislation to ensure the ICB is governed appropriately. Whether it is statutory requirements or NHS guidance, the ICB is legally accountable for meeting these obligations acting in the best interests of the organisation, patients, their carers and the wider community.

The ICB advocates adherence with the Good Governance Standard for Public Services as the guidance for best practice. It builds on the Nolan Principles for the conduct of individuals in public life, by setting out six core principles of good governance for public service organisations as illustrated below.

The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

- a. Selflessness – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- b. Integrity – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- c. Objectivity – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- d. Accountability – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- e. Openness – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- f. Honesty – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- g. Leadership – Holders of public office should promote and support these principles by leadership and example.

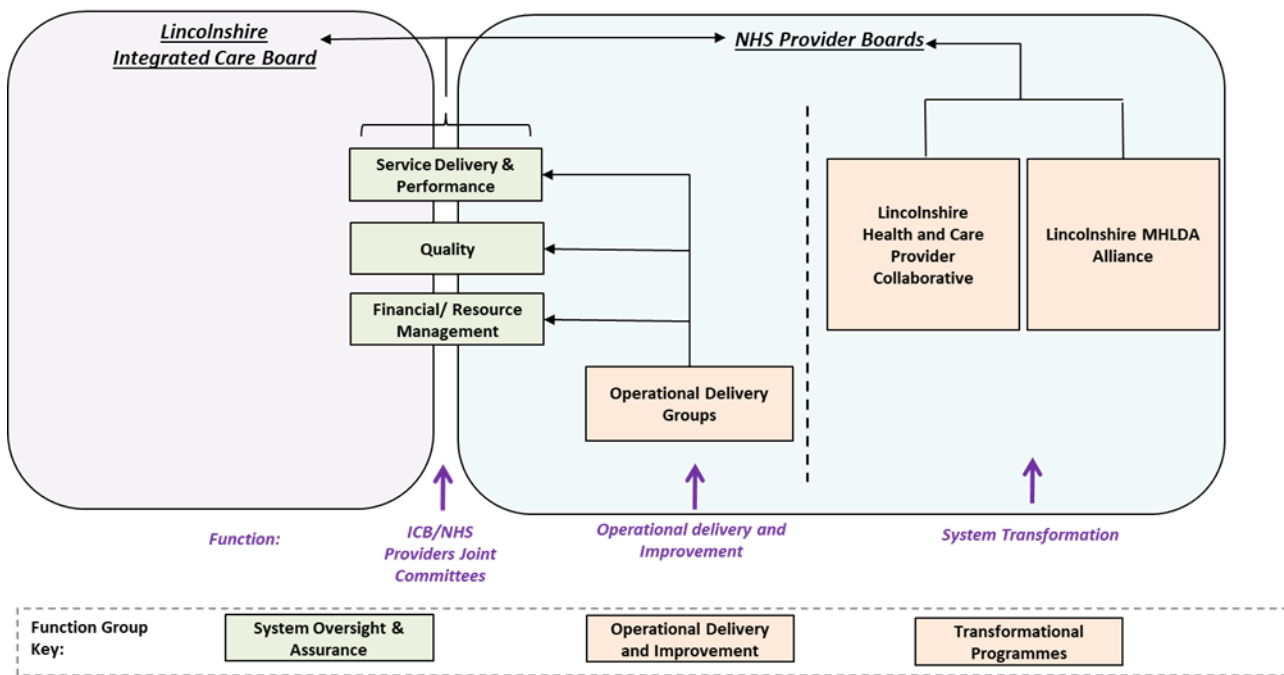
The diagram below highlights how ICB Board Members and Participants/Observers link to the wider system governance...



Sitting beneath the ICB Board there will be 14 committees and advisory groups, with four of these being chaired by a ICB NED. These range from statutory committees, i.e. Audit and Remuneration, to planning and transformation groups, delegated to local providers.

### Governance Map

Taking the agreed Lincolnshire ICBs functions map a more detailed governance map has been produced ...



NOTE: Adopted on 1 July 2022, ongoing development and evolution is expected beyond this point

## **Role of the ICB**

The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

Lincolnshire ICB is a statutory body responsible for the commissioning of healthcare services across the Lincolnshire Integrated Care System area, bringing the NHS together locally to improve population health and care. It replaces NHS Lincolnshire Clinical Commissioning Group. The statutory functions of this organisation have transferred Lincolnshire Health and Wellbeing Partnership to the ICB.

Lincolnshire ICB is part of the Lincolnshire Integrated Care System, a partnership involving the local NHS, Local Government organisations, the third sector and other relevant bodies with an active interest in the health, care and wellbeing of the residents of Lincolnshire. Together they will collaborate to address health and care inequalities, enhance integrated working, ensure optimal use of available resources and contribute to broader societal priorities.

Lincolnshire ICB is specifically responsible for a range of planning, commissioning, financial and oversight functions which will be discharged with the aims of improving the health of the local population and ensuring the efficient and effective delivery of NHS services.

**Financial governance arrangements** in line with the National Health Service Act 2006, as amended by Health and Care Act 2022, that will support the effective management of resources within the system financial envelope; including how the ICB will work with NHSE to deliver and report against the system financial plan

Finance Committee has been established to provide the ICB with assurance that it is delivering its statutory functions in relation to financial planning and management. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of financial planning and management and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

**Quality governance processes** that enable the proactive identification, monitoring and escalation of quality issues and concerns. This should include cross-system quality governance as set out in the National Quality Board's (NQB) A shared commitment to quality and in the [National Guidance on System Quality Groups](#) which sets out specific requirements for governance and intelligence sharing mechanism that ICSs are expected to have in place with system partners.

The Quality and Safety Assurance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

***Place-based governance arrangements***, including:

- decision-making, including any joint arrangements for statutory decision-making functions between the NHS and LAs
- leadership roles, for convening the place-based partnership, as well as any individuals responsible for delegated functions
- representation on, and reporting relationships with, the ICP and ICB.

The Lincolnshire place-based arrangements are focused on developing the two local provider collaboratives as detailed earlier.

