

**MEETING OF THE NHS LINCOLNSHIRE
INTEGRATED CARE BOARD
TO BE HELD ON
TUESDAY, 28th MARCH 2023
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).

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023

Time: 9.00 am

Location: The Boardroom, Bridge House, Sleaford

AGENDA

ITEM NUMBER	ACTION	ENCLOSURE/ VERBAL	LEAD	TIME	
1. INTRODUCTION					
i)	Welcome and Apologies		Verbal	Sir Andrew Cash	9.00
ii)	Declarations of Interest		Verbal	Sir Andrew Cash	
iii)	Minutes of Meeting held on 31 st January 2023	Approve	Enclosure	Sir Andrew Cash	
iv)	Matters Arising, including Action Log	Note	Enclosure	Sir Andrew Cash	
2. CHAIR AND CHIEF EXECUTIVE UPDATES					
i)	Chair • Update and Overview	Note	Verbal	Sir Andrew Cash	9.05
ii)	Chief Executive • Update and Overview	Note	Verbal	Mr John Turner	9.10
3. KEY UPDATES					
i)	Public Health, including the Director of Public Health Annual Report 2022	Note	Enclosure	Professor Derek Ward	9.45
ii)	Healthwatch	Note	Verbal	Mrs Sarah Fletcher	10.00
4. CORE PURPOSE 1: HEALTH INEQUALITIES (tackle inequalities in outcomes, experience and access)					
i)	Districts Health and Wellbeing Strategy – this will take place at 9.30 am	Receive	Verbal	Mr Ian Fytche	9.30
5. CORE PURPOSE 2: HEALTH OUTCOMES (improve outcomes in population health and healthcare)					
i)	Performance Report	Receive	Enclosure	Mrs Clair Raybould/ Mr Simon Evans	10.10
ii)	Quality Report	Receive		Mr Martin Fahy	10.20
6. CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY					
i)	Finance Report – Month Eleven	Receive	Enclosure	Mr Matt Gaunt	10.30
BREAK 10.40 – 10.55					

ITEM NUMBER	ACTION	ENCLOSURE/ VERBAL	LEAD	TIME	
7. CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE (help the NHS support broader social and economic development)					
i)	Update on the Operational Plan 2023/24	Note	Verbal	Mr Pete Burnett	10.55
8. GOVERNANCE					
i)	Delegation of Primary Pharmacy, Optometry, and Primary and Secondary Dental Services and the joint commissioning arrangements	Note	Verbal	Mrs Sandra Williamson	11.05
ii)	ICB Key Governance Documents	Approve	Enclosure	Mrs Jules Ellis-Fenwick	11.15
iii)	Report on CCG/ICB Annual Reports and Accounts April 2022 to June 2022 and July 2022 to March 2023	Note	Enclosure	Mrs Jules Ellis-Fenwick	11.25
iv)	Report from the Service Delivery and Performance Committee meetings held on 11 th January 2023 and 15 th February 2023	Receive	Enclosure	Mrs Dawn Kenson	11.35
v)	Report from the Audit and Risk Committee meeting held on the 13 th March 2023	Receive	Enclosure	Mrs Margaret Pratt	11.40
vi)	Report from the Primary Care and Delegated Commissioning Functions Committee meeting held on the 15 th March 2023	Receive	Enclosure	Dr Gerry McSorley	11.45
vii)	Report from the Finance and Resource Committee meetings held on the 21 st March 2023	Receive	Enclosure	Mrs Julie Pomeroy	11.50
viii)	Emergency Preparedness, Resilience and Response – for noting only	Note	Enclosure	Mrs Clair Raybould	11.55
9. DATE, TIME AND VENUE OF NEXT MEETING					
	Tuesday, 30 th May 2023 at 9.00 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

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

Special Resolution - The Board will be asked to consider the following resolution:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest' - (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)

Items in the private part of the meeting are either commercial in confidence or relate to individual staff and patients.

**MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD
MEETING HELD ON TUESDAY, 31st JANUARY 2023 AT 9.00 AM
AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS**

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

22/58 WELCOME AND INTRODUCTIONS

Dr Gerry McSorley welcomed all those present to the NHS Lincolnshire Integrated Care Board which was the first Board meeting being held in 2023.

Dr McSorley confirmed the meeting was quorate.

Dr Gerry McSorley emphasised that whilst the meeting was being held in public it was not a public meeting.

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

Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma which was published on the website. The Questions and Answers facility had also been made available during the Board meeting as part of the live event. Any questions submitted would be responded to after the meeting subject to inclusion of name and contact details. Questions will be published on the ICB website in future along with the response in terms of being open and transparent.

It was noted that a number of questions had been received from three separate individuals prior to today's meeting. These would be covered by Mr Turner as part of his briefing.

As a final point, Dr McSorley reminded all those present to introduce themselves when either presenting items, raising or responding to comments.

The Board agreed to:

- **Note the verbal update.**

22/59 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

Dr Gerry McSorley 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 the interest as declared.**

22/60 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 22nd November 2022 and agreed to:

- **Approve the minutes as a true and accurate reflection subject to the following amendments:**
 - **Mrs Margaret Pratt and Mrs Jitka Roberts should both have been listed as in attendance.**

22/61 MATTER ARISING

Dr Gerry McSorley presented the Action Log as included in the pack of papers. There were four actions one of which was identified as delivered. Verbal updates were provided on the other three as follows:

22/47 - Issue raised regarding the cessation of dosette boxes. Mrs Mills advised that a conversation had taken place with Mr Paul Jenks, Chair of the Local Pharmacy Committee (LPC). The situation is slightly more complex in that there is a need to ensure the pathway between patients GP's and community pharmacists is correct. The community pharmacists would then be able to advise on whether dosette boxes are right for the individual. This action could now be closed.

22/49 - Provision of prescriptions being restricted to certain times of the day. Mr Fahy advised that this issue was being looked into; the relevant surgery had been contacted and a response was awaited.

Post meeting note - the Hawthorn surgery was contacted who advised they have not made any changes to their prescription dispensing arrangements. However, they have had some recent staffing challenges which may have impacted on prescription dispensing on occasion.

22/49 – provision of domiciliary care in relation to Home Care rather than just in Care Homes. Mr Fahy advised that domiciliary care is monitored by the Local Authority and not the ICB, but the issue raised will be taken to the System Quality Group QSG for further consideration as the Local Authority Quality leads attend that forum. This action could therefore be closed.

The Board agreed to:

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

22/62

CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley advised that in the first instance he wished to welcome Mr Simon Evans to the meeting who had recently been appointed to the ICB as System Director of Clinical Integration and Leadership Development. Mr Evans was asked to provide a short introduction on his background which was duly provided.

Dr McSorley advised that Mr Pete Moore, who had previously been a Non-Executive Director (NED) and Chair of Audit for NHS Lincolnshire CCG, and subsequently appointed to the ICB as a Non-Executive Director, had taken the difficult decision to resign from the ICB as of 31st January 2023. This was primarily for ill health reasons. Dr McSorley wished to place on record his personal appreciation Mr Moore's contribution to the NHS in the last few years. It would have clearly been preferable for Mr Moore to continue with the ICB, but the reasons for tendering his resignation were fully understood. Discussions would now take place between Sir Andrew Cash and Mr Turner in the coming weeks with a view to progressing that NED vacancy.

At this point in the meeting Dr McSorley provided an overview of the additional demand the system has managed over the previous two months as a result of the festive break including industrial action, on-going winter pressures and increased levels of contagious illnesses such as flu, all of which had featured in both local briefings and national press coverage. The continued pressures on the NHS and its partners were acknowledged and together with all Board Members, the Chair expressed thanks once again to colleagues across the county for all that they are doing to support and provide care for the people of Lincolnshire.

On a final note Dr McSorley informed the Board that he had attended a number of meetings on behalf of Sir Andrew Cash in recent weeks including the East Midlands ICB Chairs, ICB Chairs Midlands briefing session and the Lincolnshire Leaders Group.

Chief Executive update

Mr Turner advised that he had a number of points to highlight but in the first instance wanted to add his appreciation to that of Dr McSorley's in respect of the outstanding efforts across the whole of the health and care system over the past few months in particular in dealing with winter pressures, a number of contagious diseases, bank holidays and strikes.

The pressures had been exceptional and the response from colleagues had been truly outstanding. A letter of appreciation from the Lincolnshire system Chairs and Chief Executives had been circulated recently expressing appreciation out to the whole of the NHS.

Mr Turner advised that he had a few points to highlight as follows:

- January through to April represents Quarter four of the year and is generally a challenging time with a number of issues to deal with, such as winter pressures, meeting performance requirements and also undertaking planning work for 2023/24.
- In early January the Prime Minister Chaired an emergency meeting with NHS leaders over the winter crisis and on Monday, 9th January 2023 The Right Honourable Steve Barclay, the Health and Social Care Secretary announced the government will make available up to £200 million of additional funding to speed up patient discharge from hospital. A significant proportion of this funding was deployed in the following week and 71 beds were rapidly made available in the Lincolnshire wider community to support this.
- There are a number of on-going national strikes by nursing staff and ambulance workers. To date Lincolnshire has only been impacted by the ambulance strikes. There were some upcoming teacher strikes which could have an impact on the NHS workforce.
- Sir Andrew Cash and Mr John Turner had a meeting with the Secretary of State for Health and Social Care in the middle of December 2022 and Lincolnshire was represented positively in that conversation. There had been further correspondence in relation to that meeting.
- Achievement of the 78 week target is a national priority and the ICB and indeed the rest of the country is under considerable pressure to deliver this. Mr Simon Evans is leading on this area and working very closely with system partners to achieve delivery of this for the people of Lincolnshire.
- The Operational Planning Guidance for 2023/24 was issued on the 23rd December 2022. Mr Pete Burnett is the lead for the system response to that guidance which also involved a significant number of other colleagues.
- Work on a review of the Provider structure continued to be progressed and it was anticipated that the current phase would come to a conclusion in the next few weeks. The next phase would be to consider the outcome of that review and how that will be taken forward.
- Discussions were on-going regarding the arrangements for the delegation from NHS England (NHSE) to Integrated Care Boards (ICBs) of Primary Pharmacy Services, Optometry Services and Primary and Secondary Dental Services from the 1st April 2023. As a basis for joint planning for delegated and devolved functions, ICB Chief Executives and officers of the eleven ICBs in the Midlands have been working closely with NHSE Midlands colleagues to put in place the governance and financial arrangements and processes to deliver this model. Work was also underway in preparing to take on delegation for specialised commissioning in April 2024. Clinical Networks are also being looked at as well as the East Midlands Cancer Alliance. Mrs Williamson is leading on this piece of work for the ICB from the East Midlands perspective.
- The district councils in Lincolnshire have issued their Health and Wellbeing Strategy for Lincolnshire. This has been considered through the Better Lives Lincolnshire Leadership Team (BLLLT). This is a piece of work which needs to be brought to the attention of the Board and consideration will be given to ensuring that takes place.
- The District Council elections are scheduled to take place at the beginning of May which will involve commencement of the pre-election phase which generally starts six weeks before which would be early March. The Board would need to be cognisant of this for the March Board meeting.
- Mr Turner and Dr McSorley had been invited to and attended an event held in Ingoldmells recently to mark 70 years since the East Coast flood disaster. Mrs Elaine Baylis, Chair of ULHT and LCHS had represented the NHS at the event.

Mr Turner advised that there were two letters included in the pack of papers for noting. The first detailed the discussion and outcome of the Recovery System Plan (RSP) meeting held in early December, and the Quarterly Review System Meeting (QRSM) held with NHS England on the 15th December. The letters were for noting.

On a final note, Mr Turner on behalf of the ICB had signed up to the Armed Forces Covenant which acknowledges and understands that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy and society that they serve with their lives. There are a number of support services in place for armed services personnel and their families, including maternity services. Lincolnshire Partnership NHS Foundation Trust (LPFT) also provide a huge amount of mental health support for veterans and are the leading co-ordinators in the East Midlands region for that area. Consideration will be given going forward to look at what further support can be provided to armed forces, veterans and their families.

The Board considered the update. Mrs Pratt referred to the discussions that had taken place about the delegation arrangements for both PODs and specialised commissioning and sought clarification on the governance arrangements for this, specifically in relation to the Joint Committee. Mr Turner advised that discussions on the governance arrangements were on-going, but the proposal is for the Midlands region to operate into two parts – East and West (five and six ICBs respectively) with the principle being subsidiarity. The aim is for the East Midlands Joint Committee to come into being in shadow form in March and then be fully operational in April. This will meet in a 'Committees in Common' basis with the West Midlands several times a year.

Mr Turner referred at this point to the questions received from three separate members of the public. A brief outline of the questions was provided as follows:

Mr and Mrs Rodwell had asked a series of questions about specific care plans and whether these could be completed by different individuals, provision of padded bumpers, training for staff and a few other points. This question was passed to Mr Fahy, Director of Nursing and Dr Sunil Hindocha, Medical Director for action and to ensure timely provision of a response.

Action: Mr Fahy and Dr Hindocha

Mr Bruce had asked questions about GP services in Stamford. This question was passed to Mrs Mills, Director of Primary Care and Community and Social Value for action and to ensure timely provision of a response.

Action: Mrs Mills

Mr Alan Meekings had asked a question about the Active Recovery Beds initiative and had been in direct contact with Councillor Bowkett.

Councillor Bowkett and Mrs Raybould advised that there had been an extremely tight timescale in respect of delivery of the Active Recovery Beds initiative, but a number of actions had been rapidly progressed through positive joint working arrangements between the NHS and Lincolnshire County Council. A written response will be provided to Mr Meekings setting out the specific details.

Action: Councillor Bowkett and Mrs Raybould

It was noted that the questions and associated responses would be attached to the minutes of the meeting for information and also published on the ICB website.

The Board agreed to:

- **Note the Chair and Chief Executive updates.**

(Councillor Woolley was not present in the room for the next two items).

Public Health

Professor Ward advised that he had a few points to highlight to the Board in relation to Public Health as follows:

- The Director of Public Health Annual Report for 2022 will be presented to the Board at its next meeting on the 28th March 2023.
- There had been a number of challenges in the health and care system in the last few months associated with an increase in outbreaks of infectious diseases such as flu, Strep A and COVID. On a positive note the numbers had reduced in recent weeks.
- A sub-variant of Omicron (COVID) has recently been identified but high rates of infection were not being seen currently in Lincolnshire or across the country. The best form of defence is to get the COVID vaccine and adopt the basic principles of hand, face and space. There is an Evergreen offer still in place in Lincolnshire to get the vaccine.
- The Public Health Team work very closely with colleagues and system partners on a number of areas including health protection. Work has been progressing well on adopting a more integrated approach across health protection and that is working well. There is both a Health Protection Board for Lincolnshire which reports into the Health and Wellbeing Board (HWBB) and also the Lincolnshire Health Resilience Partnership. Mr Turner and Professor Ward have taken over the coaching associated with this provide assurance.
- The Public Health Team work very closely with Mrs Williamson on health inequalities and a joint approach, again which is working well.

On a final note, Professor Ward advised that he had recently presented a paper to the Health Scrutiny Committee on initial plans for re-commissioning sexual health services and the intention is to do the same for substance misuse services. As those plans are developed alongside NHS colleagues they would be presented to the ICB Board for consideration for information purposes.

Dr McSorley thanked Professor Ward for his update and as there were no questions received the Board moved on to the next item.

Healthwatch

Mrs Fletcher advised that in the first instance she would cover key areas of work that Healthwatch are currently progressing as follows:

- Cost of Living Survey went live a few weeks ago, and to date 303 responses had been received. 82% of people Healthwatch Lincolnshire have heard from are anxious about the potential impacts of the cost of living crisis. 57% shared that this is negatively affecting their physical health and 71% reported a decline in their mental health.
- Complaints had been received about the lack of availability of NHS dentistry and the affordability issues associated with private dentists remained a common theme.
- Mrs Sue Jarvis, ICB lead for maternity services had contacted Healthwatch as a result of the survey to indicate an increase in the numbers of women who are not attending their antenatal appointments as they cannot afford to get there. Healthwatch Lincolnshire is working with Mrs Sue Jarvis on this, and the findings would be shared in the near future.
- A recent A&E mystery shopping exercise had yielded some positive comments about the service and staff within it, which will be reported in the near future.
- With regard to the issues with dentistry, Healthwatch Lincolnshire also reported their involvement and support with the dental strategy engagement work the ICB are undertaking in order to hear and understand more fully the public's views, from NHSE feedback had been received around patients with learning disabilities, some of which related to a lack of provision of hoists in practices for individuals with physical health needs who might need them for examinations, and annual health checks being undertaken in a quick manner and in some cases over the phone.
- Communications received by patients from the services that they are registered with continued to be an issue, primarily the lack of timeliness and accuracy, as well as the need for people to repeat information throughout a pathway.

On a final note, Healthwatch Lincolnshire had agreed to support a piece of work with the Local Authority on the new discharge hub – a light touch review on patient experience.

The Board considered the verbal report and the specific comments identified in relation to maternity services and learning disability health checks and the importance of ensuring the ICB is aware of these issues. Mr Turner advised that Mrs Jarvis is part of Mr Fahy's team and Mrs Mills is leading on supporting the work that the district councils and voluntary sector are progressing in response to the cost of living challenge. These two areas clearly need to be linked up. In respect of the comments on learning disability health checks this issue had not been raised in previous years and it would be helpful to receive further details to understand the issues.

Mr Fahy confirmed that he is the Senior Responsible Officer for LMNS and had noted the comments on access to antenatal appointments and transport issues. As indicated this linked to the work being undertaken by Mrs Mills and Mr Fahy would ensure this was picked up with the LMNS team to see what support could be provided.

Mr Fahy added that he meets regularly with Mrs Fletcher to get an early indication of any issues which have been flagged and they had last met just over a week. As such Mr Fahy was aware of the comments in respect of patient concerns but noted the comments by other Board Members in terms of seeing a thematic of the types of feedback being received to get a sense of the issues.

Mr Fahy advised that he is also the Executive Lead for the transforming care partnership. In terms of the LD health checks the meeting with the GP is only one part with most of the work carried out by the nursing and support team prior to the appointment and involves completion of a large document beforehand. If there is nothing to escalate then the call with the patient would be relatively short but that should be clearly explained. The intention this year is to carry out a piece of work on the quality of those health checks.

Mrs Raybould added that in respect of health checks during COVID it was not possible for people to physically attend for appointments and the feedback received at the time in respect of video appointments was really positive. Some patients experience anxiety when attending an appointment in the practice and they preferred not having to do so.

Following some further comments on the feedback received from Healthwatch, contributing to the national picture in terms of planning and research and cost of living aspects, Dr McSorley drew the discussion to a close.

The Board agreed to:

- **Note the Public Health and Healthwatch verbal reports.**

CORE PURPOSE 1: HEALTH INEQUALITIES

22/64

LINCOLNSHIRE DENTAL STRATEGY

It was noted that due to technical reasons it had not been possible for the representatives from the NHS England team to join the meeting to present this item. It was therefore proposed and agreed that this item be deferred to the March Board meeting. Mrs Ellis-Fenwick agreed to note for the agenda.

Post meeting note – a presentation and supporting documentation on Lincolnshire Dental Services was provided at the February Board Development Session.

CORE PURPOSE 2: HEALTH OUTCOMES

22/65

INTEGRATED QUALITY AND PERFORMANCE REPORT

Performance Section

Mrs Raybould presented the Performance section of the report and advised that she would take the report as read but wanted to highlight some key areas of operational delivery to the Board.

As described previously a refresh of the report was being undertaken and last month had included a new dashboard. No adverse feedback had been received so the changes would continue to be progressed with a new report available for April 2023.

Mrs Raybould advised that as previously mentioned the validated data does lag slightly but the Service and Delivery Performance Committee considers the latest data available even if it is unvalidated and that will be referenced throughout the update to the Board.

Referring to Urgent and Emergency Care, as referred to by Mr Turner as part of his update it has been a really challenging period particularly between December and early January. This is reflected in the report and the Board will no doubt have seen that reported in the national press. Lincolnshire like many systems during December had periods of critical incident because of increased demand and multiple pressures already touched on earlier in the meeting.

The latest position has significantly recovered and since the 12th January the system has remained in OPEL level 2 or 3 with very small numbers of plus 1hr ambulance handover delays. To put this into context, in the last week of December there was 338 +60 mins ambulance delays, last week there were 24 so the improvement was clearly evident. This was largely as a result of the work on Breaking the Cycle at ULHT and the community, better flow across acute and community hospitals and improvements in discharges.

The winter plan has been fully enacted and is overseen by Senior Representatives from partners across health and social care with regular weekly meetings taking place. It has remained agile responding to changes in demand profile and also opportunities that have arisen such as the Active Recovery Beds discharge fund and more recently the Secretary of State for Health and Social Care announcement of additional money to support increased discharges. Due to the way in which the Lincolnshire system works across health and social care it was possible to respond proactively to that and secure additional monies and beds for Lincolnshire and deliver those at pace.

As described last month the System Control Centre (SCC) went live in December; this is working well and some of the Board Members may have seen that last week on the news as ITV came to film the SCC and hear about the work that it is doing with oversight across the whole UEC pathway.

The previous day NHSE published the Delivery Plan for Recovery of UEC which included two key ambitions for the next two years, 30-minute mean time for a Category Two ambulance and 76% performance in A&E measured through 4hr target. It has been agreed that Mrs Raybould and Dr Hindocha will lead a Strategy day in March where the work actioned through the clinical summit will be looked at in terms of learning, what does the strategy need to look like over the next few years and what actions need to be progressed imminently.

- The IAPT Recovery rate has recovered but remained just slightly below target but just above the England average. As described last time the service has seen increased demand post COVID.
- Serious Mental Illness (SMI) physical healthcare checks is showing a stable improving position, additional actions are underway to improve uptake during the last quarter by working closely with GPs and locality committees. There is a high degree of confidence that will deliver an improved position.

- Inappropriate Out of area placements also remained in a good position. Previously there had been concerns with first episode psychosis, which has now shown consistent improvement and is well the above standard.

Mrs Raybould handed over to Mr Evans at this point to provide an update on cancer services.

Mr Evans advised that he would take the same approach as Mrs Raybould and take the report as read. In the first instance it was worth noting the knock-on impact of urgent and emergency care is often a significant issue for planned care and cancer services.

However, the ICB providers have largely mitigated against this effect and certainly substantially more than any other systems surrounding Lincolnshire which was to be commended.

Cancer 62 day backlog is a key indicator for the ICB, and the numbers were reducing. As with urgent and emergency care data there is a slight lag behind as a result of the national publication scheme. However, there is some more up to date intelligence available which demonstrated that across the patch the ICB providers have achieved more than a 20% reduction in the number of patients who have been waiting for more than 62 days on the cancer pathway. The numbers now being down to the 449 mark, having previously been up in the high 500's and 600's. This is largely to do with improvements and catching up in terms of some operations, but particularly around the colorectal pathway which has made a remarkable improvement in its backlog overall numbers at circa 50% reduction from its peak in quarter three last year. This a credit to clinical leadership and collaborative working across both primary and secondary care where a best practice pathway has been put in place which means that those patients that are most likely to have colorectal cancer are accessing services on a much faster basis and receiving a much more responsive suspected cancer pathway.

There is a national requisite amongst three areas in cancer pathways that NHSE have requested to be put in place at pace. These are around prostate, dermatology and colorectal and Mr Evans confirmed that all three were now in place. Clearly there is much more work to be done to address the overall backlog for 62 days and improvements are being planned in both capacity and also pathways for next year to reduce that further.

28 day faster cancer diagnosis – performance remained a concern with the ICB providers and is an area of real focus. This will sit alongside the positive work which had already commenced on Community Diagnostic Centres. The Grantham site is already up and running and has seen sizeable volumes of patients. Work continues on Skegness and the other hub and spoke CDCs in line with the ambition to ensure we have further community diagnostic capacity on-line in the current calendar year.

In terms of planned care, the Lincolnshire system is making very good progress with the 78 week target. This is as a result of a huge and combined effort by the ICB providers and independent sector in and outside of Lincolnshire and there was growing confidence that the 78 week standard would be achieved as required by the end of March.

The Board considered the update on the performance report. Mrs Pomeroy sought clarification that patients on the longer wait lists are being prioritised as looking at the report the numbers appeared to have increased. Mr Evans advised in terms of cancer this is broken down into 62 day and 104 day targets. It was acknowledged that the numbers in respect of 104 day waits have seen a small increase and a piece of work had recently been discussed and agreed with the Cancer Alliance to focus on that very complex group of patients. Mr Evans was confident that the 104 daywaits would reduce which would in turn have a positive on the 62 day waits. In terms of the overall planned care waiting list (outside of cancer) the current focus is clearly on 78 week and 104 week waits.

Mr Turner reassured the Board that this is being proactively managed on an almost hourly daily basis and a key focus is on ensuring that the capacity is absolutely directed in the right way and is an area which is continuously touched on with local provider Trusts and the independent sector to continue to meet clinical priorities.

The Board had a discussion on the timely provision of data (both validated and unvalidated data) and the point made earlier in the meeting was reinforced in that as part of the verbal update to support the narrative in the performance report more up to date intelligence and live information is provided where possible at the Board meeting. There is a requirement to reference the national publication data and that is set nationally and not within the control of the ICB. An explanation was also provided by Mr Evans on planned trajectories in terms of how they are set from both a national and local perspective, how they are monitored and the systems in place to support their delivery.

Mrs Jolly referred to the evaluation of services and sought clarification on whether all sectors are involved in that piece of work, and able to feed into the process and also whether those services introduced as part of the winter pressures which are seen to be working well will be continued throughout the year. Lastly, has the voluntary sector been invited to attend the Strategy event (Summit) taking place as referred to by Mrs Raybould.

Mrs Raybould advised that the intent of the Strategy day is do exactly what Mrs Jolly had referred to in terms of looking at the vision going forward for the next two to three years and then segmenting that down into next year and so on. The voluntary sector is absolutely invited to the Strategy event. In terms of the evaluation taking place the following week, that information gathering event had been set up by Lincolnshire County Council and Mrs Raybould was not clear on who had been invited but would check and ensure the voluntary sector was included.

Quality Section

Mr Fahy presented the patient safety and quality elements of the report; performance having already been covered off by Mrs Raybould and other Executives as part of the meeting. As referred to by Mrs Raybould the format of the report continued to be refreshed and it was acknowledged that some of the presentational aspects of the content needed further tweaking. This would be picked up going forward.

The following points were highlighted:

- There had been one Never Event reported by ULHT in relation to Lincolnshire patients. This related to a wrong site surgery. The investigation will be reviewed, and assurance secured where necessary and closure of the incident agreed, or further action identified where required.
- The completed Never Event Report will be taken through the ICB Serious Incident Review Group Meeting.
- Serious Incidents - A total of 34 serious incidents were reported between 3rd December 2022 – 10th January 2023, which was a slight increase when compared to the last report but was generally in keeping with previous serious incident reporting rates. There were no significant themes to identify from a patient safety perspective.
- Learning Disabilities - A number of planned discharges have been delayed in Quarter Three and the current number was seven above the target (target is 12 and the ICB is at 19). Some of the delays were around COVID and the associated challenges and the ICB in-patient numbers are affected by IMPACT step downs into rehabilitation placements and Children and Young People in-patients becoming adults prior to discharge.
- Health Checks - current data indicated delivery of the 85% target by year end. SMI health checks were also moving in the right direction.
- COVID Vaccination – Autumn Programme went live on the 5th September 2022 delivered in partnership by the PCNs, the Vaccination Centres, the Hospital Hub and Community Pharmacies and has been the case in previous phases. Headline Autumn Booster vaccination is currently at 70.44% this is 8.3% higher than the Midlands average and is the second highest in the Midlands region. New Joint Committee on Vaccination and Immunisation (JCVI) guidance was issued last week. The current Vaccination Programme will end 12th of February. Planning is now underway for this year's Spring and Autumn booster campaigns.

- Provision of 1st and 2nd doses still continued with 3,500 first doses given last month.
- Mortality metrics - All Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR) remained on trend for all the ICB's providers, ULHT, North Lincolnshire and Goole Hospitals NHS Trust (NLHG) and North West Anglia NHS Foundation Trust (NWAFT); there are downward trends for all providers which is really positive.
 - Care Home Quality - There are four suspensions in place by Health and Lincolnshire County Council: One in East, South and South West localities.
 - There has been a total of 20 Default Notices by Lincolnshire County Council: Themes include poor quality care homes, poor governance, safeguarding and quality concerns, inadequate staffing, poor CQC visits and poor governance. Four of these care homes were visited to ensure governance processes in place, review improvement plans and to follow up safeguarding concerns.
 - Safeguarding Adults/Mental Capacity/Court of Protection - The ICB continued to wait to receive a definitive outcome of the draft Mental Capacity Act (MCA) Code of Practice, NHSE have suggested March 2023. No date has been published on when Liberty Protection Safeguards will go live, however strategies remain in place to ensure community deprivations that are fully funded by health remain a priority and progressed to the court of protection. Completion of Initial health Assessments within statutory timescales (20 working days) remained a challenge for Lincolnshire.
 - Lincolnshire Community Health Services NHS Trust (LCHS) continue to work proactively to increase medical practitioner sessions (GPs and contract through ULHT for paediatrician sessions). To mitigate the risk, all Children in Care (CiC) who will not receive their assessment within timescales has a health and wellbeing check (completed by the CiC nurses) to assess health needs and identify issues requiring further action and referral. Mr Fahy advised that he had presented an assurance paper to the Lincolnshire Safeguarding Children's Board (LSCP) Executive on this matter the previous week.
 - Special Education Needs and Children with Disability (SEND) - The ICB's SEND Team will be Peer Reviewed in line with the new Ofsted/ CQC framework in April 2023 – and preparation is underway for this.
 - Primary Care quality - No update from last time regarding practices. At the time of writing the report the CQC report on the Branston practice had not been published. This had now been received and the rating was 'Inadequate'. Work was underway to support that practice with their recovery plan.

The Board considered the quality section of the report. Mrs Fosh requested that her appreciation to all system partners was formally placed on record for their support provided to LHCS recently from an infection prevention and control perspective, which was duly noted.

Mrs Kenson advised that it was important to acknowledge the areas of good performance given the immense pressure across the NHS. This was to be commended, which was acknowledged by the rest of the Board Members.

In terms of the vaccination statistics in the report, there appeared to be a gap in the take-up by health and social care workers and Mrs Kenson asked whether this particular group of individuals had been targeted sufficiently. Mr Fahy advised that every possible opportunity had been taken to encourage all health and social care workers to have their vaccine and boosters. Last year that particular staff group was mandated to have the vaccine, but that was subsequently changed. Lincolnshire does compare very well to other areas in terms of the take-up of the vaccine.

As a point of note Dr Baker advised in terms of face to face access for GP appointments Lincolnshire performed really well compared to other areas, which was duly noted.

The ICB Board agreed to:

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

CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY

22/66

FINANCIAL REPORT

Mr Gaunt advised that the paper included in the pack set out the current financial position as at month nine (to the end of December 2020) and the Board would be briefed on the contents.

The following points were highlighted:

- Year to date against the deficit plan of £4million there was an adverse system position of £15.3million. This is a slight deterioration from the position reported the previous month and has been driven largely by pressures in prescribing expenditure.
- The deficit is predominately attributable to two organisations - ICB and ULHT and there is a partially off-setting surplus within LPFT.
- The full year forecast outturn position is unchanged from previous periods and is to break even. The system is working with NHSE to evidence all requirements of the protocol to be able to report the anticipated deficit position from Month 10 onwards. The risk adjusted forecast outturn has reduced to £27.2m (from £35.4m). NHSE have suggested that the target for the Lincolnshire system should be to achieve as close as possible to c.£20m.
- In the subsequent two month period Lincolnshire system finance colleagues and also wider colleagues, including some of ICB Board Members have been looking at measures to improve the position. The improvement has largely been driven by LPFT increasing its expected surplus position and also by some variable cost run rates in the ICB expenditure in the last two months.

The Board was referred to Table Two in the report which showed the Cost Improvement position (System Efficiencies). The system is reporting that the £56.0m of the £63.8m full year waste reduction plan will deliver by the end of the year, which is close to 90%.

Mr Gaunt reminded the Board that at the beginning of the year the Lincolnshire system started with a very considerable unidentified cost improvement and also had challenges in deliver of that through the year, so to have improved on that position is very positive. This is currently being met through non-recurrent benefits, rather than recurrent, which will have implications for the 2023/24 financial year, and which contributes to the underlying deficit. This is a key issue facing the system as it moves into the planning phase. The other area to note is that agency spend was a significant risk at the beginning of the year and remained so at the end of the year. However, there are plans in place to manage this next year.

A further point to note is that the predecessor organisation Lincolnshire CCG and LPFT have invested in improving Mental Health and Learning Disabilities facilities and services for several years which has resulted in some areas of expenditure reducing. This along with other drivers has meant that Mental Health spend is less than plan. There is therefore a real risk that the Lincolnshire ICS will not meet the MHIS target by £7.5m.

The paper presented included a schedule which referred to capital expenditure, which is almost £60million. As referred to earlier in the meeting by Mr Evans there are plans in place to increase diagnostic capacity in the county. Work was also underway to improve A&E facilities and mixed sex accommodation, which are really positive when the system is facing considerable operational pressures.

On a final note, the Board would also be provided with information later that day on the NHSE Protocol for Changes to the Financial Forecast which would need to be agreed with NHSE in terms of the Lincolnshire system exit position and Mr Gaunt would be working closely with system partners to closedown the forecast outturn position.

The Board considered the report and supporting verbal update, noting the improved forecast outturn position. Mrs Pratt referred to the forecast outturn variance on an underspend in terms of capital and asked what actions are being taken to ensure this expenditure is fully utilised by year end going forward. Mr Gaunt advised that the allocations in terms of capital usually sits around the £20million mark – the difference between that and £59million identified in the paper is around the ability to bid for successfully for inward investment into Lincolnshire. Capital expenditure is planned in a way to over commitment with contractors in the year with the understanding that some elements will not be delivered.

In respect of building a pipeline investment for future years, this is addressed through the Financial Leaders Group and an Investment Strategy group which Mrs Connery Chairs which looks at building strategic estates and equipment.

Mr Turner advised that it was important to note that the likely position in terms of capital expenditure at year end was very positive and demonstrated a considerable amount of really good progress across Lincolnshire.

Mrs Connery added that there is a System Infrastructure Strategy in place for Lincolnshire and efforts have been made to arrange a wider Non-Executive Director session for the system to get involved in the next steps on that, but due to operational pressures this had to date not proved possible. It was understood that information on estates coming will be presented to the next system delivery and performance session.

The Board agreed to:

- **Note the Finance Report for Month Nine.**

CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE

22/67

LINCOLNSHIRE'S INTERIM INTEGRATED CARE PARTNERSHIP STRATEGY

Councillor Woolley introduced the next item and advised that as set out in the Health and Care Act 2022 the Lincolnshire Integrated Care Partnership (ICP) is required to develop an Integrated Care Strategy setting out how assessed needs can be met by partners across the Integrated Care System including the Integrated Care Board (ICB), local authorities, community and voluntary sector, and NHS England. The ICP was initially required to publish an interim strategy in December 2022, however this had now been pushed back until 31st March 2023. The purpose for the initial publication date in the guidance was in order for the strategy to influence the first NHS Lincolnshire Strategy for the next five years.

The Lincolnshire ICS area is coterminous with the Lincolnshire Health and Wellbeing Board (one of only three in the country) and the ambition throughout the development of the Integrated Care Strategy was to align it, as far as possible, with the Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire. It contained a number of priorities which were underpinned by key themes and an overarching ambition. Councillor Woolley handed over to Mr Burnett at this point.

Mr Burnett advised that he would take the paper as read but wanted to highlight a few key elements of the Strategy. Firstly, the document included in the pack of papers was not the final version – it would be subject to a detailed proofread and amendments of some formatting issues prior to publication.

The Board was advised that the document presented had been created as a partnership between the ICB and Lincolnshire County Council and outlined 'how' the health and care system will focus integration efforts on key enablers to support delivery of the Health and Wellbeing Strategy and its priorities. The systems overarching ambition and aims, with the Health and Wellbeing Board's Strategy, outline 'what' the priority areas in the health and care system will focus on in light of the Joint Strategic Needs Assessment (JSNA).

Mr Burnett advised that as referred to by Councillor Woolley through the engagement work that took place in developing the strategy an emerging ambition was developed which is: ***For the people of Lincolnshire to have the best possible start in life, and be supported to live, age and die well.***

Underpinning the ambition, the interim ICP Strategy defined four aims that set the strategic direction up to 2025. For each of these aims a set of measures has been defined and are outlined in the strategy to demonstrate progress against them. The four shared aims were set out in the paper but highlighted for information.

As previously referred to, these would be underpinned by a set of priority enablers which the Lincolnshire health and care system and its partners will focus their integration efforts on to deliver these aims and overarching ambition. Mr Burnett talked through each of the five priority enablers for the Board's information.

The Board was advised that the interim strategy will be published in February 2023. The aim is to run a wide-ranging programme of engagement, during 2023, to test the ambition and priorities and thus inform the final strategy – to be published by December 2023. The current document has also been considered by the Healthwatch Readers Panel to ensure the content makes sense. This process will align with the publication of the new JSNA and the review of the JHWS. Full details on the next engagement phase will be presented to the ICP in March 2023.

Councillor Woolley expressed her appreciation to Mr Burnett and Mrs Michelle Andrews, LCC and the team for all their hard work and efforts in pulling this document together. The outcome was really positive. Mr Turner supported Councillor Woolley's comments, adding that the content was a true reflection of the level of joint working taking place across the health and social care system. It is a really good piece of work and there are only a few systems up and down the county who were currently in a position to publish a document of this calibre which is underpinned by a high quality process. Through the ICP and the Health and Wellbeing Board the good work will continue to be progressed.

Mrs Fosh supported the comments and advised that it was very positive to be able to see a document brought to life through development in a workshop and as a result of a good level of engagement. It was a really good document.

Professor Ward reiterated some of the comments received but added that as referred to by Councillor Woolley this document would continue to be developed and further national guidance/information was expected, and the life course change in the document aligns with the amendment to the JSNA model, which will be published in the next few months.

As such there will be an evidence base which will allow the ICP and Health and Wellbeing Board to decide and be informed by what the health needs of the population are within this context.

Given the context of the conversation at the meeting today and the challenges identified in terms of funding and performance, it is clear that the health and social care system in Lincolnshire will need to be redesigned and the interim ICP Strategy and the Health and Wellbeing Strategy are key drivers for that.

Mrs Connery reiterated Professor Ward's comments, adding that the personalisation element of these strategies are the key game changers for the Lincolnshire population. On a final note this is a really excellent document, and she welcomed the focus on carers and the proportion of the health and social care workforce who are carers themselves.

Mrs Kenson sought clarification on how the strategies of the Lincolnshire NHS will be joined up with this strategy to demonstrate how they flow together and looked joined up. Mr Burnett advised that the next item on the Board agenda – Lincolnshire's Joint Forward Plan will demonstrate how those strategies will be joined up.

Mr Turner added that this document is the Interim ICP Strategy, and this strategy needs to be considered in a particular frame which is reflective of all constituent parts such as LCC, the University of Lincolnshire, the third Sector, District Councils and NHS organisations as examples, rather than just through the NHS frame. As referred to by Mr Burnett this would be covered as part of the next item on the agenda.

Following clarification that the Interim ICP Strategy contains similar aims and themes to that of the ICS (four key aims), Dr McSorley brought the discussion to a close and moved on to the next item which is a complimentary piece of work.

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

- **Note the process and the steps taken to develop the Interim Integrated Care Strategy.**
- **Note the content of the Interim ICP Strategy document, its ambition, aims and priority enablers.**
- **Note that the document is not in its final version as it requires an accessibility check prior to being published on the ICB and Lincolnshire County Council websites.**
- **Note the proposed engagement exercise with the public which will commence in quarter one of 2023/24.**

22/68

LINCOLNSHIRE'S JOINT FORWARD PLAN

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

NHSE have developed and published guidance to support the ICB and partner trusts in this exercise which was published the same day as the Operational Planning Guidance (23rd December 2022). The guidance sets out a flexible framework for JFPs to build on existing system strategies and plans as well as how the document should be developed and structured in line with the principles of subsidiarity. At a minimum, it should also describe how the ICB, and its partner trusts intend to arrange and/or provide NHS services to meet their population's needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements.

The paper presented set out the planned approach in Lincolnshire to develop the JFP and identified that the aim is to produce a 5-year NHS plan that describes the vision for the NHS in Lincolnshire and how that will be delivered. The 5-year plan sits alongside and complements the ICP Strategy which lays out how health and social care will work together to improve the health of the population in Lincolnshire.

Mr Burnett outlined the preliminary work on the development of the JFP (or Lincolnshire NHS Strategy as it will be known locally). This work will be led by NHS partners across the county, with a strong partnership approach with the public and key stakeholders at its core. Progress has already been made with a multi-partner steering group established to lead on its development. A series of workshops will also take place to agree the NHS system strategic priorities and commitments for the next five years. This will be supported by Working Groups to develop the priorities and core commitments further. The expectation is that the main public facing document will be underpinned by several key documents which were set out in the paper but covered off by Mr Burnett for information.

On a final note, throughout the process there will be regular dialogue with NHS England to ensure the final document meets the national requirements.

Prior to finalising the JFP further discussions and engagement with the public and the Health and Wellbeing Board will take place. Feedback from these processes will inform the final document which will be shared with NHSE and presented to the Board at the end of June 2023.

The Board considered the report. Mrs Pratt welcomed the direction of travel and the development of a five year plan rather than a rolling plan. This also linked with the devolution agenda which was still work in progress. Mrs Pratt added that alignment needs to take place with system-wide partners, not just partner Trusts. Mr Burnett advised that the aim of the workshop is to have all system-wide partners present and involved.

Mr Turner advised that there are three constituencies that need to be central to the design and development of the JFP which is firstly the clinicians across the system (oversight through the Clinical and Care Directorate which is across the system), the second the ICB partner organisations and then people and communities. This all about co-production and the intention is to go through an open process with the people and communities of Lincolnshire, NHS partners, and wider system partners to identify how NHS services will meet the population's physical and mental health needs over the next five years.

Mrs Fosh sought clarification that there is a document which details the specific timeframes for the development of this piece of work. Mr Burnett confirmed this was in place.

Councillor Woolley reinforced the reference made earlier by Mr Turner on the great relationships and joint working arrangements already in place in Lincolnshire. In short what can be done together, what is already being done together and moving this forward together rather than carrying this out in individual parts. In refreshing the Health and Wellbeing Strategy it is important to take the opportunity to engage with the public in a meaningful way and avoid duplication.

Mr Fahy advised that it was important to note that this is a JFP for all ages and it was really encouraging to see the reference to Safeguarding, and Children and Young People included along with the commitment to support victims of domestic violence, abuse and sexual exploitation. This a great opportunity to start aligning all organisations priorities and actions across the system and get fully behind those.

Mrs Blyth referred to the comments on engagement and advised that there is risk around public fatigue, not just for the NHS but the system as a whole. This is an opportunity to engage more substantially and less frequently, which was supported and noted.

Dr McSorley thanked Mr Burnett for his presentation and noted the planned approach to development of the JFP along with the various dates for bringing back updates to the Board.

The Board agreed to:

- **Note the requirements to develop a Joint Forward Plan with our partner Trusts.**
- **Note NHSE have published guidance which sets out a flexible framework for the development of the JFP.**
- **Note the planned process for developing the Lincolnshire JFP**
- **Note NHSE will review and comment on draft JFPs and expect ICBs and their partner trusts to produce a first draft for consultation by 31 March 2023, with a view to publishing a final version by 30 June 2023.**
- **Note each system has significant flexibility to determine their JFP's scope as well as how it is developed and structured.**

GOVERNANCE

22/69

SERVICE DELIVERY AND PERFORMANCE COMMITTEE

Mrs Kenson presented the reports from the meetings held on 16th November 2022 and 14th December 2022 and advised that she would take those as read.

There were two points for escalation to the Board:

- **Digital, Data and Technology (DDaT)** – There is now a Chief Digital Information Officer (CDIO) in place, which is very positive news, but there were some slight concerns around prioritisation and funding considerations that this will require to provide the level of muster required.
- **Provider Collaborative** – A further review of how that is working, including its structure and fundings, was recommended.

On a final note, the Committee had reviewed and identified some amendments to its Terms of Reference. The revised version was attached for consideration and approval.

The Board considered the report and agreed to:

- **Note the report.**
- **Approve the revised Terms of Reference.**

22/70

FINANCE AND RESOURCE COMMITTEE

Mrs Pomeroy presented the reports from the meetings held on 13th December 2022 and 24th January 2023 and advised that she would take the reports as read but wished to highlight the following points (which followed on from Mr Gaunt's update earlier in the meeting).

As a first point of note the NHSE Protocol for Changes to the Financial Forecast formed the focus of a considerable amount of discussion at the meeting held on the 24th January 2023. As identified by Mr Gaunt the risk adjusted forecast is £27.2 million for 2022/23 and NHSE require the ICB to deliver £20 million. The Committee agreed that a deficit of around £25 million was more realistic and deliverable. There was a considerable amount of work taking place to improve on that position.

From the Committee perspective, and the recommendation to the Board, duty of candour must be applied and the ICB should not be accepting of a figure unless it was felt achievable.

Further discussion will take place at the next Committee meeting in February when it was anticipated there would be a clearer idea of the likely outturn forecast position for the year.

The other area to highlight was the lack of delivery of Cost Improvement Plans which was having a direct impact on the outturn forecast position. Mrs Pomeroy wanted to reassure the Board there is a considerable amount of work taking place to improve the system position which is being led by Mrs Jitka Roberts, System Improvement Director and her team. This is expected to show fruition moving through the 2023/24 financial year.

The Board considered the reports and agreed to:

- **Note the reports.**

22/71

SYSTEM QUALITY AND PATIENT EXPERIENCE COMMITTEE

Mr Fahy presented the report from the system Quality and Patient Experience Committee meeting held on the 22nd December 2022. The Board was advised that the Committee discussed a range of issues and particular challenges which were detailed in the report. Particular challenges at the time included asylum seekers in terms of the rapid mobilisation work and disbursements and potential safety concerns associated with this.

The Committee was provided with reassurance on the efforts of Primary Care colleagues to address the health needs of that particular cohort of people.

The Committee also discussed and looked at in more detail the temporary closure of the Psychiatric Intensive Care Unit (PICU) in the mental health Trust, namely Lincolnshire Partnership NHS Foundation Trust (LPFT).

The Committee received assurance on the work underway to re-open that service in the not too distance future.

The Committee received some key reports through the business cycle, one of which was the Patient Engagement Group Update and the Complaints Annual Report and Quarter One update. An update was also received from the local maternity system in terms of progress against the East Kent and Ockenden actions.

The Committee also received the first Quality System Risk Register which contained a condensed summary of the quality issues raised by system partners including detailed actions that are in place to address the issues and the responsibilities in terms of the system to ensure that the actions are progressed.

The Committee again reviewed its Terms of Reference and whilst no amendments were identified on this occasion the content may change following the System QPEC Development Session planned to take place in February 2023.

Mr Fahy advised that there was an error in the report in that it stated the following:

Clinical Policies Subgroup and Terms of Reference - *The Committee supported the delegation and ratification of all future ICB clinical policies to this subgroup, the Terms of Reference will be altered to reflect this decision. It should refer to the ICB Operational Quality Assurance Group.*

There were four items identified for escalation to the Board, one of which had already been highlighted to the Board on PICU:

- PICU Update
- Clear information about association complaints returns related to delays in treatment.
- Support on Patient Safety Investigation Response Framework (PSIRF) – which is the new framework for the investigation of serious incidents going forward.
- NWAFT continued journey towards the understanding of their mortality figures

The Board considered the update. Dr Hindocha advised that NWAFT have appointed a new Medical Director who he regularly meets with, and a new culture of safety is being introduced, although it was recognised it was early days and there was some way to go.

Mrs Pratt sought clarification that the issues associated with the closure of PICU related to challenges in recruiting suitable workforce and is part of the impact on the Mental Health Investment Standard and the associated compensating out of area additional cost. Mrs Connery responded and advised that the decision to close the PICU was not related specifically to the staffing in that unit, it was related to staffing across all of the adult in-patient services which had hit such a level that it was a constant daily focus to move staff around to ensure all the services were safe. There was not enough resilience to keep all of those wards open. There were four service users at the time in the unit who were able to safely move on, so the closure had the least impact on patient outcomes.

Out of Area placements for psychiatric intensive care are tracked on a daily basis and there are currently three patients and two of those are ready for onward placement. There has been an increase in serious incidents on the acute in-patients wards as a result of absorbing that care onto the wards.

Mrs Connery outlined the work that LPFT is undertaking to recruit suitable staff and the ambition is to re-open the male PICU as soon as possible and to also establish one for females which has never been provided in the county.

The Board considered the report and agreed to:

- **Note the report.**

22/72

PRIMARY CARE COMMISSIONING AND DELEGATED FUNCTIONS COMMITTEE

Dr McSorley presented the report from the Primary Care and Commissioning Delegated Functions Committee meeting held on the 21st December 2022 and outlined the contents.

As a point of note Dr McSorley advised that he had attended the opening of the extended premises for the Abbeyview Medical Practice in Lincoln and also attended and spent time with colleagues at the Spalding dispersal event at the Johnson Hospital.

There was one item for escalation to the Board which related to the Hawthorn Medical Practice and the substantial amount of work that is being provided to support progress against their action plan following their CQC visit. The practice is making good progress.

The Board considered the report and agreed to:

- **Note the report.**

22/73

AUDIT AND RISK COMMITTEE

Mrs Pratt presented the report which provided an update on the discussions that took place at the latest Audit & Risk Committee meeting held on Wednesday, 25th January 2023. The contents were highlighted for information. There were no matters identified for escalation.

The Board considered the report and agreed to:

- **Note the report.**

22/74

DATE AND TIME OF THE NEXT MEETING

Dr Gerry McSorley thanked everyone for their attendance and advised that the next formal ICB public Board meeting will take place on the Tuesday, 28th March 2023 at 9.00 am. The meeting will be held both face to face and as a virtual live event to enable a wider audience to access the meeting.

Chair Signature

Date

Not Delivered
In Progress
On Track to Deliver
Complete

ACTION LOG - PUBLIC

Date of Meeting:	Tuesday, 28 th March 2023
Agenda Item:	1 (iv)
Reporting Officer:	Sir Andrew Cash, Interim ICB Chair

Date of Meeting	Minute Number	Item	Action	Lead	Timescale/update
22 nd November 2022	22/49	Integrated Quality and Performance Report	Provision of prescriptions being restricted to certain times of the day.	Mr Fahy	31.03.23 – Mr Fahy advised that this issue was being looked into. Update February 2023 - the surgery was contacted and have advised they have not made any changes to their prescription dispensing arrangements. However, they have had some recent staffing challenges. Action complete.
31 st January 2023	22/62	Chief Executive Update	To provide a response to the questions/comments received from three separate members of the public. Questions and response to be attached to the minutes of the meeting and published on the ICB website.	<ol style="list-style-type: none"> 1. Dr Hindocha and Mr Fahy 2. Mrs Raybould and Councillor Bowkett 3. Mrs Mills 4. Mrs Ellis-Fenwick 	08.02.23 - The questions/comments from the three individual members of the public have been considered. A response to all three has been provided is attached to the minutes of the meeting for information. The Questions and response have also been published on the ICB website. Action complete.

Date of Meeting	Minute Number	Item	Action	Lead	Due Date	Progress
31 st January 2023	22/64	Lincolnshire Dental Strategy	Item deferred to March. Mrs Ellis-Fenwick to note for inclusion on the agenda.	Mrs Ellis-Fenwick	February 2023	Post meeting note – it was agreed to include this item on the agenda for the Board Development Session on 28 th February 2023. Action complete.

Questions to the Lincolnshire Integrated Care Board – 31st January 2023

Mr and Mrs Doug Rodwell

The question I would like to put to the board relates to the communication needs, care and understanding of patients who are vulnerable through either physical or mental disability.

Our experience relates to our Nephew who has Cerebral Palsy and who is non-verbal though he has full mental capacity. The question is asked following his two most recent admissions to hospital, the latest January 2023 with Pneumonia in both lungs. His medical treatment was fine for which we are grateful, but I would ask you to consider our comments with regard to his personal needs which must vary by individual.

The question therefore is: **Do hospitals have a specific care plan for these individuals which will be shared with all staff they may come into contact with.**

To clarify this question and to give you some insight we will outline some of our experience. However, before doing so please be aware that this is not a complaint it is offered to constructively assist your thoughts.

At no time when he arrived at the hospital were we asked what his specific needs were and even though we would not leave him, we felt it was necessary to stay to assist his care and their understanding of his needs. However, not all patients would have someone in attendance at all times.

Comment: Would it not be possible to have a specific care plan which could be filled out by ambulance staff / medical staff which accompanies patients throughout their stay.

In the ambulance admissions area, he was laid on a trolley where the sides can be lowered but this means there are large gaps approximately 9 inches in between each upright. Due to his involuntary movement, he was able to put his hands and arms through these gaps presenting a risk to his limbs. Due to his posture he also needs to be supported to maintain his position. We were given 1 pillow to assist this but this clearly is not sufficient, however on requesting more, we were told no more were available due to shortage. This resulted in one of us going to Dunelm Mill and purchasing 4 pillows.

Comment: Would it not be possible to have a small quantity of padded bumpers that could be fitted to the frame. We know when beds are delivered to homes where patients are receiving palliative care that they are supplied.

While in the ambulance admissions area and after he had been assessed and we were advised that he needed to be admitted, he spent the next 48 hours on a trolley most of the time in the corridor. Due to him not having control of his bladder / bowels he wears incontinence pads which were brought with him. We advised medical staff that he had defecated and were told that it would not be dignified to change him in the corridor and there were no cubicles available. My wife requested he be changed on 3 – 4 different occasions and received the same reply. After 3 hours and expressing the view that it was not dignified to leave him laying in his own faeces he was eventually changed in the toilet which had double doors and was in the same section of corridor.

Comment: Why was he not changed in a timely manner to afford him the dignity that anyone else could expect.

On admission to the hospital, he had brought his medication with him and we had provided the ward with a copy of the instruction on dosage. Clearly this had not been passed onto other medical staff as one night we were at home and received a call requesting information regarding this.

Comment: Were there a specific care plan in place this would have addressed this issue as he could not communicate this information.

As we mentioned earlier our Nephew has mental capacity but is non-verbal. He communicates by way of two methods 1) if asked a question in a manner that requires a yes or no answer; he will move his head to the right for yes and the left for no. 2) given options he can be asked to look at two things / persons to determine his choice. We passed this on and also sellotaped a "yes" to the righthand side of the bed and a "no" to the lefthand side. Sadly, on numerous occasions this was not used and on occasions some members of staff refrained from talking to him whatsoever. Whereas others were brilliant. He was conscience of the fact that he was being ignored on occasions, which is really sad.

Comment: If there was a specific care plan in place then all staff could be aware and if there is not then could one not be introduced along with specific special needs training.

We sincerely hope you find this constructive and are pleased to say that our Nephew is back at his care home and has recovered well, thank you. While he was in the hospital, we provided 24-hour attendance, 12 hours by ourselves and 12 hours from a care agency. This was purely to assist and support hospital staff as we appreciate the pressures that the NHS is under. With his involuntary movement and lack of limb control he often pulled off his oxygen mask which he could not replace nor could he press the button as an alert.

Obviously, not everyone is able or can afford to do this, which makes a specific care plan a vital document in our opinion.

Response to Mr and Mrs Rodwell

Thank you for sharing the question submitted to the ICB Board in January. Please see below a response to the issues and queries raised which has been provided by Jennie Negus who is the Head of Patient Experience at United Lincolnshire Hospitals NHS Trust (ULHT). For completeness the response has been structured around the highlighted questions.

Do hospitals have a specific care plan for these individuals which will be shared with all staff they may come into contact with?

We do and one is attached to this email. The All About Me (AAM) booklet was co designed and developed with patients, their carers' and health and social care colleagues. The original concept was focused on people with dementia but as it grew we could see it would benefit any patient who may have difficulty communicating their needs and preferences and so it is able to be used with many different people. It is designed to be 'patient held' in that it is kept at the bedside to inform and direct staff in terms of care and should not get tucked away in the medical notes where it can't be seen or used. One of the good things about AAM is that it is used in the community as well as here in the hospitals. We know a number of care homes have picked up boxes of them to use with residents and across the community our learning disabilities staff encourage its use too.

However we recognise that the AAM is not always used as well as it should be and appreciate how frustrating it is for families and patients if they have gone to all the trouble of completing it and then staff ignore it or don't appreciate its value.

Our dementia and learning disability lead nurses have been raising awareness and we are also promoting it now through our refresh and relaunch of Caring for Carers and supporting carers as expert partners.

If you would like a hard copy of the AAM please let me know and I will post this to you or alternatively you can collect it from our PALs services.

In addition to All about Me, the ULHT Safeguarding and Vulnerabilities team can also offer support with writing a reasonable adjustment care plan to ensure communication needs are highlighted and recognised by staff on admission and throughout hospital stay. This care plan can be kept with the patient and we can keep a copy which can be accessed by all site duty managers if out of hours along with our team. This can be shared as soon as patient comes into A&E or even for OPA / scans etc. We can add an alert for communication and reasonable adjustments in hospital to patient records as patient agreed which will highlight needs on admission and direct staff to access the care plan.

If this is something you wish to take forward, please let us know as we want to assure you that we are listening and would like to engage with you to improve the service we offer.

Would it not be possible to have a specific care plan which could be filled out by ambulance staff / medical staff which accompanies patients throughout their stay?

Our work around supporting carers is about recognising them as the experts in the patients care, involving them in discussions and decision about care and treatment and welcoming them to be with the patient as much as they wish and / or as able. We are relaunching our Carers Badge which was paused during COVID and I am a member of the NHS Health & Care Advisory Board which is developing the new national Care Partners Policy and new NHS Visiting Guidance and ULHT is one of 13 pilot sites taking this work forward. I would be really interested in discussing this work with you and your family.

The ambulance team's records and observations along with emergency department team's findings and instructions all contribute to the handover to the clinical team taking over a patients care on admission. On admission and after assessment, plans of care are developed and reviewed daily and where carers are involved this should be shared and discussed with them too. We know we need to do better with communication as our patient and carer feedback highlights this as a factor and we have a number of different improvement work streams addressing this. These include communication boards at the bedsides, an initiative called 'You Care, We Care to Call' where our staff proactively call relatives to provide an update rather than them trying to get through on the ward phone, a number of training programmes and using patient stories to really illustrate the emotion and as already mentioned our Carers Badge and Care Partners work.

Would it not be possible to have a small quantity of padded bumpers that could be fitted to the frame? We know when beds are delivered to homes where patients are receiving palliative care that they are supplied.

This is an excellent idea and one which I will discuss with our emergency department staff. I don't know what it is about pillows in hospitals but throughout my (many) years in nursing they always seem like gold dust. Having full length bumpers available is a great idea.

Why was he not changed in a timely manner to afford him the dignity that anyone else could expect.

This is absolutely not the standard we would expect and I know the emergency department staff will be saddened to read this. It certainly sounds like the department was incredibly busy with no cubicles free and ambulance trolleys waiting in the corridor and that staff were struggling to cover all bases – however that is not an excuse and powerfully illustrates how the fundamental aspects of care and compassion are impacted when a service is

overwhelmed. I know the staff get very upset when they can't provide care such as this basic need for comfort and dignity and on many occasions when our departments so stretched we call on other staff to come down and help. I am so sorry for this experience.

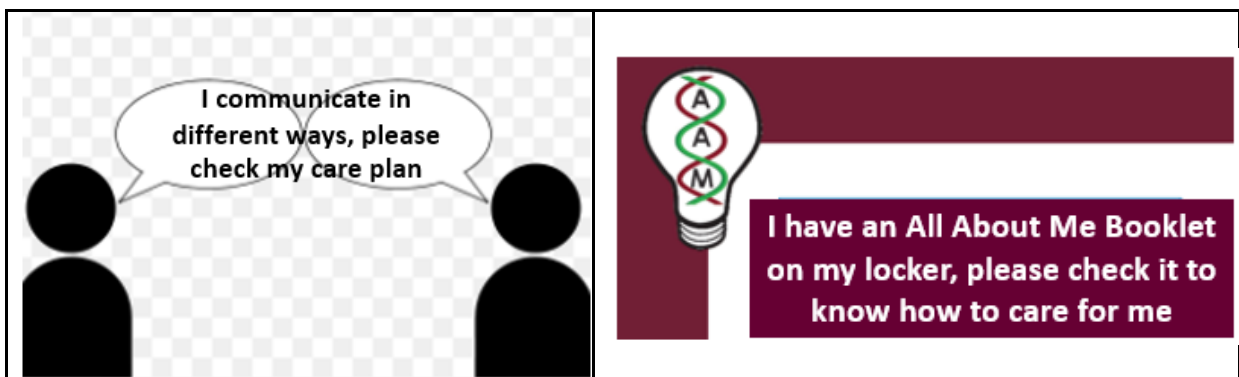
The issues raised about medication and communication techniques would, as stated been highlighted had there been an individualised specialist care plan in place such as the AAM.

I wonder too whether we could consider an adaption to an initiative we have recently introduced for patients with sight or hearing loss. Working with an expert reference group we have developed laminated A5 signs (examples as shown below) that can be put above a patient's bed that illustrate their particular communication needs so that even if some of the nursing staff are aware anyone approaching the bed can see how to communicate.



We could consider a similar sign that highlights that someone has an AAM or has specific communication needs such as I have just quickly drafted below?

If you feel this may have helped we would be very happy to work with you on this.



I trust the above responds to some of the issues raised, but as indicated above Jennie Negus who is the Head of Patient Experience at ULHT would very much like to work with you and your family if you are able and willing. She would also like to provide some reassurance either way that they have heard and listened to your story and will share this feedback and learning.

Contact details provided and Mr and Mrs Rodwell have been in direct contact with Jennie Negus.

Question received from Mr Alan Meekings

I'd very much like to ask the Board the following question:

Regarding the joint LCC/LICB 'Active Recovery Beds' proposal, specified at <https://bit.ly/3HET2wW> and scheduled to start on 12 Dec 22:

- Was this important initiative launched on time?

- How many care homes and active recovery beds have since been contracted, and where?
- Is the scheme working as intended? If so, what benefits have resulted so far?
- How are the various, agencies involved (including care homes, community services, EMAS, hospitals, etc) currently feeling about this scheme and its future viability?
- How and when will its extension beyond 31 Mar 23 be justified and funded?

What's behind is question is that, around mid-December last year, my local County Councillor, Tracey Carter, briefed me about this significant initiative and asked me to mention it to members of the public locally via the social media platform, Nextdoor.com, which I duly did . . . and the response was incredibly prolific and supportive. However, the resulting small problem was that lots of people then pressed me to find out if this new initiative was actually launched as planned and how it's going.

Hence, I was advised to write to Cllr Wendy Bowkett to ask if she could please let me know how the initiative was going in practice and I'm attaching a copy of the email I sent to Cllr Bowkett on Sun 08/01/2023 for your information.

Unfortunately, I then received neither an acknowledgement nor a response to this email. Hence people locally, especially in South Holland and The Deepings, are still extremely keen to hear the latest news about this important development.