The oversight process for providers will be led by the ICB and follow an ongoing cycle of monitoring performance and capability against the six themes as set out in the NHS System Oversight Framework 2022/23; identifying the scale and nature of support needs; and coordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

## Oversight Arrangements with NHSE

### NHS Oversight Framework (previously SOF)

The NHS Oversight Framework has 6 themes:

- Theme 1: Quality of care, access and outcomes
- Theme 2: Preventing ill-health and reducing inequalities
- Theme 3: People
- Theme 4: Finance and use of resources
- Theme 5: Leadership and capability
- Theme 6: Local strategic priorities

The oversight model should ensure that effective system governance and oversight arrangements should underpin regional oversight and assurance processes of the NHS Oversight Framework. Oversight arrangements should reflect a balanced approach across the six oversight themes, including leadership and culture at organisation and system level.

NHSE will ensure there are system-level oversight arrangements in place to regulate the ICB's performance that reflect both the performance and relative development of an ICS.

The ICB will take a leading role in oversight both at a local level and in the contribution and mutual accountability arrangements for Midlands wide performance, supported as necessary by NHSE, with a commitment to proportionality and minimising administrative burden. This will follow an ongoing cycle of monitoring performance and capability against the Oversight Framework and it will identify the scale and nature of support needs; coordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

Business intelligence and data-led approaches will be used to support collective effective decision making, in a dynamic and responsive manner.

#### Core objectives

- The Midlands oversight model recognises that effective system governance and oversight arrangements should underpin regional oversight and assurance processes.
- Systems will take a joint and leading role in oversight both at a local level and in the contribution and mutual accountability arrangements for Midlands wide performance, supported as necessary by NHSE, with a commitment to proportionality and minimising administrative burden.
- Oversight arrangements should reflect a balanced approach across the six oversight themes in the NHS oversight framework, including leadership and culture at organisation and system level.
- NHS Midlands role in system-level oversight arrangements will reflect both the performance and relative development of an ICS.
- The oversight process for providers will be led by the ICB and follow an ongoing cycle of monitoring performance and capability against the six themes; identifying the scale and nature of support needs; and coordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

- Business intelligence and data-led approaches will be used to support collective effective decision making, in a dynamic and responsive manner.

### All systems

**Quarterly System Review Meeting** led by NHS Midlands Regional Director.

- Purpose: formal accountability mechanism for The NHSE Regional Team to assess and assure system performance, what support is required and gather evidence for any change to provider or system NOF segmentation.

**Regional and sub-regional boards** include system SROs/professional leads.

- Purpose: mutual oversight and accountability for regional position and agreement of specific support and intervention to address underperformance.
- *N.B. specific pan-regional oversight arrangements will be discussed and agreed where oversight is required for services which across ICS boundaries. For example, for ambulance providers.*

### Most systems

**System oversight and assurance structures to include specific system: NHSE: provider oversight and assurance meetings.**

- Purpose: to discharge respective responsibilities for enhanced or intensive oversight and support. For example, to oversee elective and cancer recovery, quality and financial improvement actions or monitoring progress against provider undertakings.
- These should be agreed on a case-by-case basis between NHSE and the system and arranged to minimise the administrative and regulatory burden on challenged organisations.
- Where NHSE is part of system governance meetings, it should be clear in what capacity this is i.e. a critical friend support and / or to support mutual accountability.
- Where NHSE is not part of system governance meetings, the ICB will be responsible for notifying NHSE on any new issues or concerns relevant to statutory duties on a timely basis.
- A summary of current NHS England and Lincolnshire ICB meeting is contained in Annex D

**System review/oversight and assurance meeting**

- Purpose: review performance challenges within the system (which are driving the NOF ratings for the system and organisations), progress made and the effectiveness of interventions and support. Frequency and approach according to table below.

Segmentation level	Led by?	Frequency
NOF 1	n/a	Quarterly formal oversight sufficient unless new concerns emerge
NOF 2	System	Agreed on basis of frequency required given scale of system challenges and support required (at least quarterly)
NOF 3	System or NHSE	Monthly
NOF 4	NHSE	Monthly, more frequently as required

### NOF rating

The Lincolnshire system is currently NOF 4 and as such will be subject to regular system review meetings led by NHSE, to gain oversight and assurance that the challenged area(s) is/are being addressed and that the System Recovery Plan is in place on track to be delivered.

The communication and engagement processes associated with NHSE and Lincolnshire working together, will follow the support and guidance for systems at NOF 4, which are set out throughout this MOU.

## Roles and responsibilities in performance improvement

NHSE and the ICB are committed to working together effectively to support performance improvement locally and across the region, and in accordance with the respective roles and responsibilities outlined below.

### System

- ICBs will take a leadership role in driving improvement across the system, including ensuring that a quality improvement methodology underpins the approach within the ICS. In Lincolnshire, this transformation will be driven through the Provider Collaborative.
- ICBs will co-ordinate NHS support interventions within their system, where appropriate, working in partnership with NHSE, including to jointly review the impact of interventions.
- Systems are responsible for ensuring that the system develops, monitors and oversees plans to meet the agreed 'exit criteria' for systems and organisations receiving mandated support.
- Common exit criteria:
  - Realistic and ambitious recovery/improvement plan developed
  - Key trajectories being delivered
  - The system has the capacity and capability to deliver the key requirements agreed with NHSE
  - The system is proactively taking relevant actions to ensure that deliverables are maintained.