Response copied in to Councillor Wendy Bowkett, Partner Member, Local Authority

Response to Mr Meekings

Further to consideration of your question submitted to the NHS Lincolnshire Integrated Care Board recently, which was presented to and considered as part of the Board Public meeting held on the 31st January 2023, please see the formal written response below:

Active Recovery beds were one of the schemes initiated as part of the Lincolnshire systems response to planning for Winter Pressures for 2022/23. Lincolnshire County Council and the ICB worked closely together to produce a specification and procure the 'Active Recovery Beds' following formal approval. The beds were very quickly established by the County Council commercial unit and commenced as planned on 12th December to align with the peak periods of demand set out in the winter plan.

A total of 60 beds were procured across 6 care homes in different locations across the county and to date the scheme has worked as it was intended to. Additionally you may be aware that an announcement was made in January by the Secretary of State for Health and Social Care of money available to systems to continue to ease pressures and provide further capacity to support hospital discharge. As a result of the already proven scheme the system agreed to purchase a number of additional beds out of hospital which include a further 20 Active Recovery Beds.

Whilst it is still early days to evaluate fully the impact of the scheme partners feel very optimistic at this stage that they have made a positive impact in what has been the most challenging of winters so far. All winter schemes will be evaluated during February and March and this will inform any future decisions about demand and funding as part of the current planning for 2023/24.

It is worthy of note that a document entitled 'Delivery plan for recovery of Urgent and Emergency Care' was published last week by NHS England that takes into account planning for the next two years which you can see on the following link.

<https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services>

For information, please note that any questions posed to the Board and the responses are attached separately to the minutes of the meeting at which they are considered. The questions and responses are also published separately on the ICB website.

Question from Mr Donald Bruce

As you are well aware Stamford is having huge difficulty in providing a GP service for the residents of Stamford and the surrounding area. I am an elderly member of the Sheepmarket Surgery and know very well how difficult it is to see a GP. Over the past 2 years, being unable to make an appointment to see a GP I have used the "Dotorin Service" on 2 occasions. Once I received excellent and prompt service from a Physiotherapist, on the second occasion a GP saw me because I had a prostate problem. However, not all elderly patients have had the electronics and computer experience that I have had during my working life. Lakeside at Sheepmarket and St Mary's Stamford is having huge problems providing adequate care and GP support for their registered patients. I believe that although they are improving slightly they are still under CQC special measures. I simply do not understand how how Lincs NHS can support plans for a large housing expansion in Stamford North and Rutland which will increase the workload on the beleaguered Lakeside without insisting on the provision of additional Medical Facilities funded by the companies developing both sites? I am sure that you are aware that these companies will make huge profits from these developments.

I understand that the problem of GP services is not restricted to Stamford and it is a National problem. However, planning authorities have to insist that development companies include the cost of developing required medical facilities when they are constructing large housing developments. The NHS has a part to play in approving housing developments. It is the NHS's duty to insist that additional medical facilities necessary for new housing areas are funded by developers. Why should the scarce funds provided by the Government for the NHS be used to line the pockets of extremely wealthy developers.

Response to Mr Bruce

Thank you for sharing the question submitted to the ICB Board in January and for setting out your experiences as a patient at Lakeside Stamford and your concerns regarding access and the potential impact of planned housing developments on access.

The ICB is working to support Lakeside Stamford on addressing the issues highlighted in recent Care Quality Commission (CQC) inspections. The latest inspection report ([Lakeside Healthcare at Stamford - Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications-reports/inspections-reports/2023/02/15/lakeside-healthcare-at-stamford)) was published on 15 February 2023 – I am pleased to confirm that the practice is now out of special measures and the report indicates positive progress although with some work still to do.

I am pleased to hear your experience of using Doctrin has been positive – we have had similar feedback from other patients but appreciate that this way of accessing the practice is not convenient for everyone. Lakeside Stamford recognise that access isn't good enough and the ICB will be working to support them in making the required changes to ensure the practice is readily accessible to all patients.

In terms of the planned housing expansion in Stamford North I do want to assure you that we have been and continue to work with the developers regarding the development. Part of the planned development is in Rutland, and we have been meeting with our NHS colleagues in Leicester, Leicestershire and Rutland ICB, Rutland Council and South Kesteven District

Council and to ensure that we see the whole development and we are working with colleagues, including Lakeside, on how we will meet the health needs of this planned development and what facilities and services will be needed.

With housing developments, the NHS will seek either Section 106 contributions from the developer via the District Council, or in Rutland Council's case Community Infrastructure Levy (CIL) contributions. These are not automatically received capital funds but will be part of the planning authorities' negotiations with the developers.

I trust this responds to your query but if you have any further questions or concerns please do contact me.

Mrs Sarah-Jane Mills
Director of Primary Care, Community and Social Value

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	3 (i)
Title of Report:	The Director of Public Health's Annual Report 2022 - The Diverse Communities of Greater Lincolnshire
Purpose:	For the NHS Lincolnshire ICB to receive the Director of Public Health's Annual Report and note its contents.
Appendices:	The Director of Public Health's Annual Report 2022 - The Diverse Communities of Greater Lincolnshire

1. Key Points for Discussion

The purpose of this report is to present the Integrated Care Board with a copy of the Director of Public Health's (DPH) independent report on the state of health of the people they serve. The key points to note from the report are:

- The report covers the Greater Lincolnshire footprint
- The focus is on Greater Lincolnshire's communities and is structured around four different communities
- The report identifies key challenges for each of the four types of community.

2. Recommendations

For the Integrated Care Board to receive the Director of Public Health's Annual Report and note its contents.

3. Executive Summary

Directors of Public Health in England have a statutory duty to produce an independent report on the state of health of the people they serve on an annual basis. Local Authorities have a statutory duty to publish the report and make them as accessible as possible to the wider public.

This Annual Report has been created for Greater Lincolnshire, as part of the Greater Lincolnshire Public Health pilot. North-East Lincolnshire, North Lincolnshire and Lincolnshire County Council have worked together to produce this report which examines the diverse communities of Greater Lincolnshire.

In 2021, the Chief Medical Officer (CMO) highlighted the challenges of coastal communities in his Annual Report, including case studies on coastal communities in Lincolnshire and North-East Lincolnshire.

The report identified some of the reasons for inequalities and set out a range of recommendations to improve outcomes. The CMO noted the lack of available data published at a geographical level small enough to capture coastal outcomes, posing a challenge to being able to plan national and local strategies.

This Director of Public Health's (DPH) Annual Report has analysed local data and identified four types of community across Greater Lincolnshire- urban centres, urban industrial centres, coastal communities and rural and market towns. The report describes the four types of community and highlights the key challenges and opportunities for health and wellbeing, that vary across different places.

By developing a better understanding of the complexity of our local communities, approaches to prevention and treatment can be tailored in a way that better meets the needs of local people. We hope this fresh perspective will add value to the work of those supporting health and wellbeing, and delivering health and care services, across Greater Lincolnshire

The annual report has been approved for publication on the Council's website and is attached as an appendix to this covering report.

4. Management of Conflicts of Interest

Not applicable

5. Risk and Assurance

Not applicable

6. Financial/Resource Implications

The Annual Report highlights how Lincolnshire has utilised the Public Health grant monies received to enhance the outcomes of the population and further understand people's needs and future direction.

7. Legal, Policy and Regulatory Requirements

Under Section 73B (5) of the National Health Service Act 2006, the Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority and under Section 73B (6) of the Act the local authority must publish the report.

8. Health Inequalities implications

The analysis in the report identifies areas of inequalities and one of its key recommendations is to improve awareness of the diversity of Greater Lincolnshire's communities, and specifically what this means for health and wellbeing, across the workforce and volunteer community.

9. Equality and Diversity implications

Not applicable.

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

There is no statutory requirement to consult as this report belongs to the Director of Public Health.

11. Report previously presented at

Lincolnshire County Council:

- Executive- 4th January 2023
- Adult Care & Community Wellbeing Scrutiny- 11th January 2023
- Health Scrutiny – 15th February 2023
- Joint Strategic Oversight Committee (JSOG)- 3rd March 2023
- Lincolnshire’s Health and Wellbeing Board – 28th March 2023

North East Lincolnshire Council:

- Cabinet- 21st December 2022
- Health and Wellbeing/Place Board – 20th February 2023
- Health and Adult Social Care Scrutiny Panel- 22nd March 2023

North Lincolnshire Council:

- Health and Wellbeing Board- 6th March
- Health Scrutiny Panel – 6th March
- Full Cabinet Team - 13th March 2023

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

Derek Ward, Director of Public Health
Email: Derek.ward@lincolnshire.gov.uk
Tel: 01522 552902

THE DIVERSE COMMUNITIES OF GREATER LINCOLNSHIRE

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2022



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1.0 FOREWORD

Welcome to my fourth annual report as Director of Public Health, but my first for the whole of Greater Lincolnshire. Lincolnshire and neighbouring authorities of North and North East Lincolnshire have faced huge public health challenges over the past few years in steering residents through the Covid-19 pandemic as safely as possible.



As we have emerged more fully from the restrictions that the pandemic brought to us all, we have faced new challenges, not least the mental wellbeing and other health related issues arising from periods of lockdown. And new concerns have arisen such as the cost of living challenge brought about by the economic crisis.

Over recent years, previous annual reports have centred on themes such as the burden of disease, response to the pandemic and the impact of Covid-19 on children and young peoples' health and wellbeing. The Chief Medical Officer's annual report for 2021 highlighted coastal communities as having some of the worst health outcomes in England and the lack of data and understanding of the different communities in areas which would help plan local strategies and improve outcomes for health. Both Lincolnshire and North East Lincolnshire were "coastal case studies" in Professor Whitty's report.

Greater Lincolnshire typically has large areas of rural land and urban centres of differing sizes. So having analysed local data, this report identifies the four types of community we have – urban centre, urban industrial, coastal community and rural and market town – and the differences and opportunities for health and wellbeing.

There are significant challenges for preventing ill health and improving life expectancy across Greater Lincolnshire. Each community has different characteristics and opportunities that lead to different health outcomes. But the challenges can also have common themes across the region. Poor housing and fuel poverty require different solutions in urban and rural areas but is a consistent problem. The lack of a

teaching hospital means recruitment and retention of a health and care workforce is a challenge over all of Greater Lincolnshire, although it is felt more acutely in coastal strips. Poor air quality not only affects urban areas but agricultural air pollution is also a growing concern.

The report sets out how different health needs in the four types of community need different approaches. The local environment and its assets also need to be harnessed to improve health and wellbeing in our communities. We live in a beautiful, green and blue county and we should maximise the health and wellbeing benefits of being outdoors in the countryside and along our coastline and rivers.

There are also ways in which we can maximise training opportunities and recruitment to health and care, flexing the workforce to improve health and wellbeing and the support available. By developing a better understanding of the complexity of our local communities we can target and tailor our approach to prevention and treatment which meets the needs of local people.

Finally, I'd like to acknowledge and thank all of those who have supported the writing and production of this year's Director of Public Health Annual Report.

Derek Ward
Director of Public Health for
Greater Lincolnshire

2.0 INTRODUCTION

In this Annual Report, we have analysed local data and identified four types of community across Greater Lincolnshire. In the following pages we will describe the four types of community and highlight key challenges and opportunities for health and wellbeing, which vary across the different places. We hope this fresh perspective will add value to the work of those supporting health and wellbeing, and delivering health and care services, across Greater Lincolnshire.

Coastal communities have some of the worst health outcomes in England, including low life expectancy and high rates of major diseases. In 2021, the Chief Medical Officer (CMO) highlighted the challenges of coastal communities in his Annual Report, including case studies on coastal communities in Lincolnshire and North East Lincolnshire. The report identified some of the reasons for inequalities and set out a range of recommendations to improve outcomes (DHSC, CMO Annual Report, 2021).

An important challenge noted by the CMO is the lack of data and understanding at this geography to help plan national and local strategies to improve outcomes. The Coastal Communities All Party Parliamentary Group (APPG) agreed in June 2022 that a coastal strategy is needed to address inequalities in education, health, and housing in coastal areas.

In addition to 50 miles of coastline, Greater Lincolnshire has large expanses of rural land and urban centres of different size and make-up. There are some obvious geographic distinctions between these places and each has different challenges and opportunities when it comes to health and wellbeing. Some are subtle differences, for example proximity to neighbouring service centres, which if better understood will help us to promote health, reduce inequalities and provide services to those who need them. Until now, there has been limited work to explore the main characteristics of these different communities and what those characteristics mean for health and wellbeing, and service delivery.

2.1 THE FOUR COMMUNITY TYPES IN GREATER LINCOLNSHIRE

To classify communities, we used small geographies (known as Lower Super Output Areas or LSOAs) to segment areas according to key characteristics. Those key characteristics included features such as building density, industrial make-up, and proximity to the coastline. We have distilled this complex landscape into four “summary-type” models as we describe below. Clearly the geography of the county is far more complex, but to help planning and service delivery we think it is important to simplify whilst still highlighting the key differences.

The four types of community identified across Greater Lincolnshire are:

- Urban centre
- Urban industrial
- Coastal community
- Rural and market town

Each type, and the challenges and opportunities for health and wellbeing, are described in more detail in the chapters that follow.

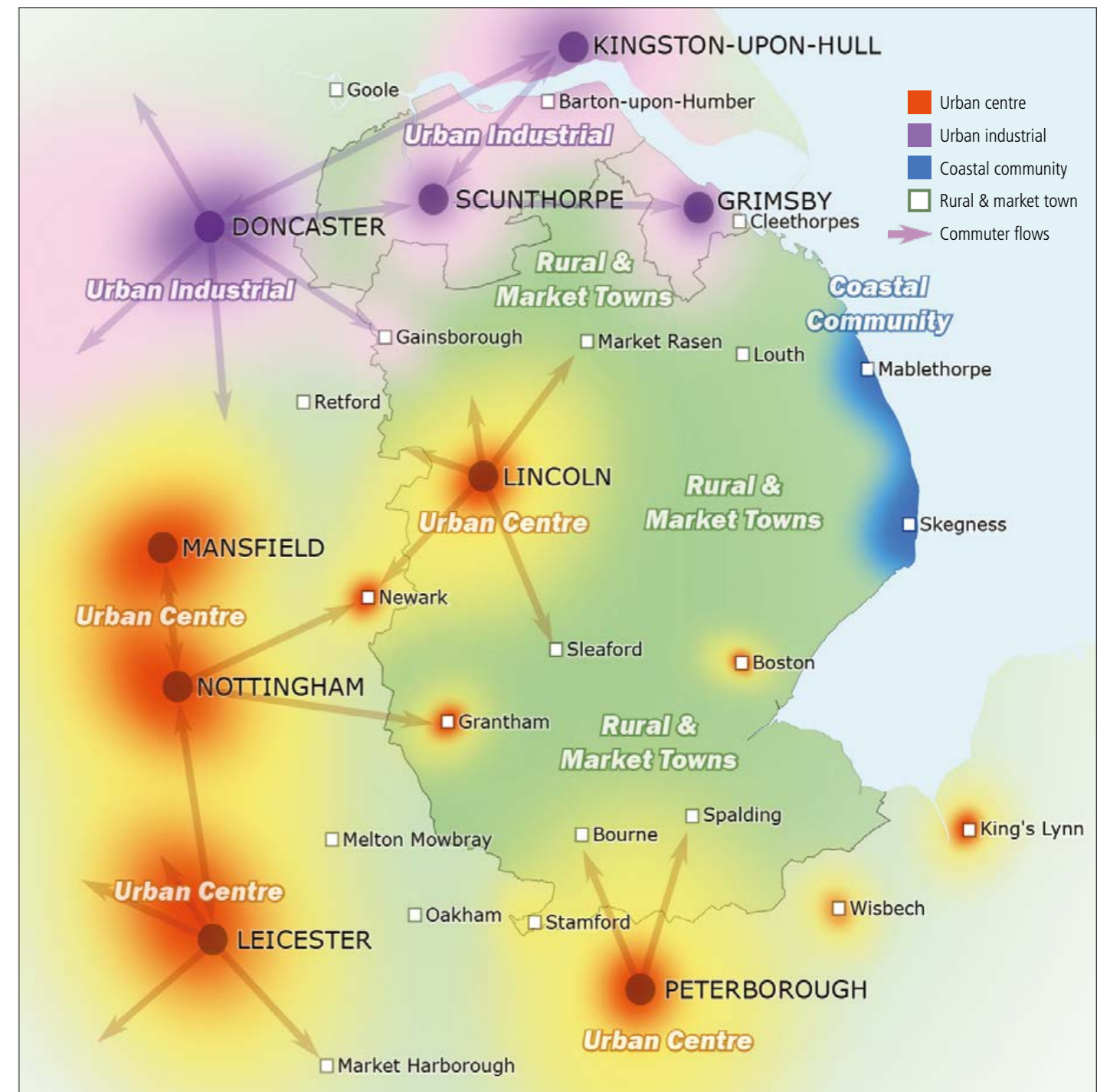
In summary, urban centre communities can be categorised as those where building density is highest. Urban industrial communities also have a high building density but, in addition are characterised by their links to heavy industry such as electricity generation, gas, steel, mining, and quarrying, with a low amount of agricultural work, financial, professional, and scientific

services. Coastal communities are those directly situated on the coast, with local business dominated by accommodation, leisure, and food services. The remaining areas are classified as rural and market town communities. See Figure 1 below for a map showing the different communities.

Whilst this work has identified distinct

geographies with different characteristics, it is important to note that many places have features of more than one type of area. The types are intended to provide greater understanding of the challenges involved in improving health and delivering services across an area as diverse as Greater Lincolnshire. Areas may fall between two types and have

Figure 1: The four types of community in Greater Lincolnshire and where they are found



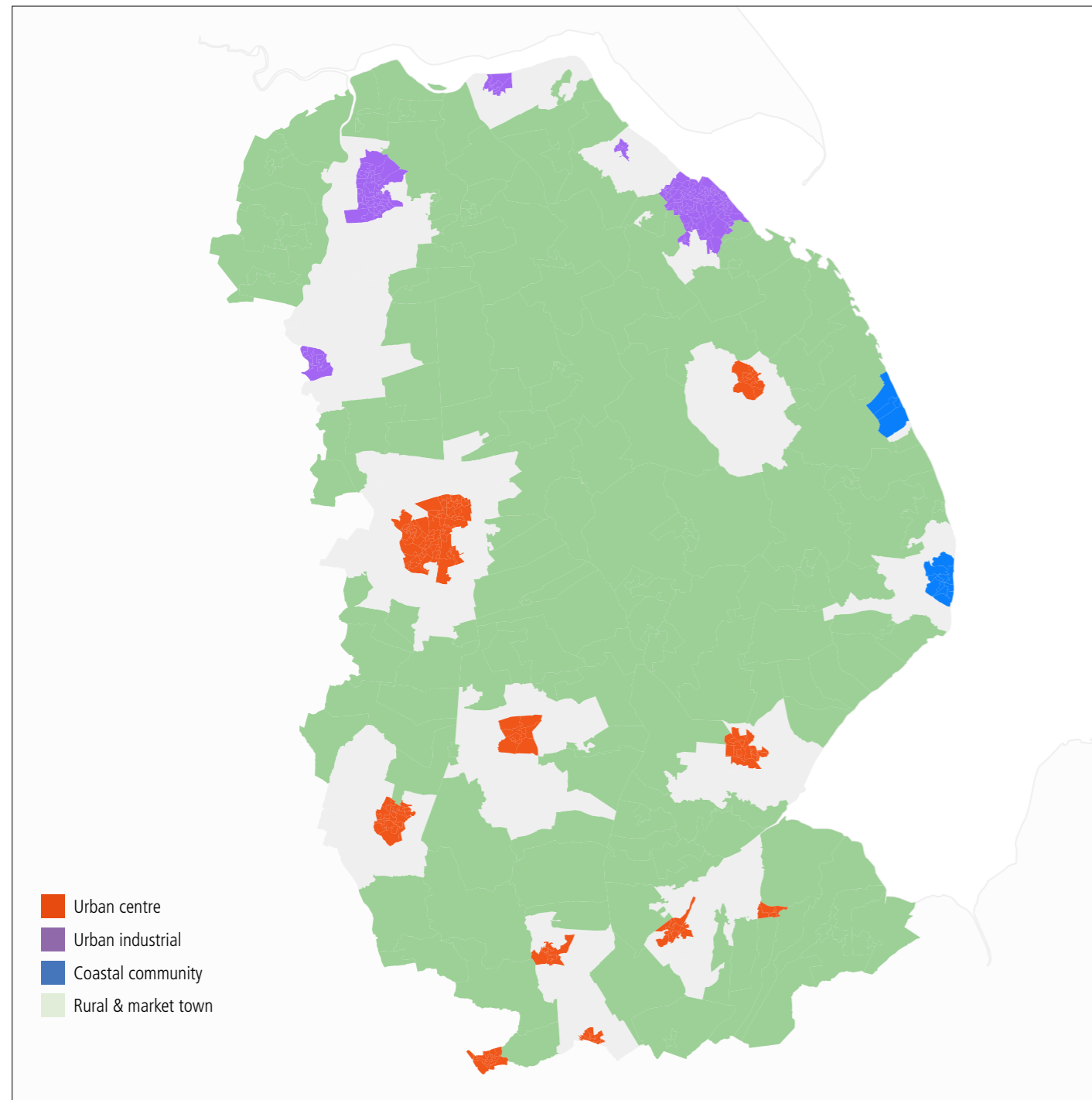
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characteristics of either, or both, depending on their connections. In some instances, an area may have strong linkages with a neighbouring category which changes the challenges and opportunities in that community. A judgement should be made of the most important factors when considering each community, to apply the findings to strategy development and the

planning of services.

To understand the main differences between, and typical natures of, each type of community, only the most central LSOAs for each category were used in statistical analyses. The LSOAs used in analyses are shown in Figure 2.

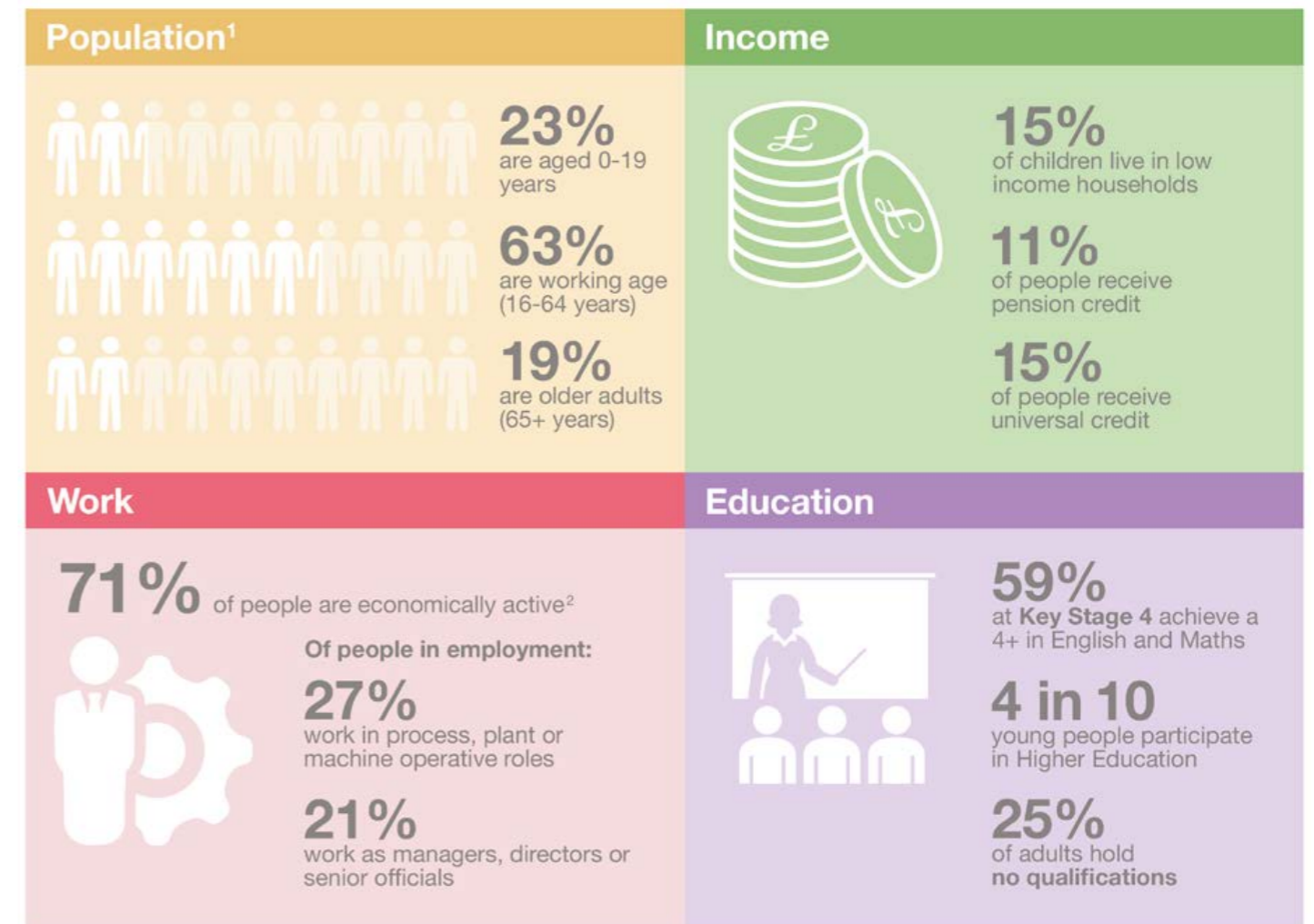
Figure 2: Lower Super Output Areas utilised in category analyses



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3.0 URBAN CENTRES

Urban centres in Greater Lincolnshire – places such as Lincoln, Grantham, and Boston – provide a range of services to surrounding communities as well as significant employment opportunities and transport linkages. Out of a total population in Greater Lincolnshire of around 1.1 million people, an estimated 325,000 live in urban centres. They are often attractive places to live and work because of the cultural, heritage and economic benefits, which mean large numbers of people choose to live in these communities. There are pockets of strong employment, coupled with low social mobility in places. Urban centre communities are younger than average, made up of an economically active population with lower-than-average levels of deprivation and living in good housing. These communities have good access to community and health services.



1. There is an overlap between those who are aged 0-19 and 16-64.
 2. People not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks.



Boston town centre

Lincoln is a regional service sector hub, with dominant employment opportunities in public services across local government and the NHS. The retail, heritage and cultural offer in the city is also strong, bucking the trend of high street decline in similarly sized towns and cities in the East Midlands. The city has a particularly young demographic due to development and investment in the University of Lincoln, and together, the University of Lincoln and Bishop Grosseteste University attract approximately 16,000 students.

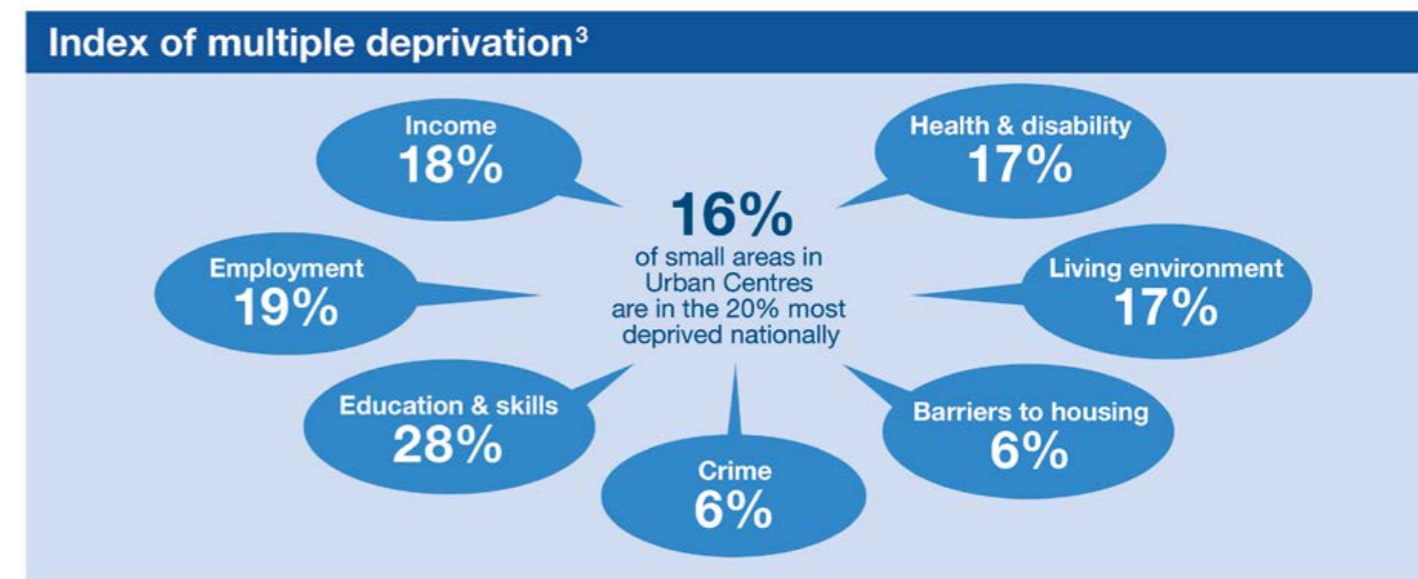
Grantham has a strong manufacturing base, although employment is dominated by public services, food, and logistics. The town is well connected to national infrastructure, intersected by both the A1 and the East Coast mainline. The strategic location of Grantham has led to recent investments to help grow the town, such as the Grantham Southern Relief Road, which will connect the A52 to the A1, bypassing the town centre and creating significant opportunity for development space.

Boston serves as a hub to the nationally important food sector, and therefore food production, haulage and logistics are the

key employment sectors in the town. A large proportion of the population is employed in agency activities, servicing the food and land-based sector. Boston also has a large population of first and second generation migrant workers, particularly from Eastern Europe. As a result, Boston's population has grown more quickly than other towns in Lincolnshire.

With a lower-than-average skills level, employment and wages pose significant risks to the town. Boston Borough is ranked as the most deprived of all local authorities in England in the 'Skills' domain of the 2019 Index of Multiple Deprivation (Department for Levelling Up, Housing and Communities & Ministry of Housing, Communities and Local Government, 2021). It has a more limited sectoral make up compared to Lincoln and Grantham. Levels of entrepreneurialism are low resulting in a relatively 'static' economy. The town centre is attractive, with significant cultural assets; however, infrastructure is a major challenge, particularly given the large flows of goods movement from the food sector and the Port of Boston into the national network.

Urban centre communities have good access



3. The Index of Multiple Deprivation (IMD) is a measure of small area deprivation in England. IMD divides England into 32,844 small areas (average population 1,500 people/650 households) and ranks them from 1 (most deprived) to 32,844 (least deprived). For each of the areas of life presented here (e.g. income, crime, etc), the % represents the number of small areas in this type of community that fall into the 20% most deprived nationally. A higher percentage than 20% means there is more deprivation than the average for England.



to health services. In Greater Lincolnshire, urban centres have above average access to general practice, pharmacy and hospitals

using public or private transport and walking. However, health problems like obesity, respiratory problems, cancer, and diabetes are made worse by unhealthy living and working conditions, inadequate green space, and noise and air pollution (e.g. from traffic congestion and industry). Safe space for walking, cycling and active living can be more limited in urban centres, discouraging healthy behaviours such as active travel.

Overall, urban centres have lower than average rates of elective and emergency hospital admissions. However, hospital admissions due to some specific causes such as cancer and emergency admissions due to falls are higher in urban centres (NHS Digital, Hospital Episode Statistics, 2022). Mortality rates are higher than average in urban centres than across Greater Lincolnshire. The highest all-age disease specific mortality rates are cancer (282 deaths per 100,000 population) and cardiovascular disease (CVD) (272.4 deaths per 100,000 population). Additionally, the all-age suicide rate is also higher than average, although this difference is not statistically significant (NHS Digital, Civil Registration Mortality data, 2022).