### Region

- Regional support will focus on learning and improvement by:
  - Working with the local system to develop capability and capacity
  - Bringing systems together and/or with experts/peers to share learning and facilitate the adoption of best practice and innovation
  - Embedding colleagues within the system to provide solution focused support, that supports problem solving and sharing of best practice
  - Supporting peer review e.g. of service quality, the model of care, the governance or the approach to quality assurance or improvement etc.
- Regional support will be tailored according to NOF segmentation level.
- Clinical Professional Leadership (CPL) to be a critical element of leadership to quality and clinical transformation agenda, working with regional leads on system quality groups, supported by quality leads meetings to review progress against improvement plans/quality metrics/SI thematic reviews/learning.
- Support will also be provided via Clinical Network Infrastructure and we will agree the approach and interfaces with system leadership.
- Support and facilitation to mediate or intervene where there is conflict or a difference of opinion within the ICB or between ICBs.
- Manage the interface and accountability of the region with the national team.
- Conduct the annual performance assessment of the ICB in each financial year and publish a summary of its findings

## System & Region

- Regular engagement between NHS Midlands SMEs / professional leads and system counterparts to:
  - Support individuals in their respective roles
  - Understand the current position
  - Assess what support and input would be helpful
  - Contribute to the development and implementation of improvement actions.
- NHSE will work with systems to identify quality, financial and operational improvement and transformation actions; and design bespoke support as and when mandated, required or requested. This will be linked to NOF and for all domains as necessary.
- NHSE relationship leads will work with systems on oversight infrastructure to provide support/critical friend input into forums such as boards for UEC, elective and cancer.
- NHSE and systems will collaborate through regional forum, such as the finance leadership group.
- Where new concerns are identified, rapid risk and review (or escalation) meetings will be used as a consistent approach to understand issues, agree actions and outcomes required. To include what further support is required, future monitoring and co-ordination arrangements.

## Overarching approach to risks and escalation

The approach to the escalation of issues within the ICB or by NHSE with the ICB or provider is dependent on the segmentation of the ICB, current levels of oversight, as well as the specific metrics and qualitative factors.

The 2022/23 [NHS Oversight Framework](#) outlines the key metrics which will be considered by NHSE to assess performance of the system and providers against six key themes or domains. Included in Annex B are some key qualitative indicators, which will influence NHSE's judgement regarding escalation levels and interventions, however, the new framework should be referred to in full for guidance on segmentation and metrics.

For individual providers, NHSE and the ICB will together discuss segmentation and any support required. However, NHSE will be responsible for making the final segmentation decision and taking any necessary formal enforcement action. Where there is a deterioration in segment NHSE and the ICB will agree exit criteria which will need to be met to exit mandated support and move to a lower segment.

## ICS development

- Systems will continue to produce plans, e.g. Five Year Forward Plan and Integrated Care Strategy, which will evolve in response to system priorities and national policy development.
- NHSE will provide an allocation of funding (figure TBC) for system development and system participation in the co-design of policy related to the long-term ambition and vision for ICSs.
- NHSE will continue to broker regional and national support in relation to needs identified in system development plans.
- NHSE will work collaboratively with systems to support the interpretation and implementation of national policy and share learning and good practice in relation to ICS development.

There are two core functions when considering ICS development:

1. Regulatory and governance oversight which is linked to National operating framework (NOF) set out above and
2. Operational and functional support.

It is considered that operational and functional support aligns to the key priority areas requiring support (as set out on page 8 and the support offer determined as to which group the priority falls into as set out below.

### **Triggers and escalations**

#### **Regulatory/governance:**

Linked to NOF.

- |       |  |
|-------|--|
| NOF 1 | No interventions- provider/system manages themselves   |
| NOF 2 | System intervention & oversight- No formal NHSE intervention but will be aware through governance reporting routes of issues. May be asked to support. |
| NOF 3 | Joint system and NHSE intervention. Agreed areas of support, NHSE offering advice and guidance, resource and expertise, areas of best practise, etc.   |
| NOF 4 | Regional and/or national NHSE intervention with intensive support. Escalation is via governance reporting structures/boards and via the QSRM           |

#### **Operational/functional:**

Linked to local involvement and agreed triggers & escalation. Linked to the escalation (RAG) in the MOU.

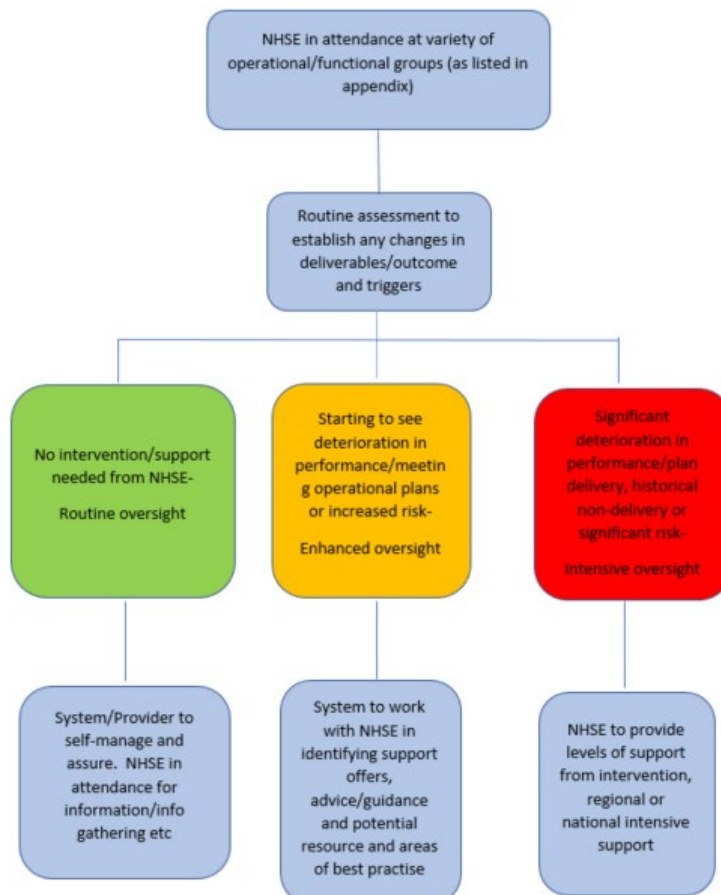
For example, if NHSE have a seat on the elective board:

- 1) **GREEN**. There are no issues. They would be classed as green, with no intervention required. NHSE will be aware of the work, progress and performance for reporting purposes, but no formal assurance processes needed.
- 2) **AMBER** If an area in electives begins to identify risk through the local risk stratification models or seeing a dip in performance with either known reasons or through another areas of concern, NHSE will be able to offer support/advice, etc. (as per NOF 3 process). Will involve potential support/advice/guidance/resource and or further intervention as required.
- 3) **RED** If an area has significant performance or risk issues as a result of long standing/historical performance or a significant event leading to high risk, not meeting operational plans or poor patient experience/outcomes, etc., similar to NOF 4, in that NHSE will support through intervention with the system, identifying actions/support offers and potential escalation into tier meetings/quality summits, etc., as required.

The structure for the MOU will be the skeleton above and then the functional areas will be able to develop local triggers and escalation as required.

System to lead the triggers with NHSE supporting and identifying support offers.

### Flow diagram for operational functional process



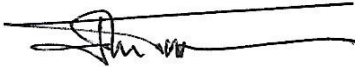
## Reviewing, amending, and monitoring of the MOU

This MOU relates to an ongoing relationship between the ICB and NHSE and will be formally reviewed and renewed on an annual basis. The ICB and NHSE agree to review the agreement every 3 months to assess whether it is still accurate and fit for purpose, as an output of the Quarterly System Review Meeting and taking account of any changes in NOF segmentation.

Changes to the MOU required outside of the proposed review period can occur at any time, if agreed by both parties.

## Signatures

The ICB and NHSE, as represented by the below officers, agree to honour the aspirations and commitments made in this MOU.



**John Turner, Chief Executive Officer, Lincolnshire ICB**



**Oliver Newbould, Director of Strategic Transformation, NHS England – Central Midlands**

**September 2022**

## Annex A: Obligations on Health Inequalities

### New ICB obligations on health inequalities

- A new duty on health inequalities for ICBs: ‘Each integrated care board must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between persons with respect to their **ability to access health services**, and (b) reduce inequalities between patients with respect to the **outcomes achieved for them by the provision of health services.**’
- A new **quality of service** duty on ICBs which includes addressing health inequalities.
- A duty to **promote integration** where this would reduce inequalities in access to services or outcomes achieved.
- Duties on ICBs in relation to several other areas which require consideration of health inequalities – in making wider decisions, **planning, performance reporting**, publishing certain reports and plans, **annual reports and forward planning**.
- In addition, each ICB will be subject to an **annual assessment** of its performance by NHS England, which will assess how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

### New requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts

- NHS England must publish a statement about use of information on inequalities in access and outcomes, setting out the powers available to bodies to collect, analyse and publish such information, and views about how the powers should be exercised.
- NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed

## Annex B: Key factors in NHSE escalation and intervention decisions

### **System Oversight Framework**

The 2022/23 System Oversight Framework outlines the key metrics which will be considered by NHSE to assess performance of the system and providers against 6 key domains.

### **Key qualitative factors**

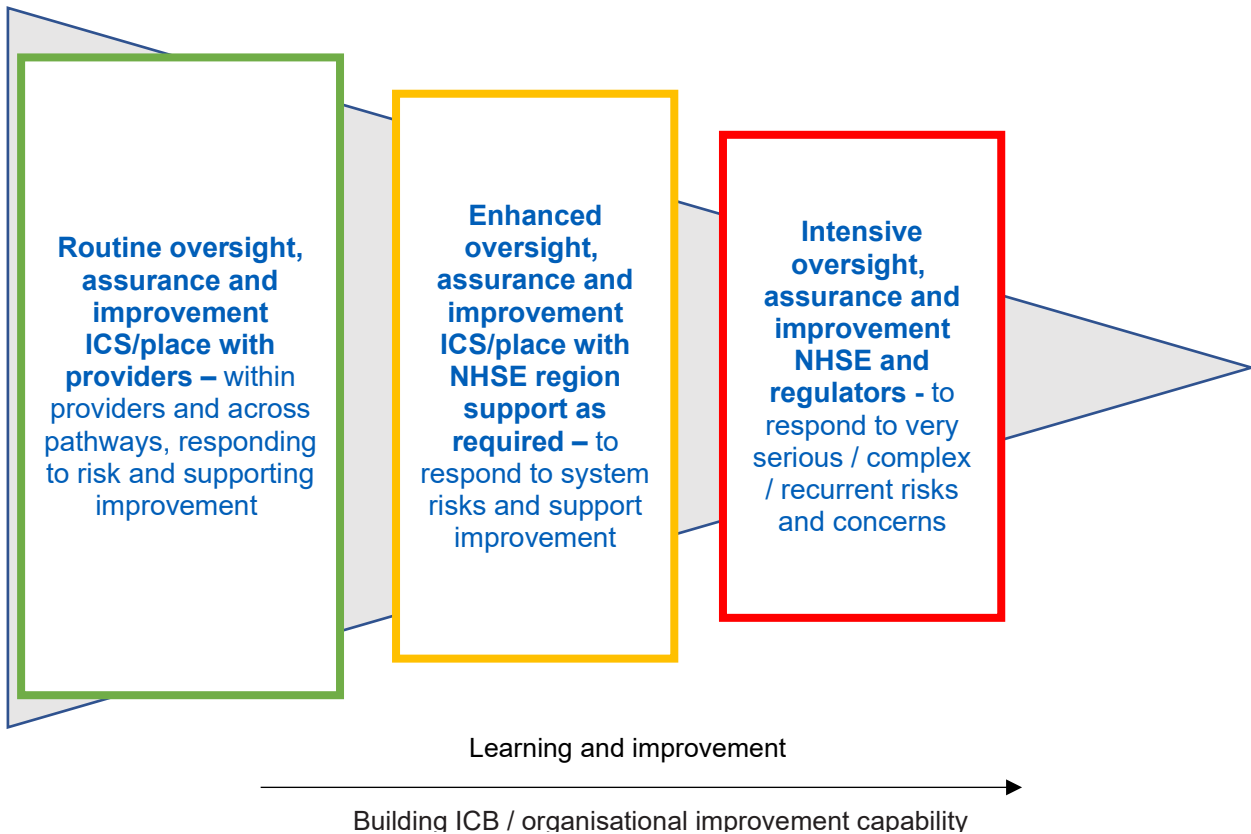
which will influence NHSE's judgement regarding segmentation decisions and if regulatory intervention is required (as a last resort):

- Lack of assurance that the issue/ concern is being addressed or managed in a timely and effective manner by the ICB
- System tensions or conflicts of interest, e.g. a whistleblowing report about an ICB exec lead
- Poor engagement with regional teams
- Lack of effective system collaboration to drive improvements
- Lack of robust governance and oversight arrangements within the ICS or within a provider
- Material concerns regarding the structure, leadership, and culture of an ICB
- Evidence that the ICB or a provider lacks the capacity and capability to effectively address the issue