KEY CHALLENGES FOR URBAN CENTRE COMMUNITIES

Within urban centre communities, key challenges include:

- Clustering of people from vulnerable groups, usually in the most deprived areas where there are fewer opportunities and more challenges around access to services, work, and health literacy. Areas of deprivation and affluence often sit closely alongside each other and so the geographical scale of analysis matters when targeting support and initiatives.
- Over recent years Boston has seen an influx of Eastern European migrant workers, and the

agri-food industry in the surrounding rural area is reliant on this workforce. There have been some issues with community cohesion, as well as instances of exploitation of migrant workers defined as modern day slavery.

- In some areas, overcrowding can be an issue with concentrations of houses of multiple occupation (HMOs) in the private rented sector. Boston and Lincoln also have the highest number of homeless people and rough sleepers in Lincolnshire. Rough sleeping is known to lead to a significant reduction in life expectancy. The homeless

problem is exacerbated where people have no recourse to public funds due to not having settled status in the United Kingdom.

- The risk of outbreaks of infectious diseases is higher in urban, overcrowded environments; for example, as observed through the Covid-19 pandemic. Health conditions such as Tuberculosis are more common in urban centres and the spread of such infectious diseases is likely to be exacerbated by overcrowded living conditions and rough sleeper congregations on the streets.
- Urbanisation is linked to high rates of depression, anxiety, and mental ill health, and is a growing concern. People living in urban areas can suffer from social isolation even though they live near

other people. Students, young professionals, and migrant workers who have re-located to urban centres are often distanced from their families and usual support networks, and so are at increased risk.

- Urban populations are among the most vulnerable to climate change, experiencing higher temperatures due to the effect of large concrete expanses and lack of green cover (known as urban heat islands). This is something made more acutely obvious during the heatwaves of summer 2022. Parts of Lincoln and Boston are also at risk from fluvial flooding (where rivers, lakes, and streams overflow).

KEY OPPORTUNITIES FOR URBAN CENTRES

- Training opportunities at undergraduate and postgraduate level are limited due to the lack of teaching hospitals in Greater Lincolnshire. Further opportunities could be explored to help seek further investment in a teaching hospital that could help to overcome the challenges presented in the recruitment and retention of a health and care workforce, such as The Campus for Future Living planned in Mablethorpe.
- Increase awareness of opportunities for people to connect and create meaningful community relations and interactions to reduce isolation and increase the feeling of belonging to benefit people's mental health and wellbeing. Continued promotion and development of the Connect to Support Lincolnshire directory of services and community assets would support this.
- Expanding accessible green space and active travel routes would improve health and wellbeing

through the reduction of vehicle traffic and would also increase healthy behaviours such as physical activity.

- Traffic congestion in urban areas can lead to longer journey times and contribute to air and noise pollution. Three of the air quality management areas across Greater Lincolnshire are in Lincoln, Boston, and Grantham. There is an opportunity to support more research into air pollution, particularly how to monitor and tackle particulate air pollution from industries and traffic.
- There should be consistent and concerted use of health impact assessments for new developments (urban extensions) and regeneration schemes. These should consider the potential to exacerbate inequalities between these and unimproved communities.

SUMMARY

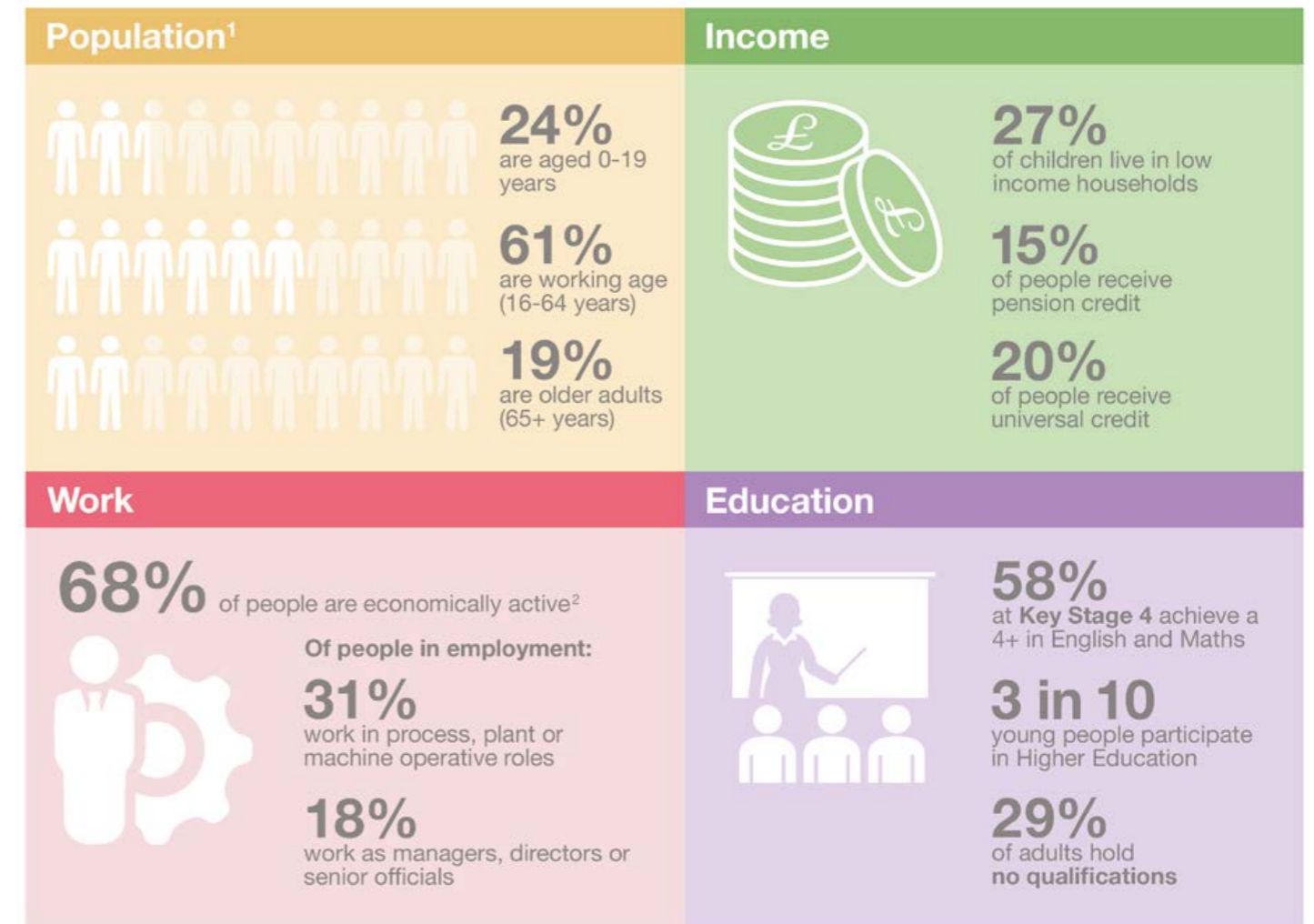
Urban centre communities are younger than average, made up of an economically active population with lower-than-average levels of deprivation usually living in good housing. These communities have good access to community and health services. However, health outcomes in some domains are worse, particularly

cancer, cardiovascular disease, and suicide. Reducing environmental challenges such as air pollution, poorer access to green space and the high density of fast-food outlets would have a significant impact on the health and wellbeing of urban centre communities.



4.0 URBAN INDUSTRIAL CENTRES

Characterised by heavier industry and industrial heritage, including oil, gas, chemicals, steel and mining, urban industrial centres are another ‘type’ of community identified in Greater Lincolnshire. The urban industrial area of Greater Lincolnshire centres around the three towns of Scunthorpe, Grimsby and Gainsborough. An estimated 253,000 people live in urban industrial communities. The heavier industrial base (as well as the industrial heritage) influences the local culture, the types of employment available and the skills needed to take up those jobs, and this is reflected in the health challenges faced. As in other urban centres, there are pockets of strong employment growth, but in urban industrial centres higher levels of economic inactivity and low social mobility are more pronounced. These areas have a younger than average age profile, with over 60% of the population aged under 50 years and almost a quarter under 19.



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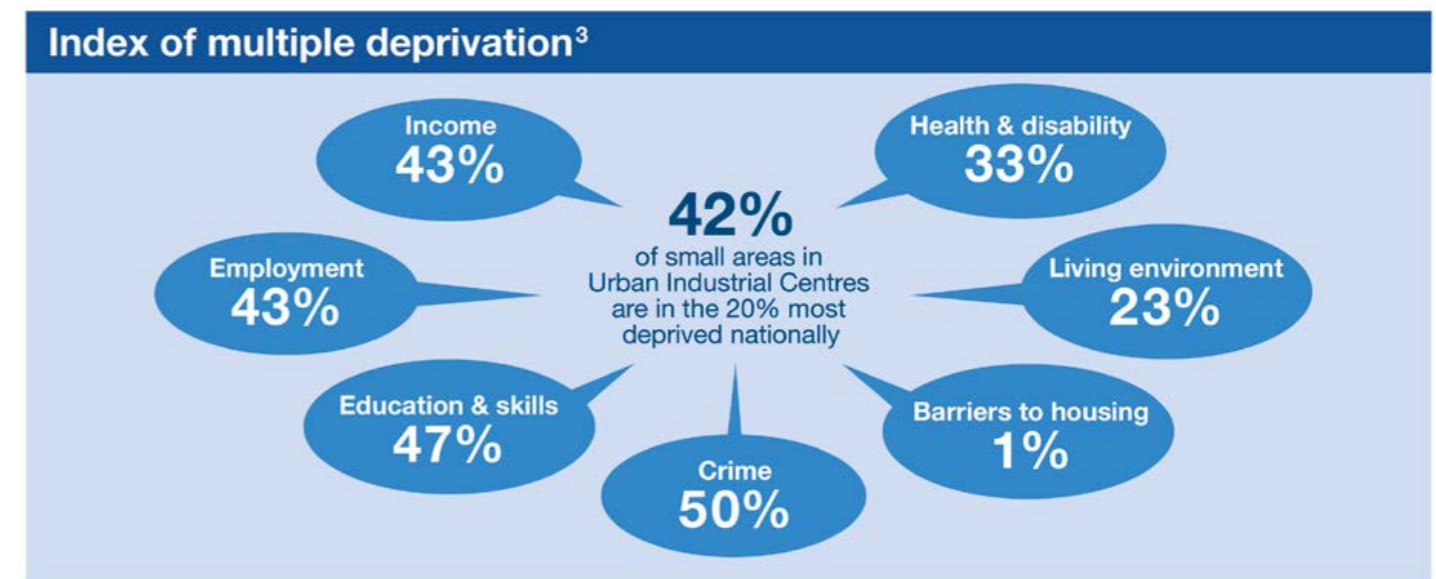
Although their expansion was driven by different industrial drivers – steel for Scunthorpe, port trade and engineering for Gainsborough, and fishing, as well as imported and exported goods, for Grimsby – in modern times all three towns face deep seated socio-economic challenges following rapid de-industrialisation. In many communities, unemployment and economic inactivity is high with low aspiration amongst communities. The Humber bank is the single most polluting cluster in the whole of the UK, connected to 25% of the UK’s energy generation. This means that the area has a major role to play in reaching net zero and big economic opportunities around decarbonisation. Significant levels of investment in the area are anticipated over the coming years making the Humber a major hub for renewables in the UK.

Urban industrial areas are dominated by single people renting low-cost homes in the short-term, families with limited resources, and elderly people. Levels of deprivation are high, much higher than in urban centre communities and rural and market towns. Educational outcomes are worse than average for Greater Lincolnshire, with fewer children achieving a

Level 4 in English and Maths at Key Stage 4 and a lower-than-average proportion of young people participating in further education. Grimsby and the surrounding areas have among of the lowest levels of qualifications in the country. Almost a third of the population is employed in process, plant, and machine operative occupations – the highest across Greater Lincolnshire (ONS, 2011 Census, 2022).

Overall, inequalities in healthy life expectancy are stark, affecting many of the communities living closest to the docks in Grimsby and Scunthorpe, and Gainsborough’s most urban areas. Within Scunthorpe and Grimsby, there are general hospitals supporting the local and surrounding populations with acute care. These hospitals also serve some residents from neighbouring rural areas of Lincolnshire. They are also well served by GP surgeries, and pharmacy provision, however the need for specialist care can result in referral to nearby cities such as Hull, or Sheffield. In comparison, residents of Gainsborough will typically travel to Lincoln for acute hospital care.

Urban industrial centres typically present higher rates of both elective and emergency



3. The Index of Multiple Deprivation (IMD) is a measure of small area deprivation in England. IMD divides England into 32,844 small areas (average population 1,500 people/650 households) and ranks them from 1 (most deprived) to 32,844 (least deprived). For each of the areas of life presented here (e.g. income, crime, etc), the % represents the number of small areas in this type of community that fall into the 20% most deprived nationally. A higher percentage than 20% means there is more deprivation than the average for England.

hospital admissions compared to the wider Greater Lincolnshire population. Hospital admissions due to liver disease are highest here, and admissions due to respiratory disease, cardiovascular disease, and substance misuse are all also higher than average. Rates of admissions due to cancer are lower-than-average, but cancer mortality rates are

significantly higher, which may suggest issues around late diagnosis. Beside cancer, urban industrial areas also have higher mortality rates from cardiovascular, liver, and respiratory disease, as well as above average all-cause mortality rates (NHS Digital, Civil Registration Mortality Data, 2022).

KEY CHALLENGES FOR URBAN INDUSTRIAL COMMUNITIES

Within urban industrial communities, key challenges include:

- Older terraced houses in these towns are more likely than housing in other areas to be poorly maintained, resulting in damp or mould. Often also poorly insulated, these properties can be difficult to heat in winter and vulnerable to extremes of heat in summer (Tunstall, 2013). Increasingly available to residents as short-term private lets, such properties and the associated 'churn' of residents moving in and out of the area, can generate instability in the local population (e.g. affecting personal support networks) and pose a challenge for continuity of services for residents with health or care needs (USCREATES, 2017).
- Urban industrial communities are exposed to higher levels of air pollution from traffic or adjacent industry (Environment Agency, 2021). Two Air Quality Management Areas (AQMAs) are currently in action, one within central Grimsby and the other within Scunthorpe, for Nitrogen Dioxide (NO₂) and particulate air pollution respectively (Defra, 2022).
- The environment is vital in supporting healthy living; however, urban industrial areas have a higher concentration of amenities such as betting shops and fast-food restaurants, as well as poorer access to green open spaces. Rates of anti-social behaviour are higher and litter is much more common, which can affect physical activity levels and reduce mental wellbeing and social connectivity (Glasgow Centre for Population Health, 2013).
- Although physical access to healthcare services is better than in other communities across Greater Lincolnshire, potential barriers remain, such as the ability to attend appointments during the working day due to working long hours or zero hours contracts, as well as educational barriers. These potential barriers are interrelated with the social determinants of health, as well as a lack of system knowledge, and these factors are likely to influence a person's ability to access healthcare in a timely way (Ensor, et al. 2004).
- Geographic isolation combined with poor transport connectivity can make access to employment opportunities in other areas more challenging. Many younger adults move away from home to university or for work and never return to the area. There are enormous challenges within health and social care, in particular the recruitment of professional staff in healthcare with numerous long-term vacancies and considerable agency dependence at the local hospitals.



The Port of Immingham

KEY OPPORTUNITIES FOR URBAN INDUSTRIAL COMMUNITIES

There are also important advantages and opportunities for our urban industrial areas:

- Northern Lincolnshire is uniquely positioned to be at the centre of growth in offshore wind and green energy industries. The ports of Grimsby, Immingham and Killingholme are collectively amongst the biggest ports by tonnage in the UK. The Humber has been made a Freeport which should facilitate the attraction of inward investment to build new facilities (such as manufacturing or research and development), with the likely accompaniment of jobs in the area. The local economy needs stronger foundations and the right support to fully exploit these growth industries and integrate them into the wider economy and community (ultimately translating into better living standards for people in the most deprived neighbourhoods).
- Levelling Up funding has the potential to dramatically improve currently under-utilised, and in parts run down, town centres. In Grimsby major plans are underway to reconnect the "Top Town" area, which includes the Freshney Place shopping centre, to the waterfront areas of the town. This development will include a new cinema, leisure facilities and revitalised indoor market. The potential for developing new healthcare facilities within existing empty town centre buildings are also being explored. The transformation of Scunthorpe town centre as part of the Scunthorpe Town Deal will seek to reduce the number of larger unoccupied shops to create a positive future for many more independent businesses and add jobs in the town centre. There are also plans to revolutionise transport and travel across Barton and Brigg.

SUMMARY

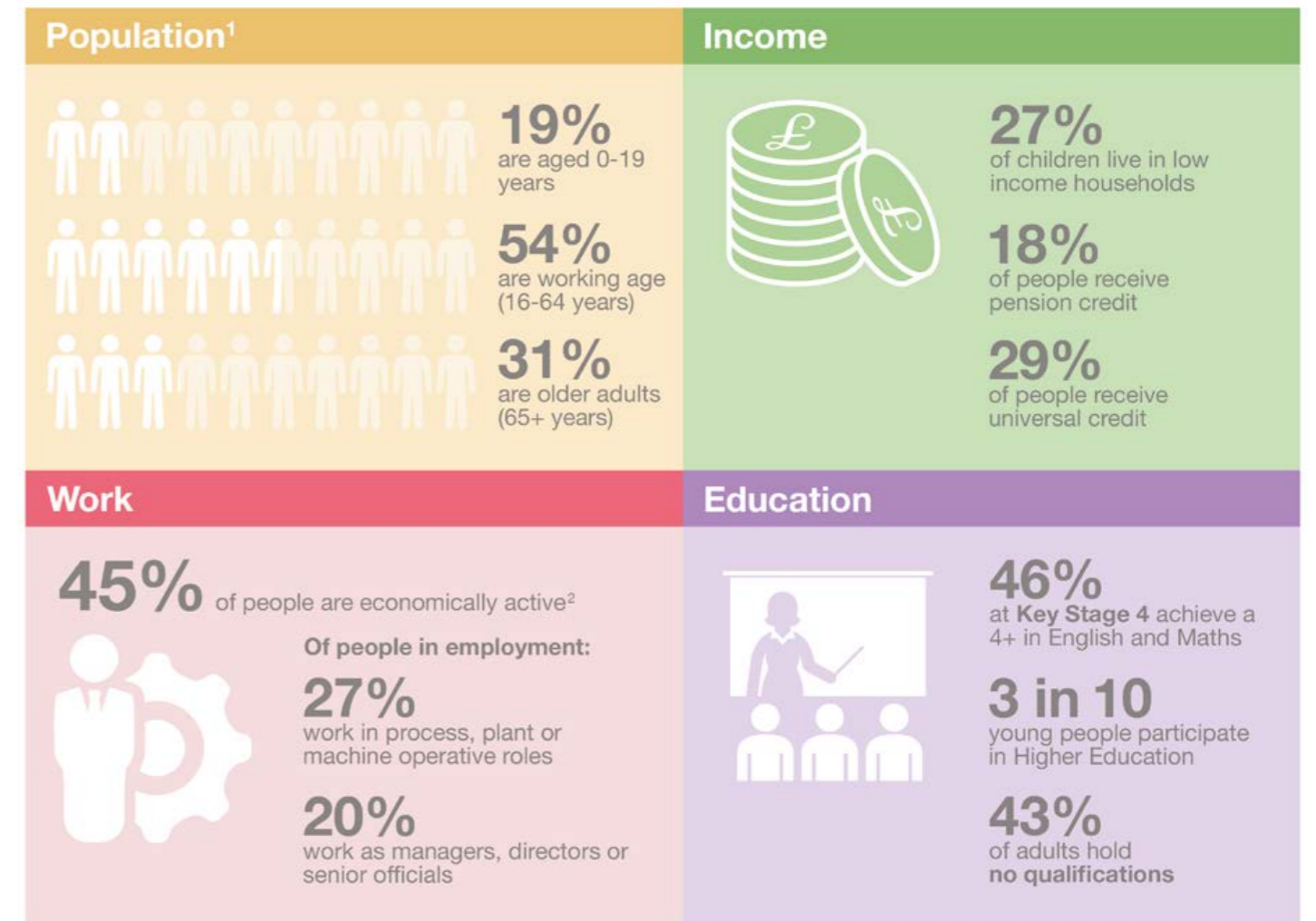
Urban industrial communities, like urban centres, are younger than average and have good access to services and support infrastructure. However, urban industrial communities are particularly challenged by historically embedded, extensive deprivation. There are fewer opportunities for higher education in urban industrial centres and the economy is predominantly focused on

heavy industry and plant/process operation occupations. This contributes to preventable ill health and early mortality. However, there are some important opportunities on the horizon for our urban industrial communities and it is vital that we work together across sectors to make the most of these inward investment opportunities.



5.0 COASTAL COMMUNITIES

From the Humber Estuary to the north and the Wash in the south, Greater Lincolnshire has more than 50 miles of coastline. The coastline is diverse, with coastal resort towns that attract tourists and day trippers (such as Skegness and Mablethorpe) alongside rural coastal communities such as Ingoldmells and Anderby Creek. In Greater Lincolnshire, an estimated 29,000 people live in coastal communities. Coastal communities have a strong local identity and clear patterns of seasonality in business and leisure activity, as well as population.



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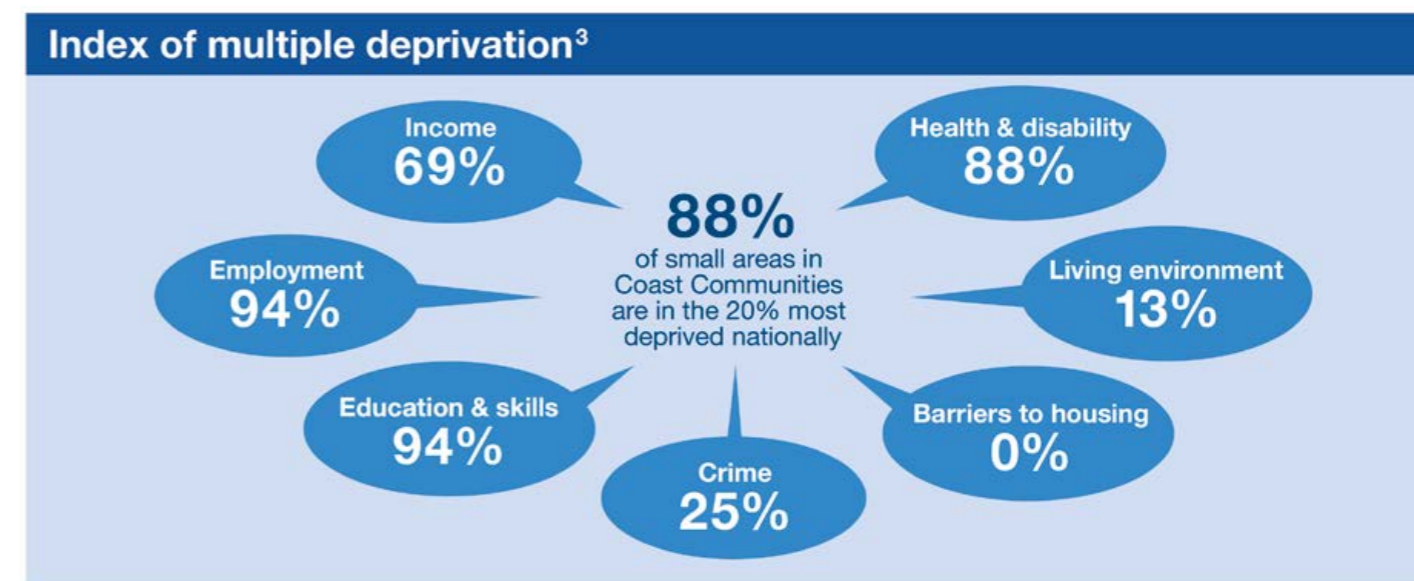
Skegness town and beach

Coastal communities such as Skegness and Mablethorpe all developed in the 19th Century when improving transport routes facilitated the development of these modern-day coastal resorts. Transport routes to coastal areas are limited and so the coast is relatively remote, especially as Lincolnshire’s coastal communities are surrounded by large rural areas. All of Greater Lincolnshire’s coastal communities have a large number of retired people who often live in residential or holiday parks, which means Greater Lincolnshire’s coastal communities have an older than average age profile.

Coastal communities experience significant challenge. They are characterised by high levels of deprivation, with nearly 9 out of 10 coastal community areas in the 20% most deprived areas of England, and over a quarter of children living in low-income households (Ministry of Housing, Communities & Local Government, English Indices of Multiple Deprivation, 2019). Educational attainment is much lower than in other communities, both among children at Key Stage 4 and in adults (Nexus, 2022). Coastal communities also have significantly higher rates of reported crime when compared to other areas, with the exception of urban industrial

communities. This may be a result of the large seasonal influx of people to tourist destinations. Local employment is dominated by low skill and low wage jobs with significant seasonality (East Lindsey District Council and Connected Coast, 2021). Given the heavy reliance of coastal communities on the visitor economy, towns such as Mablethorpe and Skegness were heavily economically impacted during Covid-19 (Centre for Towns, 2020). Flood risk continues to be a major constraint on development, particularly housing, whilst connectivity remains a significant challenge. There are high levels of fuel poverty and poor-quality housing.

The Greater Lincolnshire coastline is beautiful. This blue space includes wild coast, extensive dune-backed salt marsh, internationally recognised Special Protected Areas (SPAs), Sites of Specific Scientific Interest (SSSIs), Special Areas of Conservation (SAC), and national nature reserves fronting the Humber Estuary and the Wash. Residents on the coast can benefit from this extensive green and blue space, which brings benefits for health and wellbeing. Evidence suggests that it is important to regularly visit such sites to enjoy the health benefits, which include a positive association with mental



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wellbeing and negative association with mental distress (White et al. 2021).

Caravan parks are a particular feature of coastal communities, with upwards of 24,000 static caravans along the Greater Lincolnshire coastline (East Lindsey Core Strategy, 2018). Caravan parks bring challenges, including a seasonal influx of temporary residents who often have higher health and care needs.

Coastal communities have good access to both GP surgeries and pharmacies; however, access to more specialised services (such as acute hospitals) is poor. As an example, the journey from Mablethorpe or Skegness to Lincoln Hospital is a 77-mile round trip.

Coastal communities have the highest rates of many unhealthy behaviours (e.g. physical inactivity, smoking, poor diet) and there is a

seasonal influx of people with specific needs linked to homelessness and drug or alcohol misuse that creates a challenge for local service delivery. Coastal community residents have the highest rates of both elective and emergency hospital admissions. Admissions for a range of long-term conditions such as cancer, chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD) and intentional self-harm are significantly higher in coastal communities compared to Greater Lincolnshire as a whole (NHS Digital, Hospital Episode Statistics, 2022). In addition, coastal communities have the highest all-cause mortality rates (both for all ages and for under 75s). The highest disease specific mortality rates in coastal communities are cardiovascular disease and cancer.

KEY CHALLENGES FOR COASTAL COMMUNITIES

Coastal communities across Greater Lincolnshire experience the most entrenched issues. Key challenges include:

- High inward migration of older adults, the economically inactive and people in poorer health, coupled with outward migration of young adults, many of whom leave the area to go to college, university, or for work, and do not return.
- The employment market is dominated by low paid, low skilled, seasonal work, leading to low income and poor long-term career prospects and progression. This contributes to a vicious cycle with educational attainment, leading to significantly lower levels of qualifications, impacting opportunities for higher skilled employment.
- Lower educational attainment also affects health literacy, meaning people may have less understanding about how behaviours affect their health and wellbeing, and around how to make changes to their behaviour.
- Coastal areas often have higher concentrations of fast-food takeaway and gambling outlets, increasing the opportunities for unhealthy behaviours. These structural and environmental factors can impact on the success of individuals and families who are seeking to change health behaviours.
- Coastal communities present a unique challenge in relation to housing. Houses of multiple occupation and temporary accommodation (e.g. static caravans) are common. Whilst more affordable, these units are usually the worst type of accommodation for energy efficiency, contributing to fuel poverty. As static caravans are not meant for permanent living, they are exempt from regulations to control their condition meaning many older, vulnerable people are living in substandard shelter. Additionally, the popularity of coastal areas among retirees has driven up local house prices and newbuild locations are limited due to the coastal flood risk (with some areas, such as the Humberston Fitties, having previously experienced substantial coastal flooding).
- Recruiting and retaining skilled and experienced workers across health and social care (e.g. GPs, experienced practice nurses, dentists and health visitors) is a significant challenge. Delivery of health services is becoming ever-more challenging in coastal areas where they struggle to reach the critical mass needed to be sustainable.
- The health services infrastructure, pharmacies, hospitals, and GPs are put under extra strain during peak holiday season, due to the influx of tourists. Holiday periods, and especially the 'summer swell', cause a lot of demand on Urgent Care Services (Out of Hours) and temporary GP registrations increase across all coastal practices. This is a particular problem as it generates a large volume of work at weekends and bank holidays on an already fragile system.

KEY OPPORTUNITIES FOR COASTAL COMMUNITIES

Greater Lincolnshire's coastal communities have some exciting opportunities ahead:

- The high, and increasing, number of older people provides an opportunity to develop more localised coastal health and care provision, such as the proposed Campus for Future Living in Mablethorpe. This is a medical and innovation hub of national significance, focusing on attracting and developing healthcare professionals, research, and providing intergenerational future living (Connected Coast, 2022).
- The coastal towns of Mablethorpe and Skegness could benefit from a combination of Towns Regeneration Funding or Levelling-Up and UK Renewal Investment to help develop infrastructure in local areas that can support vibrant social networks. Good transport links, community facilities and design that considers how people live and interact are all vitally important to help people to access work, stay healthy and remain linked into their communities.
- The Government's Levelling-up White Paper discusses prosperity across the nation, investing in the poorest communities, giving everyone access to good schools and the opportunity to receive excellent education and training. It identifies good health as being just as important in "spreading opportunity, contributing not only to the economy but also ensuring that everyone, wherever they live, can enjoy fulfilling, happy and productive lives". To achieve this, we need "strong public services not only to support positive health and educational outcomes but also attract new talent and investment to an area, boosting local economies." (Department for Levelling Up, Housing and Communities, 2022). Greater Lincolnshire coast communities must benefit from this agenda.
- Create more opportunities to utilise blue space in coastal regions, for example, by promoting the benefits for both physical and mental health and wellbeing through regular visits to the sea.

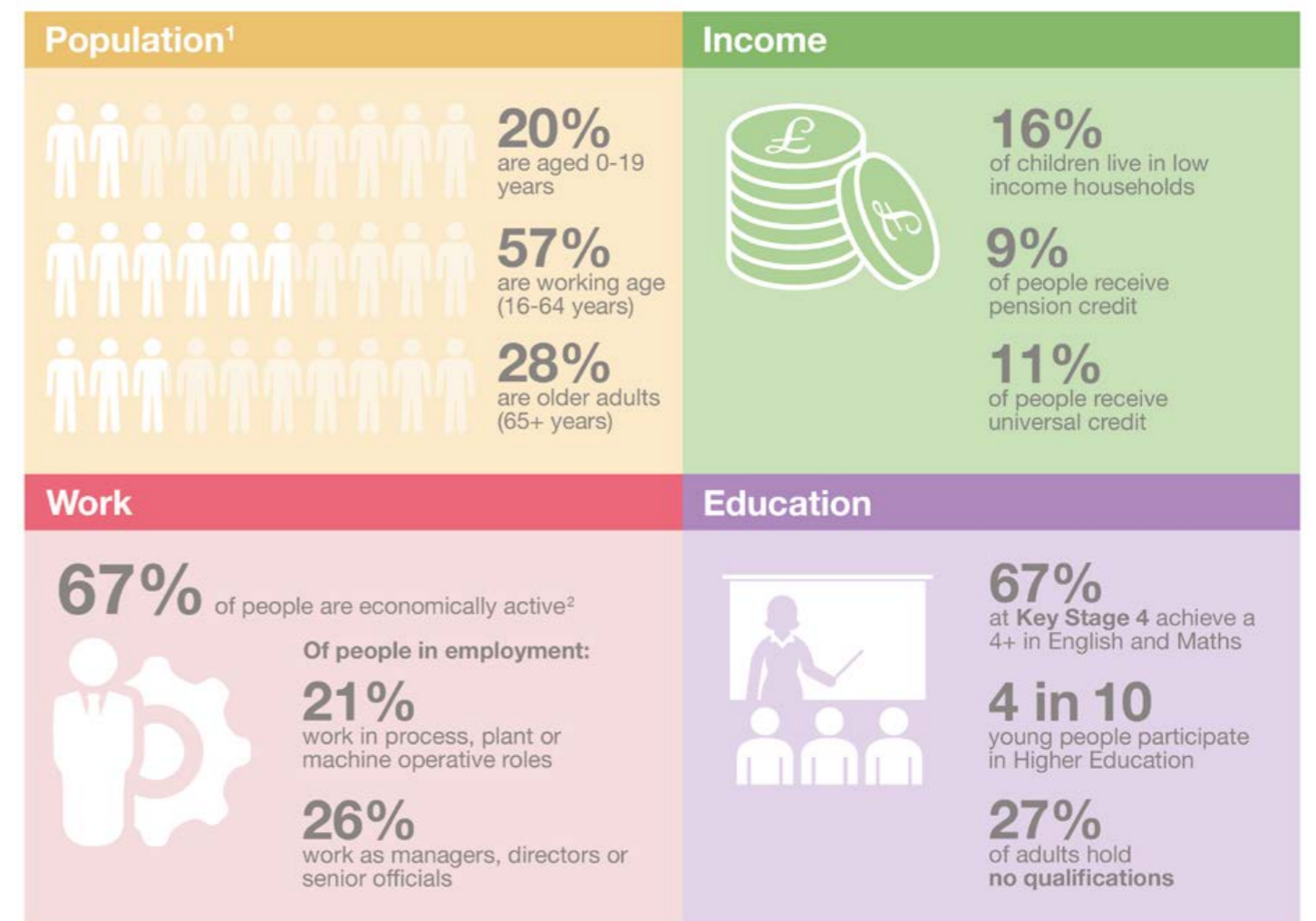
SUMMARY

Coastal communities are challenged by an ageing population and pockets of considerable deprivation. As a result, on average local people have more complex health and care needs than the wider Greater Lincolnshire population. Meeting those more complex needs is challenged by the geographical isolation of coastal communities. Many of the factors contributing to health risks in coastal communities relate to the wider social

determinants of health as well as access to health and care services, so working together with partners across all sectors is especially important. Additionally, there are specific opportunities in our coastal communities (e.g. The Campus for Future Living in Mablethorpe) that, if we work together to deliver, should bring significant benefits to the socioeconomic circumstances and health and wellbeing of coastal community residents.

6.0 RURAL AND MARKET TOWNS

Greater Lincolnshire has large areas of open countryside and farmland, dotted with market towns, villages, and hamlets. In these rural and market town communities, the local population density is low, on average 30 times lower than the national average. That said, an estimated 311,000 people live in rural and market town communities across Greater Lincolnshire. Most people live a long way from urban areas, and this means that many towns and villages have remained self-contained. They often have shops, pubs, post offices, local halls, chapels, and churches, which offer a variety of social activities for residents.



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Holbeach

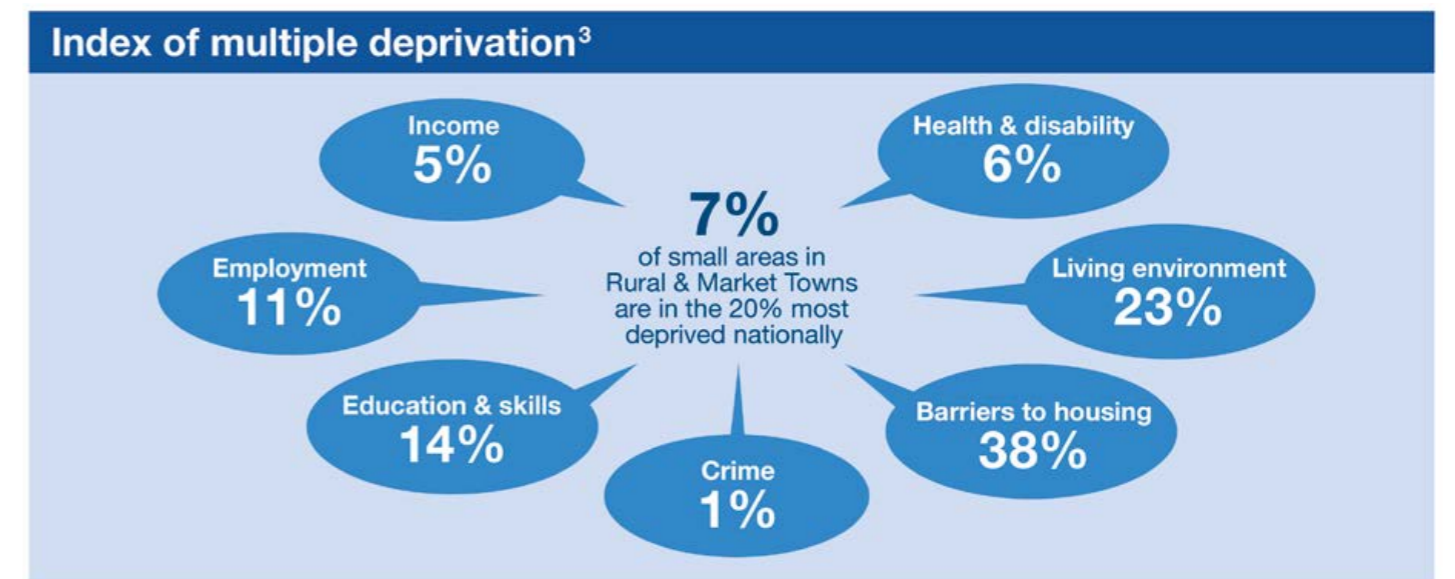
Rural and market town communities are characterised by lower levels of deprivation, apart from barriers to housing and services. Fuel poverty is a challenge for some, with many houses not connected to the gas network and so reliant upon oil or solid fuel for heating. The housing stock is often older and less energy efficient. Both transport and digital connectivity is poorer; the road network is made up of extensive single-track roads which can be a challenge for modern traffic volumes, and digital infrastructure often trails behind urban areas. This can impact on social isolation and limit access to employment and further education.

Greater Lincolnshire's rural and market town communities have good access to green space, with well-evidenced benefits for physical and mental health. Access to formal leisure facilities and events is likely to require access to a car or public transport, so interventions which make the most of abundant open space, such as health walks, are beneficial. Rates of recorded crime are lowest across Greater Lincolnshire in rural communities. Many people living in rural areas are asset rich in terms of property ownership,



but they can be cash limited which may bring additional challenges as the cost of living continues to rise.

The dispersed nature of rural and market towns impacts on access to services, with provision usually more limited than in urban areas. Health outcomes such as life expectancy, infant mortality and premature mortality are better; however, average outcomes can mask small pockets of significant deprivation and



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poor health (Local Government Association, 2017). Additionally, whilst premature mortality from cardiovascular and respiratory disease is significantly lower than average, hospital admissions for cancer and mental health are above average. This might suggest a lower awareness of certain types of support (e.g. cancer screening and mental health services) and/or that such services are more difficult to access.

To improve health and wellbeing outcomes in rural and market town communities, we must make outreach – physically or digitally enabled – a priority for service development. This is because evidence tells us that the further an individual must travel to health services,

the less likely they are to use those services (LGA, 2017). Patients in rural areas under-use health care services (Asthana et al., 2003) and tend to be in worsening health when they do present (Campbell et al., 2001), requiring a more intensive response (Rural England, 2016).

North East Lincolnshire and Lincolnshire's district councils are key to reducing health inequalities, influencing planning and housing policy, managing developments, homelessness prevention, energy efficiency promotion and Disabled Facilities Grants. Town and parish councils can also help develop an understanding of the local health profile and proactively promote health in their communities (LGA, 2017).

KEY CHALLENGES FOR RURAL AND MARKET TOWN COMMUNITIES

Within rural and market town communities, key challenges include:

- Outward migration of younger people and inward migration of older people. Older adults are likely to have comparatively more complex health and social care needs and experience greater levels of frailty than the healthier working age individuals moving out of the area, increasing pressure on health and care services.
- Increasing demand for rural living and migration from high income urban households is contributing to an acute housing crisis in rural areas and driving out low-income households. Only 8% of the housing stock in rural areas is affordable housing, compared to 20% in urban areas. This 8% is insufficient to meet demand (Institute for Public Policy Research (IPPR), 2018).
- Pastoral and arable farming are both common, affecting air quality on farms and in surrounding communities. Farm workers are particularly vulnerable to respiratory conditions, dizziness, nausea and even death, from direct and prolonged exposure to emissions. With limited regulations other than Environmental Permitting in place to protect them, nearby communities

may experience dirt and dust exposure and excessive plant and algal growth (eutrophication) of fresh water. This is an area of limited understanding but an important issue for the health of our rural communities.

- Farmers work with potentially dangerous machinery, chemicals, livestock, at height or near pits and are exposed to harsh weather, vibration, noise, and dust. The nature of the work is physically demanding and repetitive. As a result, the number of fatalities, serious injuries, illness, or disabilities directly caused by agricultural work is significantly higher than other sectors (HSE, 2010). The personal and societal costs of this can be devastating and the true levels of ill health are unclear because often individuals in this sector do not consult their doctor or report incidents.
- International migration, particularly around Boston and South Holland, where many Eastern European migrants have travelled to for employment opportunities. They often live in private rented accommodation, accepting poor and overcrowded conditions, which can contribute to the spread of communicable diseases.

- Much of the employment in rural and market town communities is precarious, low paid and seasonal in nature, contributing to poverty. Further, the transient nature of the workforce affects our understanding of population health needs. Lincolnshire continues to work with the National Centre for Rural Health and Care to develop this evidence base.
- Recruiting and retaining an appropriately sized and skilled health and care workforce is challenging and a priority for the Lincolnshire Integrated Care System. Challenges include the social (e.g. housing availability and lack of leisure opportunities), the professional (e.g. limited specialist roles and the risk of professional isolation) and the demographic (e.g. age means that many professionals are leaving the workforce).

- Rural health and care services face additional costs due to diseconomies of scale, local markets for land, building and labour, longer travel times and high staff turnover. One of the biggest challenges in rural Greater Lincolnshire is the provision of community support (home care) to speed up hospital discharge. The ageing and geographically dispersed population makes care provision costly, contributing to higher charges for social care.
- Rising costs are threatening the viability of residential care homes and there is an under-representation of sheltered housing in rural areas (Rural England, 2017). Increasing the provision of housing with care, with a range of tenure options including shared ownership and private purchase is necessary.

KEY OPPORTUNITIES FOR RURAL AND MARKET TOWN COMMUNITIES

There are also important advantages and opportunities for our rural communities, including:

- Rural neighbourhoods tend to have a strong community identity. This can lead to good community assets such as Good Neighbour Schemes and Men's Shed projects. Involvement with the voluntary sector such as the Humber and Wolds Rural Action, YMCA and branches of Age UK provides support for local communities and helps reduce isolation.
- Lincolnshire's rural strategic partnership with the Centre for Ageing Better is supporting our ageing population. East Lindsey has recently become the UK's first age-friendly district.
- Environmental Land Management Scheme funding could be used to better support rural Lincolnshire areas. Farmers and other land managers enter into financial agreements to deliver clean and plentiful water, clean air,

thriving plants and wildlife, protection from environmental hazards, reduction of and adaptation to climate change and beauty, heritage, and engagement with the environment.

- There are specific opportunities to enhance rural connectivity and access to services through enhancing provision of JustGo, Call Connect and voluntary car schemes (providing on-demand travel services), using public estates to develop rural multi-use centres and community hubs, and delivering services more rurally by using outreach, mobile services, and technology.
- Exploring use of the government's Rural Gigabit Voucher Scheme and Project Gigabit to improve broadband in rural Lincolnshire by 2026. This would enhance employment opportunities and reduce wider digital exclusion currently experienced in some rural areas.

SUMMARY

Rural and market town communities are made up of an older middle age and ageing population, which is highly dispersed across large spaces. Communities are more affluent (with small pockets of significant rural deprivation), but there are specific challenges, for example, energy inefficient properties. Access to health and community services is poorer than

average; however, the health of the population is generally better than average. There are specific opportunities to improve the health and wellbeing of the local population, for example through government schemes around land management and digital infrastructure, and through adapting services to increase outreach into local, often isolated communities.



Louth town centre

7.0 CONCLUSION AND RECOMMENDATIONS

We have identified four dominant ‘types’ of community in Greater Lincolnshire:

- Urban centre
- Urban industrial
- Coastal community
- Rural and market town

Whilst each community faces a set of opportunities and challenges that lead to different health outcomes, there are also commonalities in the challenges facing communities in Greater Lincolnshire. For example:

- Poor housing and fuel poverty are issues in pockets across the whole region but for different reasons, that require different solutions, in our urban versus rural areas.
- The lack of a teaching hospital makes it more difficult to recruit and retain a health and care workforce across the entire county, but the problem gets worse closer to the coast.
- Poor air quality is known to be a challenge in urban areas, but the impact of agricultural air pollution and its effect on farmers and farm workers is poorly understood.

So what does this mean for improving health and wellbeing across Greater Lincolnshire?

DIFFERENT HEALTH NEEDS NECESSITATE DIFFERENT APPROACHES

Differences in health outcomes, as well as access to primary and secondary care services across Greater Lincolnshire, are stark. The inverse care law states that those who most need medical care are least likely to receive it. There are several reasons for this, that vary by place, and which is why the Integrated Care Partnership must work together to understand local need and tailor services accordingly. For example, services in our coastal communities are challenged by the wicked combination of

geographical isolation and low levels of local skilled workforce. Coastal and urban industrial communities are challenged by low levels of education which impact on health literacy and a person’s ability to navigate our complex health system. And so on... There is significant analysis underpinning this Annual Report that can be used, alongside Population Health Management, to develop a more nuanced approach to health improvement and healthcare delivery across Greater Lincolnshire.

FLEXING THE WORKFORCE IS KEY TO IMPROVING HEALTH AND WELLBEING

There are health and care workforce challenges across Lincolnshire, and many of the shortages faced locally are also national challenges that are well rehearsed. Additionally in Greater

Lincolnshire, as there is no teaching hospital, there are limited training opportunities at undergraduate and postgraduate level, which adds to challenges around recruitment and

retention of the workforce. As a health and care system, Greater Lincolnshire needs to maximise the impact of developments such as the Medical School at the University of Lincoln and The Campus for Future Living planned in Mablethorpe on the workforce, for example through creating opportunities for training and recruiting health and care professionals. Lincolnshire's coastal and rural communities also have an aging population and supporting older working age adults to participate in the

health and care workforce could be another important way to expand the workforce, reduce dependency on agencies and improve health and care outcomes. The Centre for Ageing Better are working across Lincolnshire to explore how best to support older adults in the workforce (e.g. their GROW programme), and collaborating around health and care roles specifically could be a good way to tackle some of the workforce challenges across the county.

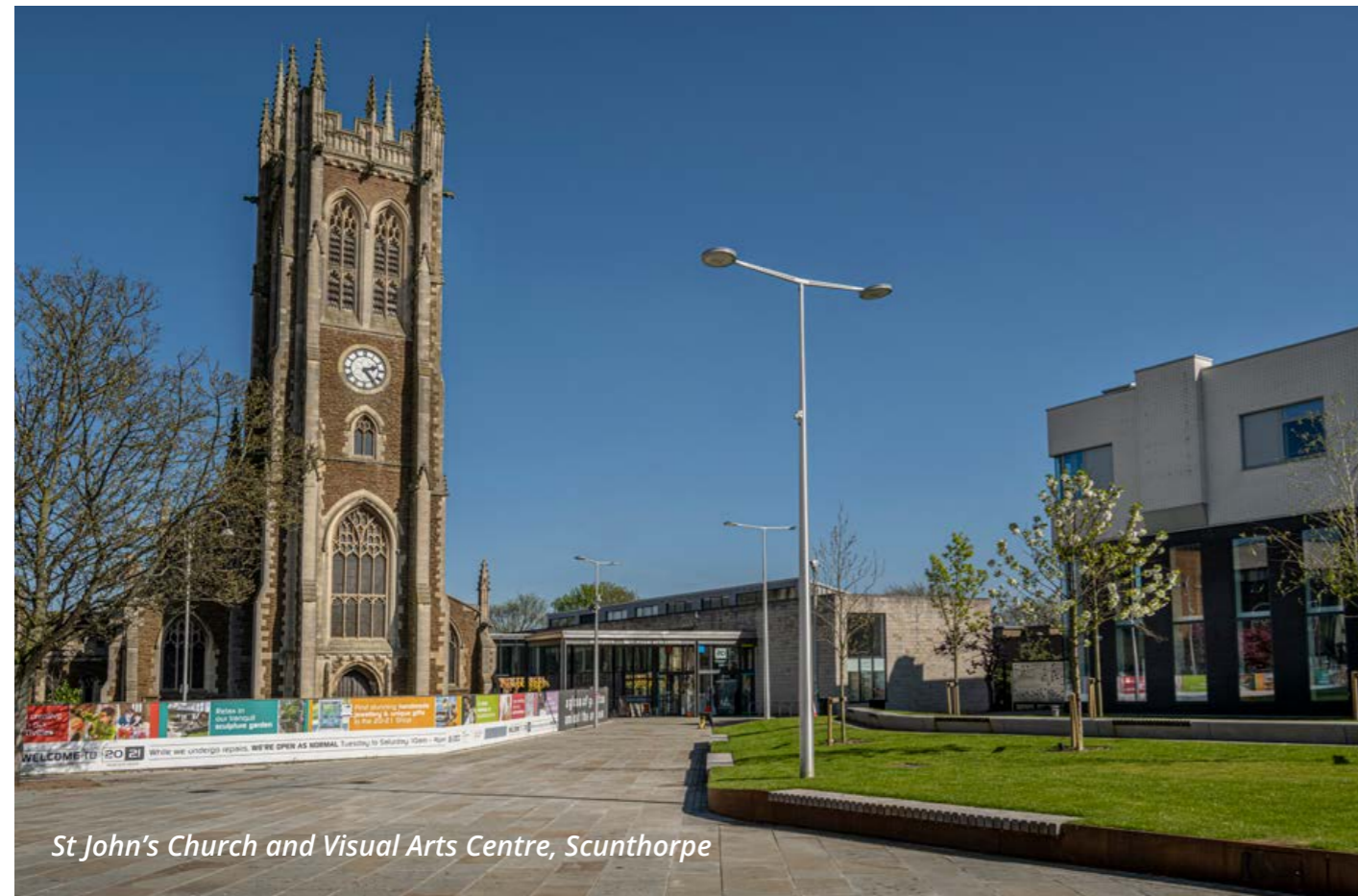
HARNESS THE LOCAL ENVIRONMENT & ASSETS

The local environment is an important enabler for health and wellbeing, but we do not always make the best use of the environment in supporting our local communities. For example, there is a growing evidence base on the benefits of blue space (both coastal and inland) for health and wellbeing, but it is not enough to have the blue space nearby to reap the benefits. Regular

visits – i.e. twice a week – bring the most health benefits. We need to make sure that our health and care workforce knows about, and knows how to support, local people to make the most of evidence-based opportunities to strengthen health and wellbeing that are on the doorstep of our different communities.

There are significant challenges for preventing ill health and improving life expectancy across Greater Lincolnshire. With the areas of greatest need also those literally the hardest to reach, there are significant challenges ahead for improving health and wellbeing and reducing

health inequalities. By developing a better understanding of the complexity of our local communities, we can begin to tailor our approaches to prevention and treatment in a way that better meets the needs of local people.



St John's Church and Visual Arts Centre, Scunthorpe

RECOMMENDATIONS

1. **Improve awareness of the diversity of Greater Lincolnshire's communities, and specifically what this means for health and wellbeing, across the workforce and volunteer community.**
2. **Embed recognition of, and a requirement to respond to, Greater Lincolnshire's diverse communities within practice across the Integrated Care Systems, to inform a more nuanced approach to service design and intervention delivery.**
3. **Explore opportunities to build understanding and intelligence around diverse communities into the Population Health Management approach across Greater Lincolnshire's Integrated Care Systems.**
4. **Support local communities to know about and act upon the benefits that natural and man-made assets, which vary across Greater Lincolnshire's diverse communities, can bring to health and wellbeing.**
5. **Raise awareness, across the health and social care system, of significant inward investment that has the potential to improve health and wellbeing, and how we can shape and influence these developments (e.g. around workforce development).**
6. **Be innovative in designing and delivering a health and care workforce to meet the needs of Greater Lincolnshire, including working with communities who may be looking for increased flexibility.**

8.0 REFERENCES

- Asthana, S., Gibson, A., Moon, G., and Brigham, P. (2003) 'Allocating resources for health and social care: the significance of rurality', *Health & Social Care in the Community*. 11(6), pp.486–493
- Appleby, J. and Deeming, C., (2001), 'Inverse care Law', *The King's Fund*, Available at: www.kingsfund.org.uk/publications/articles/inverse-care-law (Accessed, 26 July 2022)
- Brems, C., Johnson, M.E., Warner, T.D. and Roberts, L.W. (2006) 'Barriers to healthcare as reported by rural and urban interprofessional providers', *Journal of Interprofessional Care* 20:2, pp.105–118
- British Lung Foundation, (2021), 'Indoor Air Pollution', *The British Lung Foundation*, Available at: www.blf.org.uk/sites/default/files/Indoor%20air%20pollution%202021.pdf (Accessed, 11 August 2022)
- Campbell, N.C.E., Sharp, A.M., Ritchie, L.D. et al. (2001) 'Rural and urban differences in stage at diagnosis of colorectal and lung cancers', *Br J Cancer* 84(7), 910–914
- Centre for Towns, (2020), *Covid-19 and our Towns*, Available at: www.centrefortowns.org/reports/reports/covid-19-and-our-towns (Accessed, 25/08/2022)
- Connected Coast, (2022), *Campus for Future Living*. Available at: <https://connectedcoast.co.uk/project/campus-for-future-living/> (Accessed, 11 August 2022)
- DATA.POLICE.UK, (2022), *Lincolnshire Police Recorded Crime – Burglary*, Available from <https://data.police.uk/> (Accessed, 18/08/2022)
- Department for Environment Food & Rural Affairs (DEFRA), (2021), *Fuel Poverty in Rural Areas*. Available at: www.gov.uk/government/statistics/fuel-energy-and-fuel-poverty-in-rural-areas/fuel-poverty-in-rural-areas. (Accessed, 14 July 2022)
- Department for Environment Food & Rural Affairs (DEFRA), (2022), 'List of Local Authorities with AQMAs', Available at: <https://uk-air.defra.gov.uk/aqma/list> (Accessed, 26th July 2022)
- Department for Environment Food & Rural Affairs, (DEFRA), (2016), *Statistical Digest of Rural England*. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/554505/Statistical_Digest_of_Rural_England_2016_September_edition.pdf (Accessed, 14 July 2022)
- Department of Health and Social Care (DHSC), (2021), Chief Medical Officer's Annual Report 2021: *Health in Coastal Communities*, Available at: www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities
- Department for Levelling Up, Housing and Communities, (2022), *Policy Paper Levelling Up the United Kingdom*, Available at: www.gov.uk/government/publications/levelling-up-the-united-kingdom (Accessed, 12 August 2022)
- Department for Leveling Up, Housing and Communities & Ministry of Housing, Communities and Local Government, (2020), *Indices of Multiple Deprivation 2019 (IMD)*, Available at: www.gov.uk/government/collections/english-indices-of-deprivation
- Department for Transport, (2021), *Journey Time Statistics*, Available at: www.gov.uk/government/collections/journey-time-statistics (Accessed, 18/08/22)
- Department for Work and Pensions (DWP), (2022), *Stat-Explore*
- East Lindsey District Council, (2018), *East Lindsey Local Plan Core Strategy Adopted July 2019: Supporting Economic Growth for the Future*, Available at: www.e-lindsey.gov.uk/media/9791/Core-Strategy/pdf/Core
- East Lindsey District Council and Connected Coast, (2020), *Mablethorpe Town Investment Plan*, Online available at: <https://connectedcoast.co.uk/wp-content/uploads/2022/06/Mablethorpe-Towns-Fund-Proposal-V12-compressed-compressed-2.pdf> (Accessed, 25/08/2022)
- Ensor, T. and Cooper, S. (2004), 'Overcoming barriers to health service access: influencing the demand side', *Health Policy and Planning* 19(2), pp.69–79
- Environment Agency, (2021), *State of the environment: health, people and the environment*, Available at: www.gov.uk/government/publications/state-of-the-environment/state-of-the-environment-health-people-and-the-environment
- Everitt, A. (1996), 'County Carriers in the nineteenth century', *Journal of Transport History, 2nd Series*, vol.3, no.3, pp.179-202
- Experian Information Solutions, (2022), *Mosaic*, Available at: www.experian.co.uk/business/platforms/mosaic (Accessed, 18 August 2022)
- Farming UK, (2018), *More than one agricultural worker in UK commits suicide a week*. Available at: www.farminguk.com/news/more-than-one-agricultural-worker-in-uk-commits-suicide-a-week-figures-show_48613.html (Accessed, 10 August 2022)
- Fecht, D., Jones, A., Hill, T., Lindfield, T., Thomson, R., Hansell, A.L. and Shukla, R. (2018) 'Inequalities in rural communities: adapting national deprivation indices for rural settings', *Journal of Public Health*, 40(2), 419–425. Available at: <https://doi.org/10.1093/pubmed/fox048>. (Accessed, 2 August 2022).
- Greater Manchester Office of Data Analytics (GMODA), (2021), *Digital Exclusion Risk Index*, Available at: www.gmtableau.nhs.uk/t/
- Gurnham, R. (2014), *The Story of Boston*, Stroud, The History Press
- Health Education England, (n.d.), *Improving Health Literacy*. Available at: www.hee.nhs.uk/our-work/knowledge-library-services/improving-health-literacy (Accessed, 26 July 2022).
- Health and Safety Executive, (2010), *About health and safety in agriculture*. Available at: www.hse.gov.uk/agriculture/hsagriculture.htm (Accessed, 10 August 2022)
- HM Government, (2018), *A connected society a strategy for tackling loneliness*, Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/936725/6.4882_DCMS_Loneliness_Strategy_web_Update_V2.pdf (Accessed, 11 August 2022)
- Impact on Urban Health, (2019), *Urban Health*, Online, Available at: <https://urbanhealth.org.uk/our-work/urban-health> (Accessed 25/08/22)
- Institute of Health Equity, (2020), Health equity in England: The Marmot Review 10 Years on
- Institute for Public Policy Research, (2018), *A new rural settlement: fixing the affordable housing crisis in rural England*, Available at: www.ippr.org/research/publications/a-new-rural-settlement (Accessed, 14 July 2022)
- Jones, R., and Yates, G., (2013), 'The built environment and health: an evidence review', *Glasgow Centre for Population Health*, Available at: www.gcph.co.uk/assets/0000/4174/BP_11_-_Built_environment_and_health_-_updated.pdf
- Joseph Rowntree Foundation, (2012), *UK Migrants and the private rented sector*, Available at: www.jrf.org.uk/report/uk-migrants-and-private-rented-sector (Accessed, 14 July 2022)
- Lincolnshire Police, (2022), *FOI 000208 Hare Coursing*. Available at: www.lincs.police.uk/foi-ai/lincolnshire-police/disclosure-logs/2022/foi-000208-hare-coursing-2021-2022/ (Accessed, 10 August 2022)
- Lloyd, M. (1983), *Portrait of Lincolnshire*, London, Robert Hale

- Local Government Association, (2017), *Health and wellbeing in rural areas*. Available at: Health and wellbeing in rural areas (local.gov.uk) (Accessed, 13 July 2022)
- Ludlam, A.J. (2014), *Trains to the Lincolnshire Seaside... Volume 3: Cleethorpes, Ludborough, Lincolnshire Wolds Railway Society*
- Ministry of Housing, Communities & Local Government (DCLG), (2019), *English indices of deprivation 2019*, Available at: www.gov.uk/government/statistics/english-indices-of-deprivation-2019 (Accessed, 18 August 2022)
- MYBOSTON.COM, (2022), *Museum*, Online, Available at: www.mybostonuk.com/bostonguildhall/museum/ (Accessed, 12/07/2022)
- National Housing Federation, (2018), *A Manifesto for Affordable Rural Homes*, Available at: https://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/A_manifesto_for_rural_homes_web_vsn.pdf (Accessed, 14 July 2022)
- NHS Digital, (2022), *Civil Registration Mortality Data*
- NHS Digital, (2022), *Hospital Episode Statistics (HES)*. Available at: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics
- OFCOM, (2014) *Ocom Infrastructure Report*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/538822/Broadband_Indicator_May_2016v2.pdf (Accessed, 14 July 2022)
- Office for Health Improvement & Disparities (OHID), (2022), *Public Health Profiles*, Available at: https://fingertips.phe.org.uk/search/life%20expectancy (Accessed, 24/08/2022)
- Office for Health Improvement & Disparities (OHID), (2022), *Local Health*, Available at: https://fingertips.phe.org.uk/profile/local-health (Accessed, 26 July 2022)
- Office for National Statistics (ONS), (n.d.), *2011 Census*, Available at: www.ons.gov.uk/census/2011census (Accessed, 11 August 2022)
- Office for National Statistics (ONS), (2022), *Claimant count and vacancies time series*, Available at: www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/datasets/claimantcountandvacanciesdataset (Accessed: 18/08/2022)
- Office for National Statistics, (2020), *Coronavirus and loneliness*, Available at: www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/coronavirusandloneliness. (Accessed, 2 August 2022)
- Office for National Statistics (ONS), (2022), *Coronavirus (COVID-19): Main figures*, Available at: www.ons.gov.uk/ (Accessed, 11 August 2022)
- Office for National Statistics (ONS), (2022), *Population estimates for the UK, England and Wales, Scotland and Northern Island: mid-2020*, Available at: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2020#:~:text=1.,%25)%20since%20mid%2Dyear%202019 (Accessed. 12 August 2022)
- Ordnance Survey, (2022), *Greater Lincolnshire* [Crown Copyright and database right 2022. Ordnance Survey 100025370]
- Palmer, B., Appleby, J., & Spencer, J. (2019), *Rural health care: A rapid review of the impact of rurality on the costs of delivering health care*, London, Nuffield Trust
- Phillips, J.M. (2019), *An examination of culture and leisure in Boston Lincolnshire 1775-1875*, Unpublished essay for the degree of MA in History, The Open University
- Phillips, J.M. (2020), *The Development of Skegness Lincolnshire as a Leisure Resort 1870-1914*, Unpublished dissertation for the degree of MA in History, The Open University
- Public Health England, (2019), *An evidence summary of health inequalities in older populations in coastal and rural areas*, Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/824717/Health_Inequalities_in_Ageing_in_Rural_and_Coastal_Areas-Messages_and_summary.pdf (Accessed, 19 July 2022)
- Public Health England, (2019), *Health inequalities ageing in rural and coastal areas*, Available at: www.gov.uk/government/publications/health-inequalities-in-ageing-in-rural-and-coastal-areas (Accessed, 11 August 2022)
- Robinson, D.N. (1981), *The Book of the Lincolnshire Seaside*, Buckingham, Barracuda Books Ltd
- Rural England, (2016), *Older people in rural areas: Vulnerability due to poor health paper*, Available at: https://ruralengland.org/wp-content/uploads/2015/12/Final-report-Poor-Health.pdf (Accessed, 19 July 2022)
- Rural England, (2017), *State of rural services 2016*, Available at: https://ruralengland.org/wp-content/uploads/2017/01/SORS-2016-full-report.pdf (Accessed, 19 July 2022)
- Stafford, M., et al., (2018), *Social connectedness and engagement in preventative health services: an analysis of data from prospective cohort study*, Available at: www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30141-5/fulltext (Accessed, 13 July 2022)
- Tunstall, R., (2013), 'The links between housing and poverty', Joseph Rowntree Foundation, Available at: www.jrf.org.uk/report/links-between-housing-and-poverty (Accessed, 11 August 2022)
- USCREATES, (2017) 'Personal perspectives on urban health and wellbeing: Insights on the assets and risks of urban environment, diversity and deprivation, Impact on Urban Health, Guy's and St Thomas' Charity, Available at: https://urbanhealth.org.uk/wp-content/uploads/2020/12/Personal-perspectives-on-urban-health-and-wellbeing-report.pdf (Accessed, 11 August 2022)
- Walton, J. (1983), *The English Seaside Resort, A Social History 1750-1914*, Leicester, Leicester University Press
- White, M., et al., (2021) Associations between green/blue spaces and mental health across 18 countries, Scientific Reports. Available at: www.nature.com/articles/s41598-021-87675-0 (Accessed, 7 November 2022)
- White, W. (1856), *History, Gazetteer, and Directory of Lincolnshire*, London, William White
- World Health Organisation, (2020), *Retention of the health workforce in rural and remote areas: a systematic review*, Available at: www.who.int/publications/i/item/9789240013865 (Accessed, 2 August 2022)
- World Health Organisation (2021), *Global Health Observatory*, Available at: www.who.int/data/gho/publications/world-health-statistics (Accessed, 24/08/2022)
- Wright, N.R. (1982), *Lincolnshire Towns and Industry 1700 to 1914*, Lincoln, History of Lincolnshire Committee

9.0 REFLECTIONS ON 2021 ANNUAL REPORTS

LINCOLNSHIRE

The 2021 DPH Annual Report for Lincolnshire focused on the impact of Covid-19 on the children and young people (CYP) of Lincolnshire. During the pandemic, the support needs of CYP and their parents and carers increased. For example, there was an increased demand for services to support parental mental health and behavioural support for pre-school children. Lincolnshire also saw an increase in support needs for school-aged children; for example, to support children returning to school or who were missing school because of anxiety. Emotional and mental well-being has been a growing concern since the start of the pandemic, with children's mental health services under growing pressure.

A set of priorities were identified that have formed the core focus of much of the work in Lincolnshire as we moved into a period of recovery from the pandemic. Key developments against those priorities since the publication of the report include:

Work towards full restoration of the Healthy Child Programme to pre-covid levels.

Recommissioning Best Start Lincolnshire Services from 2023 to provide early learning activities for all children in their early years and their parents/carers, supporting the development of children from age 0-5 to give them the best start in life and be ready for school.

Additional central government investment into Lincolnshire that will help us, and our partners,

to build on the strong provision of children's centres and early help for families in Lincolnshire through the creation of Family Hubs.

The continued focus on trauma-informed training for teachers to support pupils returning to school and a focus in the school improvement commission on 'Recover Lincolnshire' with bespoke sessions for school leaders supporting them in dealing with the pandemic.

The establishment of a Children in Care Transformation Programme, which aims to ensure that when children do need to be in the care of the local authority, outcomes for Lincolnshire CYP are improved by providing care locally within Lincolnshire.

The start of a Children's Mental Health Transformation Programme that aims to create a seamless service for children and their families.

Supporting partners in Lincolnshire to develop and launch a new ten year all age strategy for physical activity and commissioning a new child and family weight management service.

Through the Integrated Care Board Health Inequalities programme, ensuring preventative and health care services reach and prioritise those most in need, such as Lincolnshire's most deprived communities.

A full update on developments since the 2021 report can be requested.

NORTH LINCOLNSHIRE

The previous DPH Annual Report for North Lincolnshire was released in 2020. This report focussed on the three key themes of supporting positive mental health and wellbeing, encouraging people to be more physically active and taking a whole-system approach to creating healthy environments.

Within North Lincolnshire, partnerships and strategies have been refreshed to help improve mental wellbeing and resilience across communities and work continues to expand across Greater Lincolnshire. Progress has included:

- Promotion of the Five Ways to Wellbeing.
- Development and delivery of Make Every Contact Count (MECC) for Mental Health and Safe Talk and Assist suicide prevention training programmes.
- Collaboration with colleagues across the Humber region to introduce real-time surveillance and postvention (an intervention conducted after a suicide) support to reduce the impacts of suicide.
- Introduction of Qwell, a free, anonymous online counselling and emotional wellbeing service for men.
- Development of the Social Prescribing Model for North Lincolnshire, which enables GPs and practice nurses to provide non-clinical services, like supporting uptake of physical activity.

Exercise can benefit both physical and mental health and a variety of schemes to increase uptake of physical activity have been implemented. In 2019, the North Lincolnshire Physical Activity Partnership was established. The partnership has improved physical activity via a range of initiatives, providing better information

around ways to be active, promoting active travel and working with schools.

Key achievements have included expanding the Walking the Way to Health scheme and providing funding to satellite clubs, which support community/after school offers aimed at CYP who would not usually participate in after school sports. A partnership approach to support hospital discharge patients and prevent deconditioning has been adopted.

Unhealthy weight is another key priority for North Lincolnshire, the causes of which are complex and can be influenced by the environment in which we live, work and play. To help to understand the range and diversity of factors that may influence people's weight, a systems approach which involved a wide range of partners to identify solutions was adopted. One of the main outcomes was a research project led by young people, which explored and documented issues in their local environment that they felt contributed to unhealthy weight (such as prevalence of fast-food establishments). Many other outcomes have been achieved, such as:

- Working with leisure facilities to improve their range of healthier food options.
- Developing key health policies within the Local Plan (subject to approval) to include a 400m hot food takeaway exclusion zone around schools and colleges.
- Introducing health impacts assessments for future housing developments with more than 50 dwellings.
- Working with our partners to increase Active Travel for school pupils and people travelling to work.

NORTH EAST LINCOLNSHIRE

The key priority of the 2021 DPH Annual Report for North East Lincolnshire was mental health, particularly in relation to the impacts of the Covid-19 pandemic. The pandemic had negative impacts on the mental health of a considerable number of people and mitigating these effects will be a key priority for public health policy over the coming years.

The 2021 DPH annual report highlighted many examples of ways in which the pandemic disrupted lives, impacted mental health, and undermined coping mechanisms. People in all stages of life experienced challenging circumstances, including missing education, enduring social isolation, and becoming unemployed. The range of effects suggests that recovery will be prolonged and complex for many.

Another focus of the report was the ability of mental health services to respond to these issues. Many traditional mental health services in North East Lincolnshire are under considerable strain with long waiting times, especially adolescent mental health services. Therefore, the report highlighted opportunities for other organisations to support mental health and wellbeing, such as schools, workplaces, and

the voluntary sector. The report also emphasised the critical importance new and emerging NHS structures should attach to improving these services.

However, there have been positive aspects of mental health practice which can be built on to enhance mental wellbeing across all ages. For instance, the first national lockdown coincided with abnormally fine spring weather and reduced traffic levels. This led to a large, though short term, surge in people adopting healthier lifestyle behaviours, such as enhanced walking or cycling. There has also been an increase in the number of volunteers providing support to people in more difficult circumstances. For many, voluntary activities have provided a sense of purpose to help them through these challenging times.

The report produced 11 recommendations for a range of organisations in North East Lincolnshire. These were strongly backed by the Place (Health and Wellbeing) Board at its meeting in July 2022 and all organisations have been asked to come back to the Board to identify how the recommendations are being implemented within their organisations and services.

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	5 (i) and (ii)
Title of Report:	Integrated Quality & Performance Report – March 2023
Purpose:	This report provides the Board with information on achievement against the ICB's key performance targets and quality standards
Appendices:	Performance & Quality Report

1. Key Points for Discussion	<ul style="list-style-type: none"> • This report is underpinned by the reporting that is received at the Board Committee for Quality and the monthly Service Delivery and Performance Committee as represented in the upward reports. • This report shows the latest analysis of key system operational performance and quality indicators covering normal variation, trends and shifts in performance over time for key metrics and measures across several areas of ICB delivery • The report is designed to provide assurance to the Board that there full understanding of the drivers for performance and the high-level actions in place to address off track performance and quality in areas that are likely to have the most significant impact for patients.
2. Recommendations	<ol style="list-style-type: none"> 1. To note the significant improvements in a host of key performance indicators throughout services in the county 2. To note the key issues set out in the paper and the actions in place to support continued transformation and improvement. 3. To advise on future areas of focus for operational teams.
3. Executive Summary	<p>The March integrated performance & quality report incorporates constitutional standards, quality and safety measures and recovery activity, and presents system performance updated to February where available and will be supplemented during the Board by verbal updates.</p> <p>Industrial Action (IA)</p> <p>There has been a system wide approach to health and care associated industrial action response since it became a significant and regular requirement in December 2022.</p>

Each strike action since then has been managed by the ICB as an incident during the IA days and appropriate command and control cadence during pre and post incident aligned to the national and regional battle rhythm. This has been mirrored by providers, who have had appropriate structures in place that are proportionate to the response required by the organisation and partners.

The Board are asked to note the impressive and significant efforts of partners in responding to strike action, and the collaborative work to ensure that clinical risk is managed and balanced across the entire health system.

Improvements are being seen across the entire Urgent and Emergency Care pathway, with strong indications of sustainable change occurring, a positive position which will directly support recovery for Cancer and Elective care. This is particularly welcome, given the impact of recent Industrial Action, as well as the continued unprecedented and sustained pressure this winter throughout health and social care.

Performance:

Urgent & Emergency Care

- Lincolnshire is performing well regarding the % of patients seen within 4 hours in A&E, which is above the regional average. This has increased to 70.3% during February, progressing well towards the new recovery target of 76% required by March 2024.
- The ambulance response times increase to 45 minutes for Category Two incidents has been reviewed and acknowledged to be in the context of Industrial Action during the period in question.
- Additionally, there is significant 'special cause variation' improvement in 60-minute handover delays since early January. This is therefore now regarded as significant, stable improvement.

Cancer

- Cancer performance has shown a marked improvement in February; 364 patients were waiting over 62 days, substantially reducing from 566 in January.
- Similarly, the number of patients waiting 104 days or more decreased in January to 160, from 209 in January.

Elective backlog

- Great progress was made on the number of patients waiting more than 78 weeks which decreased to 1,275 from 1,419 in January. This improved position was better than planned trajectory.

Mental Health

- Lincolnshire continues to have strong performance with regards to Out of Area Placements with a very small number of people placed out of area and is noted as best practice in the approach taken to support people in county.
- The NHS Talking Therapies (previously known as IAPT) access rate was 16.3% in December (cumulative position). It has been agreed that this will be carefully monitored to improve progress towards the national standard.

- We also continue to monitor the number of children and young people with an eating disorder (ED) referred as routine cases commencing treatment within four weeks, or one week if urgent, as this is currently not achieving national standard.

Quality:

Primary Care

- Lincolnshire's GP practices continue to perform above the national average for face-to-face appointments available.
- There are 81 practices in the ICB of which 2, require improvement and 2 are Inadequate the ICB continue to work closely with those practices to support improvement actions.
- The recent CQC reinspection report at Lakeside Healthcare in November 2022 was published in February- the practice remains rated as 'requires improvement'.

Maternity

- The Lincolnshire Local Maternity and Neonatal Services (LMNS) board has refreshed its governance and oversight arrangements; board meets bi-monthly alongside the four sub-group to drive forward transformation and provide assurance within Maternity and Neonates.
- Next Ockenden Insight Assurance visit being led by LMNS is planned for June 2023.
- Military Project now fully operational, the team are now working with several military families in the county supporting them before/ during and after pregnancy. Event held in January to showcase this innovative project with stakeholders, leaders across NHSE armed forces; Military project is being show cased Nationally, it is the only project on this kind in England.

SEND

- The Lincolnshire SEND System was selected earlier this month to undergo a joint Ofsted and CQC thematic visit. The visit will provide insights for Ofsted, CQC, government, strategic leaders and practitioners into the relationship between SEND and alternative provision and how effectively arrangements for SEND and alternative provision are working together. The feedback from the inspectors was positive for our system.

Safeguarding Issues/Risks

- The completion of Initial Health Assessments (IHA) within statutory timescales has been a long-standing issue nationally and for Lincolnshire. LCHS has worked proactively with partners to address this, to ensure that health needs are identified, and appropriate support/ onward referral implemented for this vulnerable cohort of C&YP, with the majority of IHAs now are being completed within the 20-day timescale. This is very positive news for the County, especially as this is a national issue and a challenge faced by many areas.

Covid vaccination spring booster campaign:

Work is progressing with the spring booster programme, the new vac centers Weigh room and Wainfleet have now got full CQC registration, this campaign will be delivered in partnership by PCNs, the vaccination centers, Hospital Hub and Community pharmacies, as has been the case in previous phases of the vaccination programme. National booking system opens 5th April commencement 17 April 2023.

Eligible groups:

- Adults aged 75 years and over
- All residents in a care home for older adults
- All individuals aged 5 years and over who are immunosuppressed

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 and where required are incorporated into the Risk Register at programme and ICB level.

6. Financial/Resource Implications

The report does not set out specific resource implications but any 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- although through normal operations there has been engagement and communications directly particularly in relation to winter pressures

11. Report previously presented at

Not applicable.

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

Tim Fowler
Associate Director of Contracting and Performance
e-mail: t.fowler1@nhs.net
telephone: 07810 770476

Integrated Performance & Quality Report



Lincolnshire
Integrated Care Board

March 2023



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Executive Summary

Overview

The March integrated performance & quality report incorporates constitutional standards, quality and safety measures and elective recovery activity, and presents system performance updated to February where available.



Urgent & Emergency Care

- The percentage of patients seen within 4 hours in A&E has increased to 70.3% in February which is above the regional average and an improving picture in line with new recovery target of 76% by March 2024
- Ambulance response times increased to 45 minutes for Category Two incidents (18 minute standard) this is in the context of Industrial Action during the period.
- Two hour ambulance handover delays decreased at Pilgrim to 56 from 167 last month



Cancer

- In February, 364 patients were waiting over 62 days, substantially reducing from 566 in January
- The number of patients waiting 104 days or more decreased in January to 160, from 209 in January



Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals increased by 340 to 114,066 in January
- The number of patients waiting more than 78 weeks decreased to 1,275 from 1,419 in January. This improved position was better than planned trajectory.



Mental Health

- The NHS Talking Therapies (previously IAPT) access rate was 16.3% in December (cumulative position) and is not on track to achieve the 33% standard by March 2023
- The number of children and young people with an eating disorder (ED) referred as routine cases commencing treatment within 4 weeks (68.4%); and urgent within 1 week (64.3%) are below national standard of 95%.



Primary Care

- The recent CQC reinspection report at Lakeside Healthcare in November 2022 was published in February- the practice remains rated as 'requires improvement'.
- Access for face to face continues to be above the national average

Lincolnshire ICB Performance Dashboard



							Trend	
Programme	Indicator	Standard/Plan	Period	Performance	Midlands	England	Sparkline	Variation
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	95%	Feb-23	70.3%	66.0%	71.5%		
	Ambulance response times - Mean response time- Category 1 (ICB patients)	00:07:00	Feb-23	00:08:45	00:08:30	00:08:30		
	Ambulance response times - Mean response time- Category 2 (ICB patients)	00:18:00	Feb-23	00:44:52	00:34:25	00:32:20		
Cancer	% Suspected Cancer Referrals First Seen Within 14 Days	93%	Jan-23	68.2%	84.1%	81.8%		
	Patients receiving treatment for cancer within 62 days of an urgent GP referral	85%	Jan-23	41.3%	45.1%	54.4%		
	Total 62 Day Backlog (ULHT)	-	Feb-23	364	N/A	N/A		
	Total 104 Day Backlog (ULHT)	-	Feb-23	160	N/A	N/A		
	% of patients told cancer diagnosis outcome within 28 days (ICB)	75%	Dec-22	61.8%	69.3%	70.7%		
Planned Care	RTT: % of incomplete pathways within 18 weeks	92%	Jan-23	52.7%	54.9%	58.3%		
	Percentage waiting six weeks or less for a diagnostic test	99%	Jan-23	58.3%	60.0%	69.2%		
	Patients waiting over 78 weeks for treatment (ICB) (% of total ICB waiting list size)	0%	Jan-23	1.12%	1.00%	0.63%		
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	0.8%	Q3 22/23	36.73%	26.7%	21.6%		
Mental Health	NHS Talking Therapies access - people that enter treatment (ICB)	2.75%	Dec-22	1.57%	N/A	1.33%		
	People experiencing first episode psychosis waiting to start a package of care (ICB)	60%	Jan-23	80%	N/A	70%		

Key Performance Updates March 2023

Programme	Indicator	Cause Identified	Key actions Being Taken
Urgent Care	Ambulance Handover Delays	<ul style="list-style-type: none"> Challenges remain through winter around overall demand (time profile and acuity), workforce, IPC, capacity for supported discharge and flow through all bedded services. There has been Industrial Action during the period which has impacted. Occupancy rates have remained high both in acute and community. 	<ul style="list-style-type: none"> Continued delivery of the winter capacity & demand schemes and the discharge schemes funded through the various allocations. The review and prioritisation of these schemes has been completed and they are currently being modelled for the planning submissions for 2023/24. A system wide clinical strategy workshop was held on 9th March to confirm and challenge system ambition and support development of the recovery programme for 23/24
Cancer	Cancer 62 day backlog	<ul style="list-style-type: none"> Focus of attention remains on ULHT as the acute trust that Lincs ICB leads on. The position continues to reduce and is better than trajectory at 242 patients over 62 days. Colorectal continues to account for the largest part of the backlog at 45% but has shown remarkable improvement. Referral rates have continued to reduce overall compared to the baseline however upper GI, gynae, lung, breast, skin and haematology have all seen a significant rise against baseline. 	<ul style="list-style-type: none"> Colorectal and urology recovery meetings continue to drive forward improvements with regular control meetings with clinical leaders.. Focus remains on reducing number of patients over 62 days and meeting 28 faster diagnosis standard. Work with lung is progressing well, a new consultant has been recruited at Lincoln which has reduced wait time for 1st outpatient appointment from 35 days down to 7 days.
Planned Care	Patients waiting over 78 weeks for treatment	<ul style="list-style-type: none"> The number of patients waiting more than 78 weeks decreased to 1,275 from 1,419 in January ULHT are ahead of trajectory to eliminate waits of over 78 weeks by the end of March 2023 except where patients chose to wait longer. 	<ul style="list-style-type: none"> Several in-sourcing and out-sourcing companies are delivering additional capacity for the most challenged clinical specialties as well as additional capacity put on by the main acute hospitals. The number of patients waiting over 52 weeks dropped in January for the first time since Aug 2022.
Mental Health	Children & Young People (CYP)- Mental Health Access	<ul style="list-style-type: none"> There have been significant increases in the overall demand for CYP community mental health services, in particular eating disorders, as well as the acuity of cases being referred to services for the first time. This is reflective of the national picture following the COVID pandemic. 	<ul style="list-style-type: none"> Continued roll-out of Mental Health Support Teams (MHST) will create open access to mental health support for all CYP covered by an MHST through schools/colleges. Roll-out is happening in Lincolnshire in line with the national programme, with 50% coverage expected by 2025.

Key Quality Updates March 2023

Programme	Indicator	Cause Identified	Actions Being Taken
Infection, Prevention & Control	MRSA/C-Diff Cases	<ul style="list-style-type: none"> To date 1 MRSA bloodstream infection case has been reported by ULHT. The total number of ICB cases is 9. Lincolnshire ICB has been allocated a ceiling trajectory total of 148 C. diff cases for 2022/23. 134 cases were reported up to the end of February 2023. ULHT has a ceiling trajectory total of 56 cases (a reduction of 12 from 2021/22). ULHT have reported 65 cases YTD (to end of February 2023). There have been no Periods of Increased Incident (PII) of C. diff reported at ULHT within the previous month. 	<ul style="list-style-type: none"> Each case of hospital onset MRSA bloodstream infection is investigated and managed through the Trusts Infection, Prevention & Control (IPC) group meetings. The ICB Health Protection Team attends the Trust outbreak meetings and PII meetings. The Trust have carried out a thematic review of cases and produced an action plan which is being implemented.
Learning Disabilities	LD Inpatients	<ul style="list-style-type: none"> There are currently 20 LDA ICB Inpatients, 9 above the target of 11. Lincolnshire ICB are triangulating learning from safe and well reviews, care (education) and treatment reviews, RAG Delayed Transfer of Care Learning Pilot and Strategic & Operational Training with NHSE/I to inform true ICS 'wraparound' for our Lincolnshire citizens affected by the MM judgement. 	<ul style="list-style-type: none"> Transforming care Liaison service recruitment on going. DSR process working well with significant impact on admission rates. Inherent Jurisdiction work and independent life planning programmes continue at pace to support and provide legal framework for discharge of 11 long stay inpatients ICB working with LCC to support market development of community based options for current long stay inpatients Capital bid PID to NHSE in preparation to provide additional complex care community capacity.
Primary Care	Primary Care Quality	<ul style="list-style-type: none"> The recent CQC reinspection report at Lakeside Healthcare in November 2022 was published in February- the practice remains rated as 'requires improvement'. 	<ul style="list-style-type: none"> Lakeside remains overall Requires Improvement, but further improvement demonstrated across quality domain areas. In consequence removed from Special Measures regime. The ICB and LMC will continue to work with the Practice to support the areas of improvement still required.

- Awaiting NHSE Single Maternity Plan to be published, delayed until April 2023.
- Ockenden progress consistent, there is still work ongoing with personalisation and coproduction of services with MVP. The action plan developed to achieve coproduction is now underway and nearer to completion. Personalisation work is ongoing but challenges around digital remain an issue. ULHT has completed a piece of work benchmarking their position against the forthcoming 15 IEAs and the East Kent recommendations . EMODN have also benchmarked against East Kent this information was discussed within Quality and Safety forum. Training compliance being monitored monthly with the Quality and Safety meeting as this integral to compliance of SBLCB, CNST and Ockenden. CTG interpretation remains a risk factor locally and nationally, ULHT now have Fetal Monitoring lead and action plan also monitored monthly.
- Next Ockenden Insight Assurance visit being lead by LMNS is planned for June 2023.
- LMNS board is well established with robust governance structures; board meet bi-monthly alongside the four sub-group to drive forward transformation and provide assurance within Maternity and Neonates. LMNS board escalate to the ICB as necessary. LMNS continues to provide regular assurance to NHSE via a number of avenues including Quarterly highlight reports, next due April 2023.
- Ockenden funding, meetings continue between ULHT and Maternity & Neonatal programme to maximise funding to support improvements in local maternity and neonatal provision. Work has now commenced to develop a dedicated team of specialist midwives and other healthcare professionals in Skegness to support and provide continuity of care for vulnerable women and families in who are in the top 10% of deprivation in the country
- Digital continues to be a significant challenge for Maternity, particularly with ascertaining relevant data . ULHT are working towards procurement of new maternity digital system supported by LMNS PMO, plans for a digital matron role within ULHT and digital support officer within the LMNS to drive forward the strategy and the digital agenda across Lincolnshire.
- Equity and Equality Strategy development is ongoing two events held with local population families, services providers held in Skegness and Boston (Feb, 2023). The dedicated tobacco treatment team embedding their offer in the pilot site of Skegness, Boston Spalding where we see the highest prevalence of SATOD.
- Military Project now up and fully in place, work already with several families before during and after pregnancy. Event held in January to share work with stakeholder, leaders across NHSE armed forces; Military project is being show cased Nationally.

Safeguarding

Safeguarding Issues/Risks

The completion of Initial Health Assessments (IHA) within statutory timescales has been a long standing issue for Lincolnshire. LCHS has worked proactively with partners to address this, to ensure that health needs are identified and appropriate support/ onward referral implemented for this vulnerable cohort of C&YP, with the majority of IHAs now are being completed within the 20 day timescale. This is very positive news for the County, especially as this is a National issue and a challenge faced by many areas.

PODs – consideration of the implications for the ICB in terms of safeguarding responsibilities. Discussions commenced at regional and local level.

SEND

The Lincolnshire SEND System has been selected to undergo a thematic visit as described below.

- As part of the new area SEND inspection arrangements, Ofsted and CQC are carrying out a series of thematic visits each academic year. They will conduct visits to a small number of areas to investigate a particular aspect of the SEND system in depth. The first theme they will investigate is alternative provision. Alternative Provision (AP) is defined by the government as: “education arranged by local authorities for pupils who, because of exclusion, illness or other reasons, would not otherwise receive suitable education; education and support arranged by schools, including for pupils receiving targeted support in their mainstream school; pupils being directed by schools to off-site provision to improve their behaviour; and provision for pupils on a fixed period exclusion”.

The purpose of the 2023 thematic visits is to:

- find out the extent to which alternative provision is meeting the health, care and/or education needs of children and young people
- better understand the purposes for which alternative provision is used
- identify the enablers and barriers to local area partners working together to commission and oversee alternative provision placements
- highlight good practice in commissioning and oversight arrangements for alternative provision
- These visits will also provide insights for Ofsted, CQC, government, strategic leaders and practitioners into the relationship between SEND and alternative provision and how effectively arrangements for SEND and alternative provision are working together. They will share learning to promote improvement in the sector and will use the findings to update their approach to inspection, as appropriate.

They will **not be making judgements about individual areas during these visits**, although they will share the findings in a national report to be published in autumn 2023. The national report will list the local areas visited, but will not attribute findings to individual areas unless those areas agree to be identified.

Covid Spring Booster

Covid vaccination Spring Booster programme:

Work is progressing with the spring booster programme the new vac centres, Weigh room and Wainfleet have now got full CQC registration, this campaign will be delivered in partnership with the PCNs, the vaccination centres, the Hospital Hub and Community pharmacies, as has been the case in previous phases of the vaccination programme.

National booking system opens 5th April vaccination commences 17th April

The programme will run for 8 weeks

Eligible group:

- Adults aged 75 years and over
- All residents in a care home for older adults
- All individuals aged 5 years and over who are immunosuppressed

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	6 (i)
Title of Report:	System Financial Management Report February 2023 (Month 11)
Report Author:	Rebecca McCauley, Senior Finance Business Partner
Appendices:	None

1.	Key Points for Discussion:
<p>This report sets out the financial position of the Lincolnshire Integrated Care System (ICS) and the Lincolnshire Integrated Care Board (ICB) on 28 February 2023 (Month 11). The detailed assurance and process is undertaken by the Finance and Resource Committee from which any significant escalations will be routinely made.</p>	
2.	Recommendations
<p>The members of the Board are asked to consider and note the reported financial position of the Lincolnshire ICS and the actions that are in progress within NHS Lincolnshire Integrated Care Board and system Provider executive teams.</p>	
3.	Executive Summary
<p><u>Summary System Financial Position</u></p> <p>The reported Lincolnshire system month 11 position is a £4.2m improvement from that reported at month 10. This improvement is agreed with NHS England and relates purely an expected allocation to mitigate national price increases relating to prescribing costs. On 28th February the Lincolnshire system is therefore on track to report a £16.8m deficit as shown at table 1 below. During the year the risk adjusted forecast was anticipated to be £35.4m deficit and thanks goes to the efforts of the teams across the county for managing this position down to the £16.8m.</p> <p><u>ICB Financial Position and Statutory Requirement</u></p> <p>Table 1 below shows that the ICB and former CCG combined is reporting a year-to-date adverse variance to allocation of £13.6m at Month 11. This represents a year-to-date adverse variance of £10.7m against the £2.9m deficit.</p> <p>The ICB is forecasting a deficit of £11.5m against allocation (£8.3m adverse variance to the planned deficit of £3.2m) as the combined financial performance across the CCG and ICB in 2022/23. This is a £4.1m improvement on the £15.6m forecast reported at month 10. This in month improvement is exclusively due to an anticipated allocation from NHS England to cover prescribing cost pressures resulting from national price increases.</p>	

Table 1: Lincolnshire system planned and actual net expenditure

Lincolnshire ICS Surplus (+) / Deficit (-)	Year to Date			Forecast Outturn		
	Planned	Actual	Variance	Planned	Actual	Variance
	£m	£m	£m	£m	£m	£m
NHS Lincolnshire Integrated Care Board (and former CCG)	-2.9	-13.6	-10.7	-3.2	-11.5	-8.3
United Lincolnshire Hospitals NHS Trust	0.0	-13.4	-13.4	0.0	-13.6	-13.6
Lincolnshire Partnership NHS Foundation Trust	2.8	6.6	3.8	3.3	8.0	4.7
Lincolnshire Community Health Services NHS Trust	0.0	0.1	0.1	0.0	0.4	0.4
Total	-0.1	-20.3	-20.2	0.0	-16.8	-16.8

Efficiencies

The efficiencies programme is managed through the Financial Recovery Programme Board. The ICS continues to focus on realising planned efficiencies and mitigations. At Month 11 we have realised £41.5m of which, the Lincolnshire ICB has achieved £14.3m. The forecast year end delivery is £45.9m for the ICS, of which Lincolnshire ICB is £15.0m.

Risks and Mitigations

There are no risks that remain unmitigated.

Capital

The total allocation from NHSE for 22/23 is anticipated to be £60.2m and it is expected that the full year allocation will be utilised by the financial year end to a breakeven position.

Better Payment Practice Code

The ICB has delivered the Better Payment Practice Code, to pay 95% of suppliers within 30 days. It has achieved a rate in excess of 99% both in month and on a year-to-date cumulative bases on both value and volume of invoices received.

ICB Financial Duties

The ICB, as a statutory organisation, must fulfil certain financial duties and the table below shows progress against these duties.

Duty	Duty Achieved	
	Year to Date	Forecast
Expenditure not to exceed income	No	No
Capital resource use does not exceed the amount specified in Directions	Yes	Yes
Revenue resource use does not exceed the amount specified in Directions	No	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	Yes	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	No	No
Revenue administration resource use does not exceed the amount specified in Directions	Yes	Yes

Other Financial Targets	Duty Achieved	
	Year to Date	Forecast
Better Payment Practice Code (BPPC)	Yes	Yes
To manage cash payments within the Annual Cash Drawdown Requirement (ACDR)	Yes	Yes
Period end cash balances (less than 1.25% of monthly drawdown value)	Yes	Yes

4. Management of Conflicts of Interest

None to be noted.

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

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	8 (ii)
Title of Report:	ICB Key Governance Documents
Report Author:	Jules Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance
Appendices:	Functions and Decisions Map Scheme of Reservation and Delegation Delegated Financial Authority Limits including explanation of updates to Chapter 9 of the Governance Handbook

1. Key Points for Discussion:	<p>To present updates to key documents contained within the ICB Governance Handbook.</p> <p>The ICB Board is asked to consider the documents as detailed below.</p>
2. Recommendations	<p>The NHS Lincolnshire ICB Board is requested to approve:</p> <ul style="list-style-type: none"> • Approve the revised version of the ICB Functions and Decisions Map • Approve the revised version of the Scheme of Reservation and Delegation to reflect the delegated arrangements for the Delegation of Primary Pharmacy, Optometry, and Primary and Secondary Dental Services from NHSE to the ICB. • Approve the revised ICB Delegated Financial Authority Limits. • Note that, subject to approval, the revised documents will be incorporated into the ICB Governance Handbook.
3. Executive Summary	<p>From 1 April 2023 Lincolnshire ICB will take on delegated responsibility for pharmaceutical services, general ophthalmic services and dental services (collectively known as 'POD'). This will be managed by a hosted regional function across several ICBs. Hence, approval is also needed for the delegation arrangements for these new services.</p> <p>Under this arrangement the ICB Board is required to make amendments to some of the key governance documents included in the ICB Governance Handbook.</p> <ul style="list-style-type: none"> • Functions and Decisions Map • Scheme of Reservation and Delegation • Delegated Financial Authority Limits

The ICB Functions and Decisions Map, Scheme of Reservation and Delegation and Delegated Financial Authority Limits have been amended to reflect the delegated arrangements for PODs from NHSE and also the establishment of the Joint Committee.

The Delegated Financial Authority Limits has been updated to reflect the POD detailed scheme of delegation in order to support the establishment of POD budgets in the ICB and operational transactions in the hosted function.

The ICB Board is asked to approve the key governance documents for inclusion in the ICB Governance Handbook.

4. Management of Conflicts of Interest

Not applicable in relation to this paper but the ICB Governance Handbook includes the Standards of Business Conduct and Conflicts of Interest Policy.

5. Risk and Assurance

No direct implications.

6. Financial/Resource Implications

Not direct implications.

7. Legal, Policy and Regulatory Requirements

Not applicable in relation to this paper.

8. Health Inequalities implications

No direct implications.

9. Equality and Diversity implications

No direct implications.

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

No direct implications.

11. Report previously presented at:

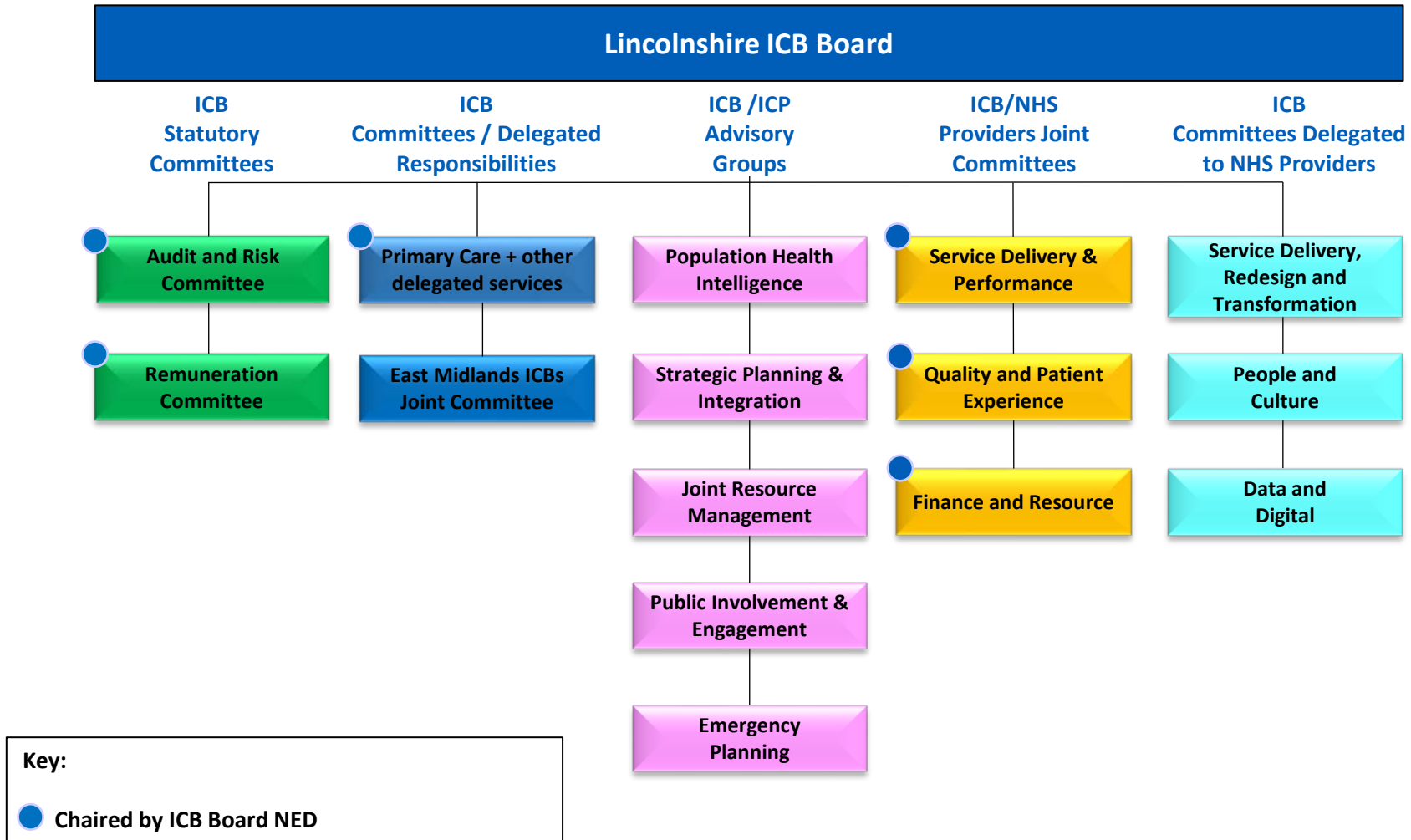
Not applicable.

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

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

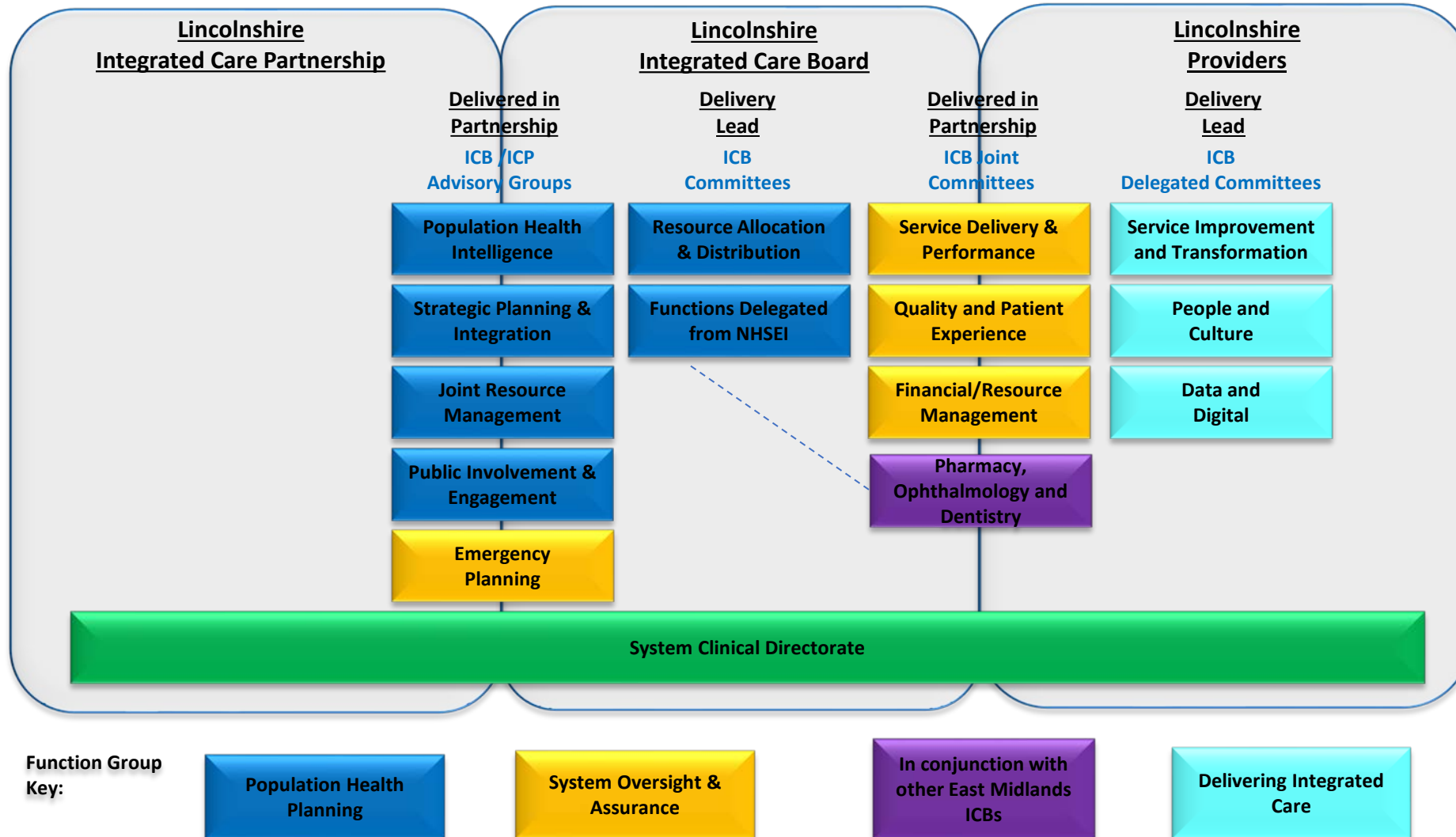
ICB Governance Structure

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



ICB Function Map

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



DELEGATED FINANCIAL AUTHORITY LIMITS

- 9.1 The arrangements made by the ICB as set out in the Scheme of Reservation and Delegation shall have effect as if incorporated into the ICB's Constitution.
- 9.2 The ICB remains accountable for all of its functions, including those that it has delegated.
- 9.3 The Scheme of Reservation and Delegation details the arrangements made by the ICB for discharging its functions.
- 9.4 The Schedule below details the overarching Scheme of Delegation (and delegated financial authority limits). These should be read in conjunction with the ICB's Standing Financial Instructions within the ICB Corporate Governance Handbook.
- 9.5 This is prepared by the Chief Executive and sets out those key operational decisions delegated to individual employees of the ICB.
- 9.6 The approval of the ICB's Delegated Financial Authority Limits presented in this chapter which underpin the ICB's Scheme of Reservation and Delegation is reserved to the ICB Board.
- 9.7 There is a further operational scheme of delegation outside of the ICB Governance Handbook which provides more clarity about the roles and responsibilities of managers within the ICB. Known as the Detailed Scheme of Delegation, it is managed by the Executive Team and allows them to balance governance requirements with the practical day-to-day business needs of the organisation.

	Responsibility	Delegation Arrangements	Further Information
1	Capital Projects and Assets		
1.1	<p>Approval of capital business cases including leases.</p> <p>All PFI schemes and other schemes greater than £250,000</p> <p>Up to £250,000</p>	<p>ICB Board</p> <p>Finance Committee</p>	<p>This includes cases that may receive external funding. These powers may not be further delegated. In the absence of the appropriate officer, authorisation must be obtained from the level above.</p> <p>In urgent cases - joint approval by the Chief Executive and Director of Finance required.</p> <p>Approval would be required for granting, terminating or extending leases.</p>
1.2	<p>Capital expenditure variations</p> <p>Any change under £10,000</p> <p>Variation over the original business case figure which is over £10,000:</p> <p>Greater than £100,000</p> <p>Greater than £25,000 and less than £100,000 or greater than 5% of the original business case (whichever is the lower)</p> <p>Less than £25,000 or less than 5% of the original business case (whichever is the lower)</p>	<p>Assistant Directors of Finance</p> <p>ICB Board</p> <p>Finance Committee</p> <p>Director of Finance</p>	<p>In urgent cases - joint approval by the Chief Executive and Director of Finance.</p>
1.3	Maintenance of the capital asset register	Director of Finance	Head of Financial Accounting
1.4	<p>Approval of asset disposals:</p> <p>Land and buildings</p> <p>Other assets - where asset has a residual value:</p> <p>Greater than £100,000</p> <p>£50,000 and up to £100,000</p> <p>£10,000 but less than £50,000</p> <p>Less than £10,000</p>	<p>ICB Board</p> <p>ICB Board</p> <p>ICB Board</p> <p>Director of Finance</p> <p>Executive Directors / Associate Director of Finance</p>	<p>Associate Director of Finance must always be informed to enable the asset register to be updated.</p> <p>Disposals include those items that are obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively.</p>

	Responsibility	Delegation Arrangements	Further Information
2	Contracts		
2.1	Financial appraisal of companies identified as potential tenders	Director of Finance	Delegated to Deputy or Associate Director of Finance
2.2	Authorisation of less than the requisite number of tenders/quotes: for all contracts of £250,000 and above For all contracts less than £250,000 including capital projects/works goods and services	Chief Executive Director of Finance	The requisite number of tenders/quotes (using Arden & GEM Procurement wherever possible): a) up to £25,000, at least 1 written quotation for goods/services obtained. b) from £25,000 to £50,000, at least 3 written quotations for goods/services obtained. c) above £50,000, a full tender is to be carried out.
2.3	Authorisation of single tender/single quote action: For all contracts of £213,000 (inclusive of VAT) and above (illegal under EU Regulations) For all contracts less than £213,000 but above £4,000 including: Capital projects/works Goods and services	Chief Executive Director of Finance	Where a single tender/single quote is sought or received, the ICB shall as far as practical, determine that the price to be paid is fair and reasonable and that details of the investigation are recorded. Where a single tender/single quote is authorised, this will be reported at the next Audit and Risk Committee.
2.4	Single tender/single quote action for maintenance or other support contracts for existings goods or assets where the ICB is contractually tied to specific companies.	Director of Finance	Delegated to Deputy or Associate Director of Finance, who will maintain a register or such contracts approved.
2.5	Monitoring of the use of single tender/single quote action. An ICB Waiver must be completed and forwarded to the Associate Director of Contracting.	Audit and Risk Committee on behalf of the ICB Board	Appropriate records to be maintained by the Director of Finance as the basis of reporting, delegated to the Deputy or Associate Director of Finance/Contracting.
2.6	Advertising of contracts/awards: - must be advertised - the ICB Procurement Manager will co-ordinate this via the appropriate web portal.	Chief Executive	Delegated to the ICB Procurement lead.
2.7	Opening of tenders (will be automatic as web portal is being used for advertising of all tenders)	Any two from the "List of ICB officers authorised to open tenders" where tender is over £50,000. Any one from the list where tender is below £50,000.	
2.8	Permission to consider late tenders	Director of Finance	

	Responsibility	Delegation Arrangements	Further Information																														
2.9	<p>Tender ratification and award, including authorisation of any actions resulting from post tender negotiations.</p> <p>All types of tenders (on the lifetime value of the contract) in accordance with the table shown.</p>	<table border="1"> <thead> <tr> <th>Role</th> <th>Healthcare, NHS Provider</th> <th>Healthcare, Non-NHS Provider</th> <th>Non-Healthcare</th> </tr> </thead> <tbody> <tr> <td>Board</td> <td>Unlimited</td> <td>Unlimited</td> <td>Unlimited</td> </tr> <tr> <td>Chief Executive</td> <td>Up to £600 million</td> <td>Up to £25 million</td> <td>Up to £2 million</td> </tr> <tr> <td>Director of Finance</td> <td>Up to £600 million</td> <td>Up to £100 million</td> <td>Up to £1 million</td> </tr> <tr> <td>Deputy, Associate or Assistant Directors of Finance or Contracting</td> <td>Up to £30 million</td> <td>Up to £5 million</td> <td>Up to £100,000</td> </tr> <tr> <td>Officer Members of the Board</td> <td>Up to £2 million</td> <td>Up to £2 million</td> <td>Up to £250,000</td> </tr> <tr> <td>Executive Directors</td> <td>Up to £500,000</td> <td>Up to £250,000</td> <td>Up to £50,000</td> </tr> </tbody> </table>	Role	Healthcare, NHS Provider	Healthcare, Non-NHS Provider	Non-Healthcare	Board	Unlimited	Unlimited	Unlimited	Chief Executive	Up to £600 million	Up to £25 million	Up to £2 million	Director of Finance	Up to £600 million	Up to £100 million	Up to £1 million	Deputy, Associate or Assistant Directors of Finance or Contracting	Up to £30 million	Up to £5 million	Up to £100,000	Officer Members of the Board	Up to £2 million	Up to £2 million	Up to £250,000	Executive Directors	Up to £500,000	Up to £250,000	Up to £50,000			
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2.10	<p>Signing of service provision contracts, including letters of intent (the below is based on the lifetime value of the contract). This includes NHS, independent care placements, private sector and non-healthcare contracts</p> <p>In accordance with the table shown.</p>	<table border="1"> <thead> <tr> <th>Role</th> <th>Healthcare, NHS Provider</th> <th>Healthcare, Non-NHS Provider</th> <th>Non-Healthcare</th> </tr> </thead> <tbody> <tr> <td>Board</td> <td>Unlimited</td> <td>Unlimited</td> <td>Unlimited</td> </tr> <tr> <td>Chief Executive</td> <td>Up to £600 million</td> <td>Up to £25 million</td> <td>Up to £2 million</td> </tr> <tr> <td>Director of Finance</td> <td>Up to £600 million</td> <td>Up to £100 million</td> <td>Up to £1 million</td> </tr> <tr> <td>Deputy, Associate or Assistant Directors of Finance or Contracting</td> <td>Up to £30 million</td> <td>Up to £5 million</td> <td>Up to £100,000</td> </tr> <tr> <td>Officer Members of the Board</td> <td>Up to £2 million</td> <td>Up to £2 million</td> <td>Up to £250,000</td> </tr> <tr> <td>Executive Directors</td> <td>Up to £500,000</td> <td>Up to £250,000</td> <td>Up to £50,000</td> </tr> </tbody> </table>	Role	Healthcare, NHS Provider	Healthcare, Non-NHS Provider	Non-Healthcare	Board	Unlimited	Unlimited	Unlimited	Chief Executive	Up to £600 million	Up to £25 million	Up to £2 million	Director of Finance	Up to £600 million	Up to £100 million	Up to £1 million	Deputy, Associate or Assistant Directors of Finance or Contracting	Up to £30 million	Up to £5 million	Up to £100,000	Officer Members of the Board	Up to £2 million	Up to £2 million	Up to £250,000	Executive Directors	Up to £500,000	Up to £250,000	Up to £50,000			
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Executive Directors	Up to £500,000	Up to £250,000	Up to £50,000																														
2.11	<p>Approval of variations or extensions to contracts:</p> <p>See 2.10 above</p>		In all contracts the ICB should endeavour to obtain best value for money																														
2.12	Sealing of documents	Chair (or Vice Chair in the absence of the Chair) and one Executive Director	Subsidiary pages of works contracts to be signed in accordance with Power of Appointment procedure																														
3	Income Generation and Research and Development Contracts																																
3.1	<p>Approval of income generation contracts and variations or extensions to income generation contracts:</p> <p>Greater than £500,000</p> <p>£250,000 and up to £500,000</p> <p>Less than £250,000</p>	<p>Governing Body</p> <p>Chief Executive</p> <p>Director of Finance</p>	<p>These powers may not be delegated.</p> <p>In the absence of the appropriate officer authorisation must be obtained from the level above.</p>																														

	Responsibility	Delegation Arrangements	Further Information
3.2	Approval of research and development contracts (including variations or extensions) Greater than £500,000 £250,000 and up to £500,000 Up to £250,000	Governing Body Chief Executive Director of Finance	These powers may not be delegated. In the absence of the appropriate officer authorisation must be obtained from the level above.
4	Purchasing and Payments (excluding Payroll)		
4.1	Non pay expenditure for healthcare contracts that have been signed in accordance with the Financial and Procedural Limits in the CCG Handbook.	Delegation arrangements shown below, but all transactions will have an escalation route through the organisational hierarchy to the Director of Finance and the Chief Executive.	In line with budget management responsibilities (i.e. delegated budgets) and subject to quoting and tendering as required (see Section 2 above)
	Contractual SLA invoices over £1 million	Budget holders and finance staff band 8b and above	To include contractual variations agreed in year.
	Contractual SLA invoices under £1 million	Budget holders and finance staff band 7 and 8a	Local procedures will apply.
	SLA adjustment invoices over £250,000	Budget holders and finance staff band 8b and above	Backing data will be required to support these adjustments.
	SLA adjustment invoices under 250,000	Budget holders and finance staff band 7 and 8a	Local procedures will apply.
	AQP activity in line with agreed contract tariff	Budget holders and finance staff band 7 and above	
	AQP activity outside the agreed contract tariff	Authorisation needed as per the Detailed Scheme of Delegation.	
	CHC activity within contract frameworks	Local procedures will apply	Separate detailed scheme of delegation approved by Assistant Director of Finance

	Responsibility	Delegation Arrangements	Further Information
4.2	All other non pay (limits include VAT) Authorisation of internal requisitions and invoices:	Delegation arrangements shown below, but all transactions will have an escalation route through the organisational hierarchy to the Director of Finance and the Chief Executive.	More detail is provided in the Detailed Scheme of Delegation managed by the Executive Team.
	Authorisation of internal requisitions and invoices	Budget holders in accordance with the Detailed Scheme of Delegation.	
	Exceptional: NCAs over £1000	Finance managers band 8a or above	In line with local procedures and supported by appropriate backing data.
	Exceptional: NCAs under £1000	Finance managers band 7 or above	
	Exceptional: AQP diagnostics over £1000	Finance managers band 8a or above	In line with local procedures and supported by appropriate backing data.
	Exceptional: AQP diagnostics under £1000	Finance managers band 7 or above	
	CHC activity outside contract frameworks	Local procedures will apply	Separate detailed scheme of delegation approved by Assistant Director of Finance
	Exceptional: HC5 patient travel claims under £1000	Finance managers band 7 or above	In line with national guidance on allowable refunds for patients on low incomes.
	Exceptional: claims for clinical assessment under £1000	Finance managers band 7 or above	In line with local ICB procedures.
	Exceptional: claims for meeting attendance under £1000	Finance managers band 7 or above	
	Exceptional: primary care capital expenditure	Budget holders in accordance with the Detailed Scheme of Delegation.	
	Professional services such as legal and consultancy expenditure. Commitments over £10,000. Commitments under £10,000.	Approval by an Executive Director, or an Assistant Director of Finance / Contracting. Budget holders	As defined in Department of Health manual for accounts. Interim / off-payroll workers: see section 5.1 Court proceedings should be approved by a Board member.
4.3	Authorisation of official orders	See "List of ICB officers permitted to authorised official orders" maintained by the Director of Finance.	
4.4	Authorisation of petty cash payments Disbursements up to £50	Authorisation for reimbursement in line with procedures as outlined in the Authorised Signatory Policy Executive Director/Budget Holder	

	Responsibility	Delegation Arrangements	Further Information
5	Payroll Expenditure		
5.1	Pay including substantive/agency (excluding timesheets) within establishment		There is an appointment control process to support the recruitment of staff to vacancies in the establishment. Following this process will be sufficient in most cases, but please note the special cases below.
	Substantive staff on VSM contracts	Remuneration Committee	
	All off payroll/agency/consultancy staff where: <ul style="list-style-type: none"> • Consultancy spend over £50k, or • Any kind of non-clinical agency, regardless of value, or • VSM role over £750 per day. Below these limits:	NHS England prior approval is required in all of these cases. If supported by NHSE then budget holders can approve in line with the detailed scheme of delegation. Budget holders, in line with the detailed scheme of delegation.	Business case templates are available from Finance. They will need to be completed by the budget holder with support from the Finance Business Partner. IR35 checks will be needed for off payroll engagements – contact Financial Accounting for advice.
	Where any of the above are not met	Chief Finance Officer and NHS England	Once approved by the establishment control process, the scheme of delegation limits apply.
	Booking of bank staff from approved lists.	Budget Holders, in line with the approved establishment.	
	All other pay expenditure up to VSM rates		
	Engagement of staff NOT within establishment		
	Authority to appoint staff	Accountable Officer or Chief Finance Officer	
	Authority to permanently amend the formal establishment	Accountable Officer or Chief Finance Officer	Authorisation of establishment changes can be further delegated by the Chief Finance Officer to an Assistant Director of Finance.
	All off payroll/agency/consultancy staff where: <ul style="list-style-type: none"> • Consultancy spend over £50k, or • Any kind of non-clinical agency, regardless of value, or • VSM role over £750 per day. Below these limits:	NHS England prior approval is required in all of these cases. If supported by NHSE then Chief Executive or Director of Finance (who may delegate to Associate Director of Finance). Chief Executive or Director of Finance (who may delegate to Associate Director of Finance).	Business case templates are available from Finance. They will need to be completed by the budget holder with support from the Finance Business Partner. IR35 checks will be needed for off payroll engagements – contact Financial Accounting for advice.
	Where any of the above are not met	Chief Finance Officer and NHS England	Once approved by the establishment control process, the scheme of delegation limits apply.
	Booking of bank staff from approved lists.	Accountable Officer or Chief Finance Officer	
	Engagement of ICB's solicitors.	Budget Holders, up to £10,000. Over £10,000: approval by an Executive Director, or an Assistant Director of Finance / Contracting.	Court proceedings should be approved by a Board member.

	Responsibility	Delegation Arrangements	Further Information
5.2	<p>Authorisation of travel claims (Mileage)</p> <p>Maximum value of any single monthly claim is restricted to £2,500 with no claims being older than 3 months unless approved by either the Director of Finance or Chief Executive</p>	<p>Line managers with delegated signatory as outlined in the authorised signatory list.</p> <p>Authorisation for claim older than 3 months can be delegated to the Deputy or Associate Director of Finance</p>	<p>Any expenses claimed by the Chair shall be authorised by the Chief Executive and expenses claim by the Chief Executive shall be authorised by the Chair or Director of Finance.</p>
5.3	<p>Authorisation of other travel and other allowances outside the ICB's Expenses Policy</p> <p>Over £300</p> <p>Up to £300</p> <p>up to £100</p> <p>No claims being older than 3 months unless approved by either the Director of Finance or Chief Executive</p>	<p>Chief Executive</p> <p>Chief Executive or Director of Finance</p> <p>Executive Director/Budget Holder</p> <p>Functional Director/Budget Manager</p> <p>Director of Finance but can be delegated to Deputy or Associate Director of Finance</p>	<p>See Travel & Expenses Policy for details of other allowable expenses</p> <p>Any study leave and associated expenses should be agreed by the Director of Finance and Executive Direct/Budget Holder in advance.</p>
5.4	<p>Authorisation of payroll timesheets</p> <p>Maximum value of any single monthly claim is restricted to £5,000 with no claims being older than 3 months unless approved by either the Director of Finance or Chief Executive</p>	<p>Delegated line managers</p> <p>Authorisation for claims older than 3 months can be delegated to the Deputy or Associate Director of Finance</p>	<p>See Authorised Signatory Policy</p>
6	Income/Debt Write-Off		
6.1	<p>Authorisation of credit notes</p> <p>Greater than £1 million</p> <p>£500,000 and up to £1 million</p> <p>£250,000 and up to £500,000</p> <p>Up to £250,000</p> <p>Up to £50,000</p>	<p>ICB Board</p> <p>Chief Executive</p> <p>Director of Finance</p> <p>Deputy or Associate Director of Finance</p> <p>Budget Managers</p>	
6.2	Authorisation to refer debts to debt collection agency	Director of Finance	Delegated to Deputy or Associate Director of Finance

	Responsibility	Delegation Arrangements	Further Information
6.3	<p>Authorisation of debt write-off</p> <p>Individual debts:</p> <p>Greater than £100,000</p> <p>£50,000 and up to £100,000</p> <p>£10,000 and up to £50,000</p> <p>Up to £10,000</p>	<p>Governing Body</p> <p>Chief Executive</p> <p>Director of Finance</p> <p>Associate Director of Finance</p>	<p>All write offs to be reported to the Audit and Risk Committee</p>
7	Losses and Special Payments		
7.1	<p>Authorisation of losses and special payments, including ex-gratia payments.</p>	<p>See the losses procedure contained in the ICB Corporate Governance Handbook.</p>	<p>All cases must be brought to the attention of HM Treasury in advance if they are:</p> <ul style="list-style-type: none"> • Special payments greater than £95,000 (for approval); • Losses greater than £300,000 (for consultation); • Any case regardless of value which is considered to be “novel, contentious or repercussive” (for approval). <p>In particular, the ICB has no delegated authority to make special severance payments and retention payments and will require NHS England prior approval to make any such payment.</p>
	<p>Losses and special payments below the HM Treasury thresholds can be approved by the ICB according to the following delegated limits.</p> <p>In all cases, the loss or special payments will be reported to the Audit and Risk Committee and recorded in the ICB losses and special payments register.</p>		<p>The Director of Finance will report any cases they consider to be “novel, contentious or re-percussive” to the Chair of the Audit and Risk Committee as soon as they become aware of the case, and the case should be reported to NHS England in line with guidance.</p>
	<p>Greater than £50,000</p>	Governing Body	After advice taken by lawyers where appropriate.
	<p>£10,000 and up to £50,000</p>	Chief Executive	
	<p>Up to £10,000</p>	<p>Audit and Risk Committee or in an emergency Director of Finance or Deputy/Associate Director of Finance</p>	

	Responsibility	Delegation Arrangements	Further Information
7.2	Authorisation of clinical negligence payments - Up to the CNST excess - Above the CNST excess	Director of Finance Governing Body	
7.3	Monitoring of losses and special payments	Audit and Risk Committee	Liaison with the ICB's Local Counter Fraud Specialist & Police as required and in line with the ICB's Fraud, Corruption and Bribery Policy.
7.4	Authorisation of early retirement, redundancy and other termination payments to staff: Greater than £100,000 £50,000 and up to £100,000 Up to £50,000	Governing Body AND Remuneration Committee Chief Executive Director of Finance	

	Responsibility	Delegation Arrangements	Further Information
8	Budgetary Control		
8.1	Approval of budgets and resources Delegation of budgets Approval to spend	ICB Board Chief Executive and Director of Finance Budget Holder/Manager is permitted to incur costs in accordance with their budgets and authorisation limits	The approval of budgets and resources will usually take place during the March Governing Body meeting. Budget holders should comply with all authorisation limits and procurement processes described elsewhere in this document.
8.2	Approval of budget virements If virement is the result of an authorised contract variation Greater than £100,000 Greater than £25,000 up to £100,000 Greater than £500 up to £25,000 £500 and below For other virements Greater than £10,000 Up to £10,000	Chief Executive, Director of Finance or Deputy/Associate Director of Finance Executive Director Budget Holder Budget Manager Clinical and Lay Commissioning Committee Budget Holder	Virements within a budget holder's approved budget are permitted in accordance with virement rules, as set out by the Director of Finance A Business Case is required as part of the investment process.
8.3	Approval of transfers from reserves	Director of Finance	
8.4	Approval of revenue Business Cases (not capital) Greater than £500,000 Up to £500,000	ICB Board Finance Committee	In urgent cases - joint approval by the Chief Executive and Director of Finance required (up to limits of approval by the Clinical Executive Committee)

	Responsibility	Delegation Arrangements	Further Information
9	Stores		
9.1	Management and control of stores: General Pharmacy	Executive Director of Corporate Strategy and Delivery Medical Director	Delegated to ICB Procurement Manager
10	Bank accounts and payment methods		
10.1	Opening of bank accounts or changes to banking arrangements	Director of Finance	Governing Banking Services only Should be reported to the next Governing Body meeting
10.2	Signing of cheques for cash, signing of other cheques, and authorisation of electronic payments, cheque and BACs payment schedules.	See authorised signatory list	Lists to be maintained by the Director of Finance, delegated to the Deputy/Associate Director of Finance
11	Fees and charges		
11.1	Approval of fees and charges	Director of Finance	Examples are course fees, mobile phone use, private use of NHS equipment and facilities (such as photocopiers and rooms)
12	Standards of Business Conduct		
12.1	Maintenance of the ICB Register of Interests	Director of Finance	Maintained by CCG Board Secretary
12.2	Maintenance of the ICB Gifts and Hospitality register	Director of Finance	Maintained by CCG Board Secretary
13	Insurance		
13.1	Decision of level of and claims against Non Clinical Insurance	Director of Finance	The risk should be managed by the Chief Executive in conjunction with the ICB's lead for Governance
13.2	Decision of level of and claims against Clinical Insurance	Director of Finance	The risk should be managed by the Chief Executive in conjunction with the ICB's lead for Governance
14	Fraud and Irregularity		
14.1	Counter fraud and corruption work in accordance with Secretary of State's Directions	Director of Finance	In liaison with Local Counter Fraud Specialist, Counter Fraud Operational Service and Police as appropriate
14.2	Investigation of suspected cases of irregularity not related to fraud or corruption	Director of Finance	
15	Investments		
15.1	Approval of Investment Policy	ICB Board	
15.2	Investment decisions	Director of Finance	
16	Borrowing		
16.1	Approval of loans: All Loans	ICB Board	

Updates to Chapter 9 of the ICB Governance Handbook, Delegated Financial Authority Limits

Paragraph reference	Section heading	Description of changes made
Introduction, p.65	Section 9.4	Reference to the Prime Financial Policies updated to the Standing Financial Instructions.
Introduction, p.65	Section 9.7	New section added introducing the Detailed Scheme of Delegation under the management of the Executive Team.
2.9	Contracts	References to Governing Body in the table replaced by Board. Maximum limit for Chief Executive and Director of Finance for NHS healthcare contracts reduced from Unlimited to £600 million. Maximum limit for Director of Finance for non-NHS healthcare contracts reduced from Unlimited to £100 million. Office Member of the Board delegated limit increased from £100,000 to £250,000 for non-healthcare.
2.10	Contracts	References to Governing Body in the table replaced by Board. Maximum limit for Chief Executive and Director of Finance for NHS healthcare contracts reduced from Unlimited to £600 million. Maximum limit for Director of Finance for non-NHS healthcare contracts reduced from Unlimited to £100 million. Office Member of the Board delegated limit increased from £100,000 to £250,000 for non-healthcare. The text formatting of the previous version meant that some of the wording was not visible.
4.1	Non-pay expenditure	The wording now recognises that CHC approvals are managed using local procedures which are approved by the Assistant Director of Finance.
4.2	Non-pay expenditure	A reference to the CCG Handbook has been updated. Text formatting has been corrected. The wording now recognises the local procedures within CHC described at 4.1 above. Reference to the Detailed Scheme of Delegation has been added.
5.1	Pay including agency arrangements	The requirements for off payroll engagements have been updated to reflect new NHS England regulations. Also, authority limits for expenditure on legal and professional services have been updated to be consistent with paragraph 4.2. Also, confirmation that authorisation of establishment changes can be further delegated by the Chief Finance Officer to an Assistant Director of Finance.
6.3	Authorisation of debt write-off	Delegation to write off bad debts up to the value of £10,000 introduced for the Assistant Director of Finance.
7.1	Authorisation of losses and special payments	The narrative has been updated to reflect advice from NHS England about the management of losses and special payments.

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023

Location: Boardroom, Bridge House, Sleaford

Agenda Number:	8 (iv)
Title of Report:	Update from the Service Delivery & Performance Committee
Purpose:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	None

1. Key Points for Discussion:	The purpose of this paper is to provide the Board with a summary of the ICB Service Delivery & Performance Committee meetings held in January & February 2023.
2. Recommendations	The Board is asked to note and consider this report.
3. Executive Summary	<p><u>January 2023</u> The meeting received information on progress on:</p> <p>Children & Young People’s Mental Health services.</p> <ul style="list-style-type: none"> ➤ Increased investment in Healthy Minds Lincolnshire has been agreed and included as part of the ICB’s investment plans. Funding will be used to maintain countywide mental health prevention and promotion work within education settings and early, low-moderate intervention for CYP and families in Lincolnshire, enabling recruitment and development of an increased workforce and supporting increased access for more CYP. ➤ Four MHSTs are now operational in Lincolnshire, another four will be implemented by January 2025 in line with NHSE timeframes, prioritised to the areas of greatest inequality and need, building to an estimated 50% coverage by 2024/25 ➤ Increased staffing in CAMHS to provide sufficient capacity to meet the increased demand on specialist services, address the existing waiting list and reduce waiting times. ➤ A physical health care pathway for YP with an eating disorder has been developed with primary care and needs to be extended through to acute physical health care. In 2022/23 CYP-EDS has secured GP time to support the physical healthcare monitoring required within the service, which has been very effective in eliminating previous issues. This needs to be formalised and embedded into ongoing practice. ➤ Continued investment in transition lead MH workers within CAMHS to lead on improving and supporting transitions for YP between 16-25, especially supporting the transition to community support past 18.

- Continued implementation of the CYP Complex Needs Service and delivery of the framework for Integrated Care.
- Continued implementation of the CYP Key working service as per project plan to be operational by the end of 2022/23.
- Continued implementation of CYP MH Primary Care Practitioner roles as part of the CYP ARRs pilot; implement these roles across IMP and South Lincs Rural PCNs to improve access and primary care links.
- Continue regional delayed discharge programme to build in early engagement and discharge planning for CYP mental health inpatients.

Current risks and issues:

- Workforce recruitment/retention of qualified mental health practitioners providing additional challenges to meeting demand, particularly in certain teams (Crisis and Enhanced Treatment Team) and certain localities (South Lincs, Boston, East Coast).
- Increased demand and acuity of CYP being referred for specialist MH support was adding pressure across all CYP teams.
- Difficulty accessing Tier 4 inpatient provision for Lincolnshire CYP is providing challenges for local teams in having to support interim solutions in partnership with local acute services as well as delays to appropriate treatment for these CYP.
- Delivering services and offering access across a large, rural county is a constant challenge especially with existing capacity issues.

Cancer

- Significant focus on backlog clearance for all Planned Care, not just Cancer.
- Focus is on 62-day treatment target for cancers and the backlog associated with this. Additionally, focus on Faster Diagnostic Standard (FDS).
- Progress has been made with regards to the Colorectal Cancer pathway. This would continue to be looked at in order to understand what the ingredients to its success were (clinical involvement, best practice, interfaced into a good delivery model and a change cycle which led to a rapid improvement).
- Continue work with both acute and primary care clinical directors to look into lung and prostate cancer. Lung was a particularly fragile service at ULHT, including Respiratory. The backlog of these patients has been growing. The Respiratory service was fragile due to not being able to recruit to posts.
- 62-day patient numbers have taken some deterioration, but this figure was now coming back down. The trajectories had been accurate in reflecting that December and Christmas would have an impact. Some of this was due to patient choice.
- Faster Diagnostic Standard, the system was doing well and achieving over the 75% standard. There are a number of other services that are close to standard but there are a few areas of concern, particularly surrounding Gynaecology. There was a need to undertake more work to formalise the recovery strategy.

Planned Care

- Change in the approach with regards to how patients who have waited longer than 78wks are monitored. The target for those waiting 78 weeks or more at the end of March is zero.
- 78wk trajectory, Lincolnshire was still performing better than trajectory but this would get more difficult as we approach March. The patients have been through a validation process, and this identified that some had in fact received treatment or had alternative plans in place. 78% of the patients are waiting for an outpatient appointment and a large number of these are waiting for their first appointment. Due to this, there is a subsequent risk that after the patients have been seen they may then need an operation to complete their pathway.

- A number of specialties within ULHT have made excellent plans for the use of the independent sector, and these were in the process of being mobilised. The benefits from this will help mitigate two or three of the higher risk specialties with the largest backlogs.
- There was still a requirement for mutual aid in order to be able to deal with the planned care backlog overall. A number of systems have indicated that they are looking to support Lincolnshire with this.
- An update letter was expected from Amanda Pritchard to advise that every patient that has waited for more than 78wks needs to be given a date for either their outpatient appointment or their 'To Come In' date (TCI) before the end of March and the activity would need to be completed within the next 14 days.
- Community Diagnostic Centres (CDC) - these were a significant conversation point with the Secretary of State for Health & Social Care and we would shortly be sharing the details regarding the Lincolnshire spoke model CDC at Skegness.
- Critical incidents and the various strikes were having a knock-on effect and were a high risk to planned care. Mr Evans highlighted that this was not just an issue for Lincolnshire.

Urgent & Emergency Care

- Some of the key schemes that have been rolled out collectively across the system have had a large impact, especially Breaking the Cycle 1&2. Breaking the Cycle 1 was the implementation of the full capacity protocol within ULHT and this focused on the +1 model that has been utilised across the country. This has increased the number of patients in ward areas with teams trying to decongest the ED in order to assist with the ambulance handover position. Breaking the Cycle 2 was a step on from this. There has been a focused piece of work within the community, and this included adding in additional capacity, but also a focus on discharges and discharge pathways. Breaking the Cycle 1&2 combined to help achieve a real improvement in the ambulance handover position for November.
- Due to demand increasing and the impact of the industrial action and the bank holiday period, this has resulted in ambulance handover times suffering. Whilst it has deteriorated, it is still an improvement on earlier months.
- 7 of the 11-winter assurance framework capacity and demand schemes have been mobilised with additional schemes in place, including within primary care. The December planned position of increased capacity was achieved. The Halo scheme had not been mobilised as yet - having dedicated clinical navigator paramedic roles at the front door had been delayed due to recruitment issues but it was anticipated that this scheme would be live by the end of January. Other schemes that are being focused on relate to having senior clinical decision makers within the Emergency Operations Centre within EMAS. It has been very difficult to secure that additional capacity, so the team are in the process of starting to rescope what this would look like and how best the funding could be distributed if it was not deliverable.
- Winter plan has been enacted, with the related action plans in delivery.
- System Co-ordination Centre was now fully established, and staff are in place. This team have taken over the operational aspects for UEC for the system.

The main risks to highlight with regards to the UEC programme are:

- Increased pressures on services increases the clinical risk both to patients within the acute and community settings.
- Continued non-delivery of national clinical standards.
- Programme capacity due to management of operational pressures and incident response.
- Ongoing financial risk attached to the EMAS contract due to handover delays.

System Planning

- 2023/24 Planning Guidance was released in December by NHSE. The main emphasis was on recovery of core services and improved productivity. Some of the key themes are:
- Reinforcing local decision making.
- Emphasis on outcomes.
- Sustained recovery of core services and productivity improvement have to be delivered within the same financial envelope as 2022/23. There are a couple of exceptions to this - additional funding when elective targets are exceeded and growth of Better Care Funds to support discharge.
- The Joint Forward Plan Guidance was also issued in December (5yr plan) which details how ICBs needed to work with partner organisations in terms of how health and care services over the next five years are to be delivered.

February 2023

The meeting received information on progress and discussed the following:

Terms of Reference (ToR)

Discussions took place on the ToR, and a number of amendments were suggested to reflect the work of the Committee as this develops.

System Planning

Submission requirements (Draft 23/02/23 and Final 30/03/23), covering:

- Activity and Performance.
- Capacity, demand & flow.
- Workforce.
- Finance.
- Narrative (planning approach; elective care; cancer; diagnostics; UEC; productivity & efficiency).

Activity & Performance Overview for 23/24 (RAG rated against national expectation):

- Cancer RAG rated Green.
- Discharge and Community – RAG rated Green with the exception of Community services waiting lists for both adult and children which are RAG rated Amber.
- Learning Disability RAG rated Green.
- Mental Health – RAG rated Green with the exception of Access to IAPT, Access to CYP Mental Health Services, Overall access to core community mental health services for Adults & Older Adults - RAG rated Red.
- Primary Care – RAG rated Green

Next steps for 2023/24 operational planning

- Completing the draft submission for submission on 23/02/23
- Developing the final submission for submission on 30/03/23.
- Developing a system-facing 2023/24 plan that covers all programmes and organisations.

Integrated Community & Primary Care

- A comprehensive review was being undertaken across Lincolnshire with regards to Care Co-ordination as it was acknowledged that this was a key enabler.
- Conversations were taking place with PCN Clinical Directors and the neighbourhood teams in order to understand what is out there and what is working.
- Evident from the review was that there was a lot of variation across the county. Some areas have got well established Care Co-ordination functions that deal with their population and prioritise their interventions. Others are more limited in terms of both their capacity and focus.

- Mrs Mills was working with Mrs Ceri Lennon regarding the complexity and arrangement for employing people who work in these integrated roles.
- Working in parallel with this was the focused piece of work associated with frailty.
- There is a requirement to recognise and quantify the level of investment needed to enable the team to extend Care Co-ordination. The team are working with K2 who have an established model which will enable us to use their evaluation and insight in developing the case for change for Care Co-ordination and the level of investment that will be required.

People Plan

- The system was currently showing a steady rise in substantive staff in post in line with the planned workforce model.
- The rise in agency has begun to plateau and the interventions in place appear to be driving a slight reduction over the last month.
- Although there has been an increase in the overall sickness rate, this is in line with the national and regional picture. Lincolnshire's absence rate tracks lower than many regional counterparts.
- Progress in the 'Belonging' theme with Allyship toolkit and our Carers' Network.
- KPMG Workforce Modelling Solution has been launched with initial data being rated as good quality.
- Good progress was being made on the attraction strategy with digital partner procurement concluded and agreed branding for 'One Workforce'.
- Staff retention programme (People Promise Exemplar Programme) gaining regional and national recognition with pending visit from the National Director for Engagement at NHSE.
- The Occupational Health review and the apprenticeship strategy has been delayed but will now be an integral part of the 2023/24 plan.
- The Lincolnshire system was working towards a £20m cost saving target and in light of this, the People and OD Directorate of the three individual trusts have come together along with the system people hub to identify, implement, and embed specific improvement projects.

Health Inequalities

- Tackling Health Inequalities – 3 aspects:
 - Access to effective treatment, care and support
 - Prevention – How it integrates into Public Health.
 - Wider determinants, such as access to work, skills, housing etc.
- The work on Health Inequalities aligns with the five national Strategic Priorities for Health Inequalities and the Core20plus5 approach. The five strategic priorities are:
 - Strategic Priority 1 – Restore NHS services inclusively.
 - Strategic Priority 2 – Mitigate against digital exclusion.
 - Strategic Priority 3 – Ensure data sets are complete.
 - Strategic Priority 4 – Accelerate preventative programmes.
 - Strategic Priority 5 – Strengthen leadership and accountability
- There are four workstreams – Embedding a system approach to health inequalities; Prevention; HI Performance, Data & Intelligence and HI in Clinical Pathways, with Communication and Engagement the golden thread running through the programme
- The Committee is to receive a highlight report with performance information for challenge and assurance before it is presented to the ICB board.

Green Plan

- This was now mandated as part of the Health & Social Care Act 2022 and there are now duties on each of the trusts and the ICB to contribute towards statutory emissions and environmental targets.
- The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets.

- It also covers measures to adapt to any current or predicated impacts of climate change identified within the 2008 Climate Change Act.
- The Greener NHS programme has been arranged into a number of workstreams:
 - Model of Care
 - Workforce
 - Medicines
 - Estates and facilities
 - Travel and Transport
 - Supply Chain
 - Adaptation
 - Research and innovation
 - Digital
 - Data and analytics
- The Midlands priority deliverables for 2022/23 are Travel and Transport, Medicines, Estates and facilities, Supply Chain and Workforce & Leadership.

Estates

- Operational Group has been established and are effectively working through the issues.
- Single procurement of office and desk booking app being rolled out in LPFT and LCHS. This was the same system as LCC so was an opportunity for further integration.
- Estates Infrastructure Plan – draft report being circulated. Base for Expressions of Interest to New Hospitals Programme and the ULHT 5-year Estates Strategy. Same place-based approach and external support being used for PCN Estates Strategies which are part of the regional programme.
- Agreed single approach to measuring social value. Procured Social Value Engine Licenses and training for use across the ICS.
- Senior representation from all organisations engaged.
- Commitment to working with NHSPS to agree new system approach to funding the Johnson Hospital, Spalding.

Performance Highlight Report – Winter/78wks

- The system managed well over a number of industrial action days.
- Staffing pressures remained an issue.
- 78 weeks - progress has been made with regards to capacity for patients but there have been issues with patient choice and patients not wishing to have to travel for appointments.
- The Choice Policy concerned the Committee – this is in respect of the impact of two appointments offers being declined.
- Mr Morgan and Mr Turner link in weekly with NHSE who have indicated that the Lincolnshire system was on the right track.
- Respiratory specialty was flagging up as still being an issue.
- Cancer – Mr Turner has been advised that Lincolnshire was very close to being moved into Tier 1. If the system was moved into Tier 1 this would reduce motivation amongst the staff.
- Patient Tracking List has reduced.
- Ambulance Handovers – these have improved and there has been a long period of sustained improvement.
- Discharges are still proving to be an issue which is having a knock-on effect within ED for patients who are waiting to be admitted. A piece of work was underway with IMPOWER regarding discharges.
- Virtual wards – the average occupancy was 71% which was an increase from 65%.

It was highlighted that the ICB Board needed to note the risk with regards to the possible move to Tier 1 for Cancer and the implications of this.

March 2023

The meeting received information on progress and discussed the following:

- Adult Mental Health, Learning Disabilities and Autism
- Children's Mental Health
- System Planning
- Winter Plan Delivery
- Cancer
- Planned Care
- Committee Self-Assessment

There was one item identified for escalation to the Board:

- **Children and Young People** - concern that the targets are not achieved, and risks in not achieving future improvements.

A report will be presented to the May meeting which contains further detail on the items discussed at both the March and April meetings.

4. Management of Conflicts of Interest

No conflicts of interest were declared at the committee.

5. Risk and Assurance

No escalations from the 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)

N/A

11. Report previously presented at

N/A

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

Dawn Kenson – Non-Executive Director & Chair of System Delivery & Performance

Committee – d.kenson@nhs.net

Clair Raybould – Director for System Delivery – clair.raybould@nhs.net

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	8 (v)
Title of Report:	Audit & Risk Committee Update
Purpose:	Mrs Margaret Pratt – Interim Chair of the Audit and Risk Committee (Non-Executive Director)
Appendices:	N/A

1. Key Points for Discussion:

This paper provides an update on the discussions that took place at the latest Audit & Risk Committee meeting held on Monday, 13 March 2023.

2. Recommendations

The Board is asked to note the update and progress.

3. Executive Summary

The Audit & Risk Committee meeting held on 13 March 2023 focused on a number of areas including the following:

- External Audit Progress Report for Lincs CCG and Lincs ICB Audit Planning Report
- Internal Audit Progress Report
- Internal Audit Report – Primary Care Commissioning
- CCG & ICB Annual Reports Update including Draft annual report and annual accounts
- Audit Action Update
- Counter Fraud Progress Report
- Risk Management Update

Key points for noting were as follows:

***External Audit Progress Report for Lincs CCG & Lincs ICB Planning Report
 Progress Report for Lincs CCG***

Good progress has been made on the report, with just a few items to close off and an update will be provided at the next meeting.

ICB Planning Report

The Audit & Risk Committee formally received the ICB plan.

Internal Audit Progress Report

Progress continues to be good. Three pieces of work remain outstanding on the plan, which have now all commenced; Corporate Governance, Business Continuity & EPRR and the DSPT. All three are expected to be completed by end of March. Interim opinion has been drafted and will be shared with the ICB in line with deadlines and submission date of June.

Internal Audit Report

Primary Care Commissioning

This report is rated medium and is around the fragility within the GP practice sector. The five findings identified were 1) the lack of overarching localised procedure documents/framework to support officers, 2) lack of formalized term of reference for working groups, 3) lack of primary care contracts tracker, 4) lessons learnt exercises are not undertaken and 5) competency assessments and training plans.

CCG & ICB Annual Reports Update including Draft annual report and annual accounts

A draft annual report including annual accounts were received by the Committee. The update report identified the process and deadlines. There are additional elements in terms of the annual report this year around safeguarding. It was agreed to share a further draft with members in May.

Audit Action Update

There are three open and overdue actions, one on BCF and two on Risk Management. There are 10 open actions, nine of which have been completed. There are 14 new actions. Pushing to get as many of these actions completed by end of March.

Counter Fraud Progress Report

Proactive work continues including a newsletter, staff quiz and training. There had been no referrals, however, some intelligence had been received from NHSFA which had been assessed and confirmed there was no element of fraud involved.

Risk Management Update

A copy of the Risk Management Strategy Policy, corporate risk register, Journey of a Risk SOP and BAF were shared with members. All members agreed to endorse the Risk Management Strategy Policy.

4. Management of Conflicts of Interest

The management of conflicts of interest is dealt with in accordance with the agenda and items.

5. Risk and Assurance

As indicated in the report.

6. Financial/Resource Implications

Detailed in individual reports, if applicable.

7. Legal, Policy and Regulatory Requirements

Nil specific to note.

8.	Health Inequalities implications
Nil specific to note.	
9.	Equality and Diversity implications
Nil specific to note.	
10.	Patient and Public Involvement (including Communications and Engagement)
Nil specific to note.	
11.	Report previously presented at
Regular updates provided to the Board	
12.	Sponsoring Director/Partner Member/Non-Executive Director
Margaret Pratt – Interim Non-Executive Director and Chair of the Audit and Risk Committee Matt Gaunt – Director of Finance & Contracting – m.gaunt@nhs.net	

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	8 (vi)
Title of Report:	PCCC Public Committee Meeting Update
Author:	Dr Gerry McSorley, Chair Sarah-Jane Mills, Director of Primary Care, Community & Social Value Sarah Bates, Deputy Board Secretary
Appendices:	N/A

1.	Key Points for Discussion:
<p>This paper provides an update on the discussions that took place at the Public Primary Care Commissioning Committee meeting that was held on 15th February 2023.</p>	
2.	Recommendations
<p>The Board is asked to note the update.</p>	
3.	Executive Summary
<p>The February 2023 Public Primary Care Commissioning Committee focused on the following agenda items:</p> <ul style="list-style-type: none"> • Director of Primary Care, Community and Social Value: Director of Primary Care, Community and Social Value: it was noted that this is a new report. An update was provided on the validation exercise that is being undertaken in relation to the number of GP appointments offered. It was noted that during 2022, General Practice delivered 3,596,421 appointments in total, an increase of 12.9% compared to 19/20, (this excludes COVID-19 vaccination activity and the Additional Roles that have been introduced in PCN's). It was noted that 70.7% of patients are being seen face to face with 81.6% seen within two weeks of the patient contacting the Practice. • In terms of the delivery of Learning Disability and Serious Mental Illness health checks this is expected to increase over February and March, both are above or close to the Year-to-Date target. <p>For the diabetes eight care process performance is significantly off-target and remedial actions are under review.</p> <p>An update was provided on the dispersal of patients from the Spalding GP Practice and that the majority of patients were transferred to alternative providers last week and the remaining 34 patients with a registered address outside of the Spalding area have been contacted and asked to register with a Practice close to their home address. Members of the public and the staff were thanked for their support during the transition process.</p>	

In terms of the Sidings Practice, Omnes the new healthcare provider has been working to strengthen service provision.

Concerns have been raised regarding the cost of living and the impact on GP Practices in particular with the end of the government subsidiary in April 2023 for energy costs. Furthermore, the wage increase by 9.7% and the uplift through the GMS contract at only 2.1%.

The PCNA is working to maximise the opportunity to recruit to the remaining Additional Roles that will extend the primary care provision and provide increased access for the general public.

From April 2023 the ICB will assume the responsibility for the local management and commissioning of Pharmacy, Optometry and Dental services and that significant work has been taking place to support the transition.

In terms of system planning the Operational Plan for 2023/24 has been received however the specific guidance for primary care is still awaited. Work is ongoing in reviewing the Five Year Forward View.

- **Quality, Patient Safety, Experience and Effectiveness Update:** there are known and ongoing quality issues with a few of our General Practices which rate higher on the ICB Quality GP Risk Register. To note below specifically:
 - **Lakeside Stamford Practice** currently rated Requires Improvement overall by the CQC, with Inadequate in the Safety domain. A re-inspection took place at the end of November 2022, the outcome of that re-inspection is expected. The ICB and LMC are satisfied that improvements are progressing well, there is a particular focus on continuing to improve access as there continue to be concerns raised by patients in this area, albeit less prolifically.
 - **Hawthorn Practice** in Skegness had a CQC inspection in August 2022 and was rated as Inadequate overall and placed in Special Measures. The outcome of a follow up inspection by the CQC in December 2022 is also expected. The Practice has been making steady progress with required improvement actions.
 - **Branston Practice** had a CQC inspection in November 2022 and was rated as Inadequate overall and placed in Special Measures. A recent CQC re-inspection occurred in January 2023 and the outcome of this review is currently awaited.
 - **Spalding Practice** has a Requires Improvement CQC rating. List dispersal for this Practice is currently underway to neighbouring Practices. While that occurs the ICB and Lincolnshire Community Health Services, who currently run this Practice, continue to have robust oversight to ensure safe care during the list dispersal.
 - **Trent Valley Practice** has a Requires Improvement CQC rating post CQC inspection in September 2022. The ICB is satisfied that appropriate improvement actions are underway.
- **Risk Register Update:** an update as provided in relation to the Risk Register and the following was noted:
 - **Energy Costs**
This risk has increased. The high energy costs are affecting GP practice resilience and financial viability. National support for businesses ends in April 2023 with potential impact on Practice finances.
 - **Resettlement Programme**
This risk has decreased to a current risk rating of 12.
 - **Oral Anticoagulation**
This risk has increased. Work is ongoing in reviewing the service provision and providing this on a larger footprint.
 - **Group A Streptococcus concerns and antibiotic supply**
This risk has been reduced. Presentations by concerned patients and parents at GP Practices has increased significantly in December and fulfillment of antibiotic prescriptions where required has been raised by GP Practices.

Items for escalation to the ICB Board:

- Spalding Practice and the support during the patient list dispersal process.
- Financial impact and the cost of living on GP Practices.

Management of Conflicts of Interest

The management of conflicts of interest are dealt with in accordance with the agenda and items.

5. Risk and Assurance

Practices have been identified and placed on the ICB Risk Register.

5. Financial/Resource Implications

Where required additional funding has been provided by the ICB to facilitate additional support to vulnerable Practices as appropriate, where not covered via existing funding routes.

6. Legal, Policy and Regulatory Requirements

Legal considerations include:

- The statutory duty to consult and engage on service changes as set out above.
- Primary medical services contractual compliance and formalities.

The planning and implementation of this service change should have due regard for the principles and values as set out in the NHS Constitution.

7. Health Inequalities implications

Include details of health inequalities implications.

8. Equality and Diversity implications

Include details of any equality and diversity implications.

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

Patient and public engagement processes are utilised to secure patient experience information for each Practice that informs the Quality Risk Rating and Quality Improvement actions.

11. Report previously presented at

Regular monthly progress reports have been provided at PCCC meetings.

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

Sarah-Jane Mills - Mobile: 07870 898428

sarah-jane.mills1@nhs.net

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	8 (vii)
Title of Report:	Update from Finance and Resource Committee – 21.02.23 and 21.03.23
Purpose:	For information
Appendices:	

1. Key Points for Discussion:	
	The purpose of this paper is to provide the Board with a summary of the ICB Finance and Resource Committee meetings held on 21 February 2023 and 21 March 2023.
2. Recommendations	
	The Board is asked to note and consider this report.
3. Executive Summary	
	<p>The ICB Finance and Resource Committee was held on held on 21 February 2023. The Committee focused on the following key areas:</p> <ul style="list-style-type: none"> • System financial forecast outturn of £21m deficit. <p>The ICB Finance and Resource Committee was held on 21 March 2023. The Committee focused on the following key areas:</p> <ul style="list-style-type: none"> • ICS Financial Outturn 2022/23 <ul style="list-style-type: none"> ○ ICS Forecast Outturn position is now £17m • ICS Financial Plan 2023/24 <ul style="list-style-type: none"> ○ Challenging programme of efficiencies. ○ Delivery over the next six months is vital to exit NOF4. ○ Committee will 'own' the deficit plan. • Financial Recovery Programme (FRP) <ul style="list-style-type: none"> ○ Delivery of FRP is fundamental to the system's exit of the National Oversight Framework. ○ Committee assured by the work of the Improvement Director and team to deliver the plan effectively and in a timely manner. ○ Important to maintain momentum around identification and delivery for future years and appropriate resources were key to this. ○ Committee has some concerns around the unidentified efficiencies which range from £13-24m.

	<ul style="list-style-type: none"> o Committee would like to highlight to LLC and Boards the excellent partnership working on the FRP.
4.	Management of Conflicts of Interest
	No conflicts of interest were declared at the committee.
5.	Risk and Assurance
	No escalations from the establishment committee meeting
6.	Financial/Resource Implications
	As per the reports presented.
7.	Legal, Policy and Regulatory Requirements
	N/A
8.	Health Inequalities implications
	N/A
9.	Equality and Diversity implications
	N/A
10.	Patient and Public Involvement (including Communications and Engagement)
	N/A
11.	Report previously presented at
	N/A
12.	Sponsoring Director/Partner Member/Non-Executive Director
	Julie Pomeroy – Non-Executive Member & Chair of Finance & Resource Committee – julie.pomeroy1@outlook.com Matt Gaunt, Director of Finance – m.gaunt@nhs.net

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 28th March 2023
Location: The Boardroom, Bridge House, Sleaford

Agenda Number:	8 (viii)
Title of Report:	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance Process
Report Author:	Rebecca Neno, Deputy Director for System Delivery, NHS Lincolnshire ICB
Appendices:	-

1. Key Points for Discussion:

The purpose of this paper is to provide the ICB Board with an update with regards to the outcome of the annual NHS England EPRR Core Standards Annual Self-Assessment for 2022- 23 for NHS Lincolnshire ICB.

2. Recommendations

Members of the ICB Board are asked to note the Lincolnshire Integrated Care Board assurance process and ICB compliance rating for 2022/23.

3. Executive Summary

In July 2022, NHS Lincolnshire Integrated Care Board (ICB) was formed, formally NHS Lincolnshire Clinical Commissioning Group (CCG). This transition to ICB included an acquisition of Category 1 responder status, as defined within the Civil Contingencies Act (2004). As a Category 1 responder, additional civil duties now apply to the ICB compared to those held as a CCG as a Category 2 responder.

All NHS organisations are required to undertake a self-assessment against the 2022 updated core standards relevant to their organisation which should then be taken to a public board or, for organisations that do not hold public boards, be published in their annual report.

The annual EPRR self-assessment against a set of core standards provides an assurance that NHS organisations are working to meet their EPRR statutory duties and obligations. The applicable core standards vary between organisations depending on the type of services they deliver.

In 2022/23 the ICB declared non-compliance against the overall core standards which is a reduction from substantial compliance that its predecessor CCG held in 2021/22. Although perceived as a reduction in compliance, this self-assessment was undertaken as a new organisation where a set of new arrangements were required for the new category 1 responder status.

The ICB has recruited specialist EPRR resource and completed work in 2022/23 that will achieve compliance for 2023/24. Additional plans have been implemented including the Incident Response Plan and Adverse Weather Plan. An ICB EPRR oversight & assurance group has also been formed to provide an independent assurance on progress made in achieving full compliance in 2023/24.

Further arrangements continue to be developed which enable the ICB to provide a coordinating function for the local health system during incident response. Local Health Resilience Partnership (LHRP) members now work more closely ensuring interoperability in both response and recovery. This has been demonstrated throughout 2022/23 whilst also working alongside multi agency local resilience forum partners.

It is worth noting that the ICB and predecessor CCG has been in formal Incident Response throughout the Covid pandemic including acting under delegation from NHSE for their duties and therefore has real time evidence of its ability to perform the statutory duties required.

4. Management of Conflicts of Interest

None noted

5. Risk and Assurance

Assurance in relation to EPRR core standards completed annually by NHS England. ICB has developed an EPRR Assurance and Oversight Group to provide additional rigor and challenge to the Core Standards process. ICB has also engaged internal audit to scope best practice and benchmarking.

6. Financial/Resource Implications

None noted

7. Legal, Policy and Regulatory Requirements

Health Care Act 2022
 NHS England EPRR Framework
 Civil Contingencies Act 2004
 NHS England EPRR Core Standards 2022-23

8. Health Inequalities implications

None noted

9. Equality and Diversity implications

None noted

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

None noted

11. Report previously presented at

Detail of outcome of EPRR Core Standards have been discussed previously at LHRP and ICB Executives.

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

Clair Raybould, Director for System Delivery, clair.raybould@nhs.net