### **Instances where NHSE might by-pass the system**

- Evidence of a conflict of interest
- A need to act rapidly to protect patients or staff (but we would notify the ICB at the earliest opportunity).
- Evidence of a failure of system governance to identify the issue
- Whistleblowing issues raised with NHSE

## Annex C: Escalation approach



The different escalation levels are as follows:

- Routine oversight, assurance and improvement:
  - Day-to-day activity when there are no risks or minor risks which are being addressed effectively
  - Includes standard monitoring and reporting, due diligence and contract management.
- Enhanced oversight, assurance and improvement:
  - Undertaken when there are system risks that are serious, complex and/ or recurrent and require action/ improvement plans and support.
- Intensive oversight, assurance and improvement:
  - When there are very serious, complex or recurrent risks, which require intensive support, including mandated support from NHS England for recovery and improvement.

## Annex D: NHS England and Lincolnshire ICB Meetings structure

Name of meeting	Frequency	Lead	NHSE attendance	Purpose of NHSE involvement*
<b>Statutory</b>				
Lincs ICB	Monthly	ICB	S&T	
Lincs ICP	Quarterly	ICB	S&T	
HWBB	Quarterly	LA	S&T	Concurrent meeting
Planning review	Weekly	Joint Lincs& NHSE	S&T	Assurance/oversight/support
Strategic Command Group	Ad hoc	ICP	S&T	Incident management
Lincolnshire System Quality Group	Bi-monthly	ICB	N&Q	Assurance/oversight/support
<b>Functional</b>				
Lincolnshire Leaders Group	Monthly		S&T	
Cancer Board	Monthly	Lincs Cancer lead	S&T Cancer Alliance	Info gathering/Support
Elective Board	Monthly	Lincs elective lead	NHSE transformation team	Info gathering/Support
Urgent care board	Weekly	Lincs UEC Lead	S&T/UEC	Oversight/support/info
People board				
Digital board				
MH LDA Alliance				
Transforming care				
System escalation calls UEC	Daily (+ x2)	Lincs UEC Lead	S&T/UEC	Operational oversight & support

Classification: Official

Primary Care and Integrated Commissioning Committee	Monthly		Caroline Goulding/ Anna Nicholls	
Service Delivery and Performance	Monthly	Joint committee with providers	x	
Lincs Performance support call	Fortnightly	Joint Lincs & S&T	S&T	Support/oversight
Quality ICB Joint Committee	Monthly	Joint committee with providers	x	
Finance and Resource Management	Monthly	Joint committee with providers	x	
Programme Oversight Group (used to be Community MH Transformation Group)	Monthly	Joint committee with providers	Angela Heathcote	
MHLDA Partnership Group	Monthly	Joint committee with providers	Angela Heathcote	
Dementia Expert Reference Group	Monthly	Joint committee with providers	Angela Heathcote	
Out of Area Reduction meeting	6-weekly	Joint committee with providers	Angela Heathcote	

## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date: 27<sup>th</sup> September 2022**

**Location: Bridge House, Sleaford**

<b>Agenda Number:</b>	8 (ii)
<b>Title of Report:</b>	Proposed amendments to the NHS Lincolnshire ICB Constitution
<b>Purpose:</b>	For approval Mrs Jules Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance
<b>Appendices:</b>	Annex B - Summary of Required Amendments to the ICB Model Constitutions Document

<b>1.</b>	<b>Key Points for Discussion:</b>
<p>The ICB received an email from the NHS England Midlands Strategy &amp; Planning Team on the 15<sup>th</sup> September 2022 advising that they had been asked to make the ICB aware of the attached technical amendments which will need to be made to all ICB Constitutions.</p>	
<b>2.</b>	<b>Recommendations</b>
<p>The ICB Board is asked to approve the proposed amendments.</p>	
<b>3.</b>	<b>Executive Summary</b>
<p>Following commencement of the Health and Care Act (2022) NHSE's legal team conducted a review of the model constitution that was published by NHSE in May 2022 and identified several small amendments that need to be made. These are summarised in the attachment marked Annex B.</p> <p>The Board is asked to approve these amendments along with a change to section 1.6.2 (a) as below.</p> <p>From:</p> <ul style="list-style-type: none"> <li>• The Chief Executive may periodically propose minor amendments to the Constitution which shall be considered and approved by the ICB prior to submission to NHS England.</li> </ul> <p>To:</p> <ul style="list-style-type: none"> <li>• The ICB Constitution currently states under section 1.6.2 that the Chief Executive may periodically propose minor amendments to the Constitution which shall be actioned and submitted to NHS England.</li> </ul>	

The Board is asked to approve the proposed amendments for submission to NHS England in line with their *Guidance to Integrated Care Boards on applying to NHS England to amend their Constitution* as published in July 2022.

**4. Management of Conflicts of Interest**

The Constitution sets out the arrangements for managing Conflict of Interests.

**5. Risk and Assurance**

No direct implications for this paper.

**6. Financial/Resource Implications**

No direct implications for this paper.

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

As detailed in Annex B to the paper.

**8. Health Inequalities implications**

No direct implications for this paper.

**9. Equality and Diversity implications**

Not direct implications for this paper.

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

No direct implications for this paper.

**11. Report previously presented at**

The ICB Constitution was presented to the ICB Board at its inaugural meeting held on the 1<sup>st</sup> July 2022.

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

Jules Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance –  
[julieellis1@nhs.net](mailto:julieellis1@nhs.net)

## **Annex B**

### **Summary of Required Amendments to the ICB Model Constitutions Document**

Following commencement of the Health and Care Act (2022) NHSE's legal team conducted a review of the model constitution that was published by NHSE in May 2022 and identified several small amendments that need to be made. These are summarised as follows:

- Section 1.4.7 (f) – Health and Care Act reference 'section 14Z44' corrected to read 'section 14Z45'
- Section 3.2.4 – Reference to the 'sections 56A to 56K of the Scottish Bankruptcy Act 1985' replaced with 'Part 13 of the Bankruptcy (Scotland) Act 2016'.
- Section 3.2.7 – 'A health care professional (within the meaning of section 14N of the 2006 Act)....'. First line updated to remove reference to section 14N of the 2006 Act and capital letters for 'Health Care Professional'. Line to read as follows 'A Health and Care Professional or other professional.....'.
- Section 7.1.1 – Reference to 'paragraph 11(2)' amended to 'paragraph 12(2)'.
- Appendix 1 – Add definition of 'Health Care Professional' to the table. Definition to be added: 'An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.'

## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date:** 27<sup>th</sup> September 2022

**Location:** Bridge House, Sleaford

<b>Agenda Number:</b>	8 (iii)
<b>Title of Report:</b>	Update from Finance and Resource Committee
<b>Purpose:</b>	For information Julie Pomeroy – Non-Executive Member & Chair of Finance & Resource Committee
<b>Appendices:</b>	None

<b>1.</b>	<b>Key Points for Discussion:</b>
<p>The purpose of this paper is to provide the Board with a summary of the Inaugural ICB Finance and Resource Committee held on 16 September 2022.</p>	
<b>2.</b>	<b>Recommendations</b>
<p>The Board is asked to note and consider this report.</p>	
<b>3.</b>	<b>Executive Summary</b>
<p>This was the first meeting of the Finance and Resource Committee and was held on held on 16 September 2022. The Committee focused on the following key areas:</p> <ul style="list-style-type: none"> <li>• <b>Terms of Reference</b> – These were presented in draft for approval with key amendments noted as follows:             <ul style="list-style-type: none"> <li>○ <b>Membership</b> – All Provider Directors of Finance (not a nominated), All Provider Directors of Operations, a quality representative requires further consideration.</li> <li>○ <b>Vice Chair</b> – requires further consideration.</li> <li>○ <b>Frequency</b> – to be held monthly for at least the first year i.e. up to March 2023.</li> </ul> <p>Compare and contrast with Provider Finance Committee (or equivalent) Terms of Reference.</p> </li> <li>• <b>Ways of Working</b> – At the next meeting there will be a discussion on content i.e. how discussions will take place at the appropriate level with presentable information that supports strategic aims and high level of complexity. At times there will be operational drivers, strategic risks and opportunities. Review papers at the end of every meeting to assess understanding, what needs to be better, views from members. Agree any items of risk for escalation to Boards.</li> <li>• <b>System Financial Report</b> – The Month 5 report for the system was presented and</li> </ul>	

the Committee noted that all 3 providers in Lincolnshire have been without a ledger to work with (due to a cyber-attack) and so M5 reports from providers are based on M4 figures adjusted for known in-month movements. The system has a target of £1.478m deficit at M5, and a plan to breakeven against allocations by the end of March 2023. The actual position is a deficit of £10.267m, so £8.789m adverse variance to plan.

The forecast is to recover and have a small surplus of £0.049m, but this is subject to substantial risks.

- **Risks** - substantial financial risks exist in the system with regard to delivering the year end position. The need to take a longer term view of efficiency schemes over a 18 to 24 month rolling period was agreed. Urgent action was needed to minimise and mitigate these risks
- **Q2 Financial Stocktake** – The Committee received a presentation and noted that early indications showed that the position is not improving across the system. Monthly monitoring will continue with updates provided to the Committee.
- **Investment Panel Report** – The ICS Investment Panel had met for the first time on 31.08.22 and the Committee received a report detailing the recommended actions. The Panel had been well received and the next one will be on 19.10.22.
- **Items for Escalation to Boards** – The Committee considered the following to be escalated:
  - Delivery of the system plan is a significant risk with some high-risk items. Mitigations continue to be worked through.

#### 4. Management of Conflicts of Interest

No conflicts of interest were declared at the committee.

#### 5. Risk and Assurance

No escalations from the establishment committee meeting

#### 6. Financial/Resource Implications

As per the reports presented.

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

N/A

#### 8. Health Inequalities implications

N/A

#### 9. Equality and Diversity implications

N/A

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

N/A

#### 11. Report previously presented at

N/A

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

Julie Pomeroy – Non-Executive Member & Chair of Finance & Resource Committee –

[julie.pomeroy1@outlook.com](mailto:julie.pomeroy1@outlook.com)

Matt Gaunt, Director of Finance – [m.gaunt@nhs.net](mailto:m.gaunt@nhs.net)

## Public Meeting of NHS Lincolnshire Integrated Care Board

**Date:** 27<sup>th</sup> September 2022

**Location:** Boardroom, Bridge House, Sleaford

<b>Agenda Number:</b>	8 (iv)
<b>Title of Report:</b>	Update from Service Delivery & Performance Committee
<b>Purpose:</b>	For information
<b>Appendices:</b>	None

<b>1. Key Points for Discussion:</b>
The purpose of this paper is to provide Board a summary of the inaugural ICB Service Delivery & Performance Committee in September 2022.
<b>2. Recommendations</b>
The Board is asked to note and consider this report.
<b>3. Executive Summary</b>
<p>This was the first meeting of the committee aimed at ensuring members were clear on the purpose, the role within the wider governance and to approve the Terms of Reference.</p> <p>The meeting received information and background on:</p> <ul style="list-style-type: none"> <li>• <b>ICB Function Map &amp; Governance</b></li> <li>• <b>Terms of Reference</b> - these were agreed with a commitment that a further discussion would take place at the December meeting to review implementation and discuss some additional points in relation to patient voice.</li> <li>• <b>Forward Work Plan</b> - a work programme has been developed to cover the performance areas the Committee will oversee and assure and was approved. The work programme has been split into three distinct categories that require updates to be provided on either a bi-monthly, quarterly or half yearly basis. Bi-monthly will include: Operational Delivery Programmes (Cancer, Planned Care, Urgent and Emergency Care, Mental Health, Integrated Primary and Community Care); Quarterly:- LHCC Programmes (Digital, People Plan, Lincolnshire Health Care Collaborative); Half yearly:- Estates and Infrastructure, Green Plan. It was proposed that performance on Health Inequalities needed to be included in the forward work plan.</li> <li>• <b>Lincolnshire System Plan 2022/23</b> - the plan gave visibility of all system change initiatives for 2022/23. The plan provides the context for the committee's oversight of service delivery and performance.</li> <li>• <b>Lincolnshire System Performance Report</b> - the report shows the performance variance of key metrics for monitoring the delivery of the Lincolnshire System Plan. The committee felt assured that the right level of information was contained but that it required a dashboard summary.</li> </ul>

- **Next Steps in Increasing Capacity & Operational Resilience in Urgent and Emergency Care Ahead of Winter** - an update on development of the Winter Plan and Assurance Framework was given, the Committee agreed it would need to see the plan and monthly delivery throughout the Winter period to enable any appropriate escalation to the Board. The update outlined the core objectives and actions.
- **Escalation Report for Boards** – It was recognised that a report would go to the ICB Board but agreed this should be shared with all boards on the joint committee.

#### 4. Management of Conflicts of Interest

No conflicts of interest were declared at the committee.

#### 5. Risk and Assurance

No escalations from the establishment committee meeting

#### 6. Financial/Resource Implications

N/A

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

N/A

#### 8. Health Inequalities implications

N/A

#### 9. Equality and Diversity implications

N/A

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

Discussed the role of PPI in the committee – deferred to December meeting once established.

#### 11. Report previously presented at

N/A

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

Dawn Kenson – Non-Executive Director & Chair of System Delivery & Performance Committee – [d.kenson@nhs.net](mailto:d.kenson@nhs.net)  
 Clair Raybould – Director for System Delivery – [clair.raybould@nhs.net](mailto:clair.raybould@nhs.net)

## BOARD COVER SHEET

### Public Meeting of NHS Lincolnshire Integrated Care Board

**Date: 27<sup>th</sup> September 2022**

**Location: Bridge House, Sleaford**

<b>Agenda Number:</b>	8 (v)
<b>Title of Report:</b>	Audit & Risk Committee Update
<b>Purpose:</b>	For information Mrs Julie Pomeroy – Interim Chair of the Audit and Risk Committee (Non-Executive Director) Mr M Gaunt – Director of Finance & Contracting
<b>Appendices:</b>	Audit and Risk Committee Terms of Reference

<b>1. Key Points for Discussion:</b>	
	This paper provides an update on the discussions that took place at the last Audit & Risk Committee meeting held on Tuesday, 13 September 2022.
<b>2. Recommendations</b>	
	The Board is asked to note the update and progress.  There are no issues from the meeting that the Committee need to escalate to the Board
<b>3. Executive Summary</b>	
	The Audit & Risk Committee meeting held on 13 September 2022 focused on a number of areas including the following: <ul style="list-style-type: none"> <li>• Internal Audit Plan</li> <li>• Internal Audit Q1 Update</li> <li>• Audit Action Update</li> <li>• Internal Audit Reports <ul style="list-style-type: none"> <li>○ Corporate Governance</li> <li>○ Risk Management</li> </ul> </li> <li>• External Audit Approach – Q1 and 2022-23</li> <li>• Counter Fraud Progress Report for Q1 &amp; Counter Fraud Plan</li> <li>• ICB Audit &amp; Risk Committee Terms of Reference</li> <li>• Risk Management &amp; BAF Update</li> <li>• Information Governance Q1</li> </ul>

- 21-22 Q1 Accounts Process
- 22-23 Q1 Annual Report Process

Key points for noting were as follows:

#### ***Internal Audit Plan***

The plan sets out the work for 2022-23 and this had been split between Q1 for the CCG and the Q2-4 indicative plan for the ICB.

The audits for Q1 were Corporate Governance and Risk Management, which were discussed as part of the agenda.

#### ***Internal Audit Q1 Update***

The report shared included the annual report for 21-22 with an update on Q1 work. .

The annual report is satisfactory with some improvements required, which is the standard opinion given to the CCG for the last couple of years.

#### ***Audit Action Update***

There are currently 20 actions that remain open and escalation was discussed and to be implemented including responsible officers attending the Audit committee where high risks were identified and where actions were not progressing..

#### ***Internal Audit Reports***

The following reports were presented to the committee: -

##### Corporate Governance

This was scored as an overall low risk.

##### Risk Management

This was scored as an overall low risk.

#### ***External Audit***

The CCG audit was completed in June and results were issued alongside the report at the end of June. The report includes the VFM commentary which is a requirement to be reported on.

#### ***Audit & Risk Committee Terms of Reference***

A copy of the revised Terms of Reference was discussed and minor changes identified. The revised TOR are attached for the Board's approval.

#### ***Risk Management & BAF Update***

A summary of the risk management group's current position was discussed, and it has been agreed to move the risk register to Aspyre with the programme risk logs following suit. A review of the strategy and framework is currently being undertaken to reflect the ICB changes.

#### ***Information Governance***

Confirmation that the CCG met all standards on the data security protection toolkit for the year to 31 March 2022. This was followed up by an internal audit in Q1.

#### ***22-23 Q1 Accounts and Annual Report Process***

Would like to undertake the Q1 audit early in the year. Need to ensure the audit is planned around staff. The annual report first draft is required by 5 October. The report will be produced in-house.

<b>4.</b>	<b>Management of Conflicts of Interest</b>
	The management of conflicts of interest is dealt with in accordance with the agenda and items.
<b>5.</b>	<b>Risk and Assurance</b>
<b>6.</b>	<b>Financial/Resource Implications</b>
	Detailed in individual reports, if applicable.
<b>7.</b>	<b>Legal, Policy and Regulatory Requirements</b>
	Nil specific to note.
<b>8.</b>	<b>Health Inequalities implications</b>
	Nil specific to note.
<b>9.</b>	<b>Equality and Diversity implications</b>
	Nil specific to note.
<b>10.</b>	<b>Patient and Public Involvement (including Communications and Engagement)</b>
	Nil specific to note.
<b>11.</b>	<b>Report previously presented at</b>
	Regular updates provided to the Board
<b>12.</b>	<b>Sponsoring Director/Partner Member/Non-Executive Director</b>
	Matt Gaunt – Director of Finance & Contracting – <a href="mailto:m.gaunt@nhs.net">m.gaunt@nhs.net</a>

## **AUDIT AND RISK COMMITTEE**

### **TERMS OF REFERENCE**

#### **1. CONSTITUTION**

- 1.1 The Audit and Risk Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.
- 1.2 These Terms of Reference (ToR), which must be published on the ICB website as part of the ICB Governance Handbook, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
- 1.3 The Committee is a Non-Executive Committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

#### **2. AUTHORITY**

- 2.1 The Audit and Risk Committee is authorised by the Board to:
  - Investigate any activity within its Terms of Reference;
  - Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;
  - Commission any reports it deems necessary to help fulfil its obligations;
  - Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
  - For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, other than for the following exceptions:

#### **3. PURPOSE OF THE COMMITTEE**

- 3.1 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
- 3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.
- 3.3 The ~~Audit Committee~~Audit and Risk Committee has no executive powers, other than those delegated in the SoRD and specified in these Terms of Reference.

## 4. MEMBERSHIP AND ATTENDANCE

### Membership

- 4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 The Board will appoint no fewer than three members of the Committee who are Non-Executive Members of the Board.
- 4.3 Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.
- 4.4 Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

### Chair and Vice chair

- 4.5 In accordance with the Constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.
- 4.6 The Chair of the Committee shall be independent and therefore may not chair any other committees. ~~In so far as it is possible, they will not be a member of any other committee.~~
- 4.7 Committee members will appoint a Vice Chair of the Committee who will be one of the Non-Executive Members of the Board.
- 4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

### Attendees

- 4.9 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:
  - Director of Finance or their nominated deputy;
  - Representatives of both internal and external audit;
  - Individuals who lead on risk management and counter fraud matters;
- 4.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.
- 4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
- 4.12 The Chief Executive should be invited to attend the meeting at least annually.
- 4.13 The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

### Attendance

- 4.14 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

- 4.15 Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

#### Access

- 4.16 Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the ~~Audit Committee~~Audit and Risk Committee.

## **5. MEETINGS QUORACY AND DECISIONS**

- 5.1 The ~~Audit Committee~~Audit and Risk Committee will meet not less than four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.
- 5.2 The Board, Chair or Chief Executive may ask the ~~Audit Committee~~Audit and Risk Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
- 5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

#### Quorum

- 5.4 For a meeting to be quorate a minimum of two independent Non-Executive Members of the Board are required, including the Chair or Vice Chair of the Committee.
- 5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

#### Decision making and voting

- 5.7 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 5.8 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

## **6. RESPONSIBILITIES OF THE COMMITTEE**

- 6.1 The Committee's duties can be categorised as follows.

#### Integrated governance, risk management and internal control

- 6.2 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

- 6.3 To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.
- 6.4 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.
- 6.5 To have oversight of system risks where they relate to the achievement of the ICB's objectives.
- 6.6 To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.
- 6.7 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- 6.8 To identify opportunities to improve governance, risk management and internal control processes across the ICB.

#### Internal audit

- 6.9 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:
  - Considering the provision of the internal audit service and the costs involved;
  - Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
  - Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;
  - Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
  - Monitoring the effectiveness of internal audit and carrying out an annual review.

#### External audit

- 6.10 To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:
  - Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;
  - Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
  - Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

#### Other assurance functions

- 6.11 To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.
- 6.12 To review the work of other committees in the ICB, whose work can provide relevant assurance to the ~~Audit Committee~~Audit and Risk Committee's own areas of responsibility.
- 6.13 To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.
- 6.14 To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:
- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and
  - Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

#### Counter Fraud

- 6.15 To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.
- 6.16 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.
- 6.17 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.
- 6.18 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.
- 6.19 To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

#### Freedom to Speak Up

- 6.20 To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

#### Information Governance (IG)

- 6.21 To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

- 6.22 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.
- 6.23 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.
- 6.24 To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

#### Financial Reporting

- 6.25 To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
- 6.26 To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- 6.27 To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:
- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
  - Changes in accounting policies, practices and estimation techniques;
  - Unadjusted mis-statements in the Financial Statements;
  - Significant judgements and estimates made in preparing of the Financial Statements;
  - Significant adjustments resulting from the audit;
  - Letter of representation; and
  - Qualitative aspects of financial reporting.

#### Conflicts of Interest

- 6.28 The Chair of the ~~Audit Committee~~Audit and Risk Committee will be the nominated Conflicts of Interest Guardian.
- 6.29 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.
- 6.30 Where a member of the Committee is aware of an interest, conflict or potential interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.
- 6.31 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflicts of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting.
- 6.32 Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 6.33 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing conflicts of interest, and may result in suspension from the Committee.

### Management

- 6.34 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 6.35 The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.
- 6.36 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

### Communication

- 6.37 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.
- 6.38 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

## **7. ACCOUNTABILITY AND REPORTING**

- 7.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 7.2 The ~~Audit Committee~~Audit and Risk Committee will be required to:
- a) Provide a written report to the Board following each meeting outlining the key matters discussed, any points for escalation, assurance and/or decision and/or any new areas of risk. The Chair of the Committee shall attend the Board (public meeting) to present the report.
  - b) A Committee Chair may also request an Executive lead to attend the ~~Audit Committee~~Audit and Risk Committee to discuss significant risks or matters or issue arising from internal audit reports in greater detail.
- 7.3 The ~~Audit Committee~~Audit and Risk Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:
- The fitness for purpose of the assurance framework;
  - The completeness and 'embeddedness' of risk management in the organisation;
  - The integration of governance arrangements;
  - The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
  - The robustness of the processes behind the quality accounts.

## **8. BEHAVIOURS AND CONDUCT**

### ICB Values

- 8.1 Members will be expected to conduct business in line with the ICB values and objectives.
- 8.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

### Equality and Diversity

- 8.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

## **9. SECRETARIAT AND ADMINISTRATION**

- 9.1 The Committee shall be supported with a secretariat function which will include ensuring that:
- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
  - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
  - Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
  - Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
  - The Chair is supported to prepare and deliver reports to the Board;
  - The Committee is updated on pertinent issues/ areas of interest/ policy developments;
  - Action points are taken forward between meetings and progress against those actions is monitored.

## **10. REVIEW**

- 10.1 The Committee will review its effectiveness at least annually.
- 10.2 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of Review: