NHS
Lincolnshire
Integrated Care Board

MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD TO BE HELD ON TUESDAY, 31st JANUARY 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).

NHS
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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Time: 9.00 am
Location: Boardroom, Bridge House, Sleaford

AGENDA

ITEM NUMBER		ACTION	ENCLOSURE/ VERBAL	LEAD	TIME
1. INTRODUCTION					
i)	Welcome and Apologies		Verbal	Dr Gerry McSorley	9.00
ii)	Declarations of Interest		Verbal	Dr Gerry McSorley	
iii)	Minutes of Meeting held on 22nd November 2022	Approve	Enclosure	Dr Gerry McSorley	
iv)	Matters Arising, including Action Log	Note	Enclosure	Dr Gerry McSorley	
2. CHAIR AND CHIEF EXECUTIVE UPDATES					
i)	Chair • Update and Overview	Note	Verbal	Dr Gerry McSorley	9.10
ii)	Chief Executive • Update and Overview • Recovery System Plan (RSP) and Quarterly Review System Meeting (QRSM) – Letters from NHS England • Armed Services Covenant	Note	Enclosures	Mr John Turner	9.20
3. KEY UPDATES					
i)	Public Health	Note	Verbal	Professor Derek Ward	9.40
ii)	Healthwatch	Note	Verbal	Mrs Sarah Fletcher	9.50
4. CORE PURPOSE 1: HEALTH INEQUALITIES (tackle inequalities in outcomes, experience and access)					
i)	Update on the Lincolnshire Dental Strategy	Receive	Enclosure	Mrs Sandra Williamson/Mrs Caroline Goulding and Mr Shaun McGill	10.00
5. CORE PURPOSE 2: HEALTH OUTCOMES (improve outcomes in population health and healthcare)					
i)	Performance Report	Receive	Enclosure	Mrs Clair Raybould/ Mr Simon Evans	10.15

ITEM NUMBER		ACTION	ENCLOSURE/ VERBAL	LEAD	TIME
ii)	Quality Report	Receive		Mr Martin Fahy	10.30
BREAK 10.40 – 10.55					
6. CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY					
i)	Finance Report – Month Nine	Receive	Enclosure	Mr Matt Gaunt	10.55
7. CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE (help the NHS support broader social and economic development)					
i)	Lincolnshire's Interim Integrated Care Partnership Strategy	Consider	Enclosure	Mr Pete Burnett	11.05
ii)	Lincolnshire's Joint Forward Plan	Consider	Enclosure	Mr Pete Burnett	11.15
8. GOVERNANCE					
i)	Report from the Service Delivery and Performance Committee meetings held on the 16th November 2022 and 14th December 2022 - Terms of Reference	Receive	Enclosures	Mrs Dawn Kenson	11.25
ii)	Report from the Finance and Resource Committee meetings held on the 13th December 2022 and 24th January 2023	Receive	Enclosure	Mrs Julie Pomeroy	11.30
iii)	Report from the System Quality and Patient Experience Committee meeting held on the 22nd December 2022	Receive	Enclosure	Professor Sir Jonathan Van Tam/ Mr Martin Fahy	11.35
iv)	Report from the Primary Care and Delegated Commissioning Functions Committee meeting held on the 21st December 2022	Receive	Enclosure	Dr Gerry McSorley	11.40
v)	Report from the Audit and Risk Committee meeting held on the 25th January 2023	Receive	Enclosure	Mrs Margaret Pratt	11.50
9. DATE, TIME AND VENUE OF NEXT MEETING					
	Tuesday, 28th March 2023 at 9.00 am at Bridge House, Sleaford	Note	Verbal	Dr Gerry McSorley	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.

NHS
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MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD MEETING HELD ON TUESDAY, 22nd NOVEMBER 2022 AT 9.00 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Sir Andrew Cash	Interim ICB Chair
	Dr Dave Baker	Interim Partner Member, Primary Medical Services
	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mrs Sarah Connery	Executive Board Mental Health Member
	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 Gerry McSorley	Non-Executive Member and Chair of the Primary Care and Delegated Functions Committee and Remuneration Committee
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mr John Turner	Chief Executive
	Professor Sir Jonathan Van-Tam	Non-Executive Member and Chair of Quality and Patient Experience Committee (for part of the meeting only)
IN ATTENDANCE:	Mrs Jules Ellis-Fenwick	ICB Board Secretary and Head of Corporate Governance
	Mrs Jacqui Bunce	Programme Director – Strategic Estates, Partnerships & Planning
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mrs Sarah Fletcher	Healthwatch Representative
	Mrs Sue Jarvis	Maternity and Neonatal Programme Manager
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Professor Derek Ward	Public Health Representative
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board
APOLOGIES:	Dr Sunil Hindocha	Interim Medical Director
	Mr Pete Moore	Non-Executive Member, Chair of Audit and Risk Committee

22/42 WELCOME AND INTRODUCTIONS

Sir Andrew Cash welcomed all those present to the NHS Lincolnshire Integrated Care Board including Mrs Margaret Pratt who had joined the Board as a Non-Executive Director until the end of March 2023 and Mrs Jitka Roberts, System Improvement Director.

Sir Andrew Cash asked that rather than all those present introducing themselves, Mrs Pratt and Mrs Roberts provide a short introduction on their background and experience, which was duly provided.

Sir Andrew Cash also welcomed Mrs Sue Jarvis who was in attendance to present the report on the partnership work and approach to Equity and Equality across the Lincolnshire Maternity and Neonatal System (LMNS) which was included in the pack of papers along with a supporting set of presentation slides.

Sir Andrew Cash confirmed the meeting was quorate.

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

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

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

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

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

The Board agreed to:

- **Note the briefing.**

22/43 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

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

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

Declaration of Interest from Committees:
Mrs Kenson advised that she is a registered patient of Trent Valley Surgery which is referred to as part of the papers. This was noted for recording in the minutes.

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

The Board agreed to:

- **Note the interest as declared.**

22/44 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 27th September 2022 and also the minutes of the Annual Public Meeting held on the 26th September.

The Board agreed to:

- **Approve both sets of minutes as a true and accurate reflection of each meeting.**

22/45 MATTER ARISING

Sir Andrew Cash presented the Action Log as included in the pack of papers. There were two actions, one of which was identified as delivered. The information requested as part of the second action identified for Healthwatch would be brought to the December meeting.

The Board agreed to:

- **Note the action log.**

22/46 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

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

Sir Andrew Cash highlighted the following items which had taken place since the Board had last met:

- The country now has a new Prime Minister, Chancellor of the Exchequer and Secretary of State for Health and Social Care.
- In respect of the Chancellor's Autumn statement the financial aspects would be touched upon by Mr Turner as part of his Chief Executive update and further detail would be referred to by Mr Gaunt as part of the finance update.
- Sir Andrew Cash and Mr Turner had attended a meeting in London the previous evening at which the Secretary of State for Health and Social Care, the Rt Hon Steve Barclay was present. As part of the Chancellor's Autumn Statement, it was announced that he had appointed the Rt Hon Patricia Hewitt to essentially reduce the amount of targets ICS's operate under along with a review of the oversight and governance arrangements of Integrated Care Systems (ICSs). Patricia Hewitt is currently the Chair of Norfolk and Waveney Integrated Care Board.
- The timelines for completion of the review and report to the Secretary of State for Health and Social Care were extremely tight (currently the middle of December). All systems would be consulted as part of the review.

It was noted Councillor Woolley currently sits on a programme for leaders of ICSs of which Patricia Hewitt is involved and the review should be considered as an opportunity to provide feedback and identify potential options for consideration in terms of systems working better together.

Sir Andrew Cash briefed the Board on several events he had attended recently as followed:

- Providers conference in Liverpool along with Mr Andrew Morgan, Chief Executive, United Lincolnshire Hospitals NHS Trust (ULHT) and Mrs Sarah Connery, Chief Executive, Lincolnshire Partnership NHS Foundation Trust (LPFT). It was a positive event.
- Lincolnshire Leaders Group along with Mr Turner and Mrs Debbie Barnes, Chief Executive, Lincolnshire County Council.
- Midlands System Leaders meeting involving the 11 systems across the Midlands region.
- Midlands Chairs and CEO's meeting where discussion took place on the preparation for devolved services from NHS England to the five ICBs in the East Midlands and six ICBs in the West Midlands.

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

Chief Executive update

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

- The national changes in terms of context had been referred to by Sir Andrew Cash but from the local perspective the Lincolnshire system remained subject to a number of operational challenges in the same way as across the whole of the country. These included Urgent and Emergency Care (UEC), cancer, electives and GP access which would be addressed during the meeting but primarily as part of the Integrated Quality and Performance Report.
- The Winter period had now commenced, and a huge amount of work has taken place across the system in pulling together the Winter Plan, which was included in the pack of papers, and would be covered off by Mrs Raybould later in the meeting.
- It was really important to take the time to recognise the excellent efforts of everyone involved across primary care, Trusts and partner organisations in continuously coming together to manage the significant amount of challenges associated with operational pressures.
- ULHT have recently commenced a new programme of work entitled 'Breaking the Cycle' which has been implemented with a view to achieving some progress in terms of the ambulance handover challenges. It was early days with a long way to go but the initial signs in terms of improvements were very encouraging. The challenge will be to maintain that position through the months ahead.
- Financial position – the NHS has received a relatively good settlement, certainly in comparison to other parts of the public sector which needs to be recognised. As has been conveyed through the media, the settlement does fall short of the ideal level of resource but Amanda Pritchard, NHS Chief Executive had recently indicated a level of satisfaction with the allocation. In short this has set the financial frame for the NHS for the next couple of years.
- Mr Gaunt is taking the work forward for the ICB and system in terms of establishing the Three Year Financial Strategy (Plan).
- The Adult Social Care funding was allocated the previous week which is £500 million. In broad terms in Lincolnshire approximately £5 million had been provided to the NHS and slightly more to Lincolnshire County Council.
- The NHSE new Operating Model of downsizing by 30-40% continued to be a huge piece of work for that organisation.
- As introduced earlier, Mrs Jitka Roberts had joined the Lincolnshire system recently as the System Improvement Director (SID). A stocktake and audit with NHS England was scheduled to take place on the 8th December 2022. A week after that is the next Quarterly System Review Meeting (QRSM) with the NHSE Regional Director and his team.
- In terms of planning priorities, a huge amount of work has been taking place in respect of four specific areas – Winter, Development of the ICS Strategy by the end of December 2022, Three Year Financial Strategy and operational planning work for 2023/24 has also commenced.
- At the beginning of November 2022 the Integrated Care Partnership (ICP) held a workshop at the New Life Centre in Sleaford. Several of those in the Board meeting were involved in that workshop which went very well. The output from that event was currently being pulled together to inform the overall content of the ICS Strategy, which is being led on by Mr Pete Burnett, ICB Director of Strategic Planning, Integration and Partnerships and Michelle Andrews, Assistant Director – ICS, Lincolnshire County Council. The initial draft will be presented to the ICP at its next meeting on the 6th December 2022.

There were a few other points to share:

- Mrs Williamson along with Professor Ward and Mr Andy Fox, Public Health had been working together to put forward an expression of interest for Lincolnshire to be a Health Inequalities Accelerator Site. The submission went in on the 21st November 2022.

- Mr Turner attended the Healthwatch Annual General Meeting which took place a few weeks ago. Dr McSorley and Mr Fahy also attended. It was a really positive event.
- The Cost of Living Group referred to at the last Board meeting by Mrs Mills continued to meet. This was being led by local district council and third sector colleagues with full support of other key partners.
- A piece of work was due to commence around co-production and the steps that could be taken to ensure Lincolnshire is considered to be an exemplar in this area. This work involved Mr Turner, Mr Glen Garrod, Director for Adult Social Care, LCC and Councillor Sue Woolley along with a number of other individuals. In summary this is about designing health and care in the round with the people of Lincolnshire, not to them or for them.
- Industrial action – there are a number of strikes taking place up and down the country, and these now include nurses, although the ballot carried out in Lincolnshire did not achieve the required threshold for nursing staff to strike.
- A considerable amount of work was taking place in relation to asylum seekers. There are some very significant issues that the ICB, district council and Lincolnshire County Council colleagues are having to manage in relation to that and it is proving a challenge.
- Psychiatric Intensive Care Unit (PICU) – the ICB was working very closely with colleagues in Lincolnshire Partnership NHS Foundation Trust (LPFT) in relation to the temporary closure of that unit and how that is taken forward.
- Mr Turner recently attended the opening of the new in-patient unit at St Barnabas Hospice in Lincoln. Very positive event and development.
- A number of teams within the ICB had recently been successful in receiving awards – the first of which was the Living with Cancer Team who had won a national award for integrated care. The Primary Care Innovation Team were shortlisted for a Health Service Journal Award last week.
- Mr Turner attended the Lincolnshire Sport and Physical Activity Awards evening recently, which was very well attended by a large number of sectors. It was a very uplifting event.

As referred to by Sir Andrew Cash earlier in the meeting, a question had been received from a member of the public, namely Mr Andrew Nebel. Mr Turner provided some background and context to the question which primarily related to primary care and hospital services in the Stamford and Rutland area. Mr Turner outlined the response to the question which it was noted would be attached separately to the minutes for information and also published on the ICB website in line with standard practice.

Sir Andrew Cash thanked Mr Turner for his comprehensive update and asked whether there were any questions in relation to both updates. Whilst there were some comments made in relation to co-production and ensuring this is factored into the ICB response to the Patricia Hewitt review, these were no questions requiring a response and the details were therefore not captured for the minutes.

Mr Turner advised that for the Lincolnshire ICS to move forward in a positive way and to see improvements in health and wellbeing across the county, there are three constituent voices right at the heart of this:

- Public and the population we serve
- Clinical Leaders
- Partners

Mr Kevin Lockyer, Chair of LPFT had agreed to convene a short-life advisory group which would involve colleagues across the Lincolnshire system to take this forward.

Dr Gerry McSorley advised that at the recent Healthwatch event he had made contact with Dr Sam Cooke from the University of Lincoln who are interested in participatory arrangements and co-production.

They also have a collaboration and knowledge exchange arrangement in place which has contributors around the whole issue of participation and co-production. This information was noted by Mr Turner.

The Board agreed to:

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

22/47 KEY UPDATES

Public Health

Professor Ward advised that his update would cover three broad areas: Infectious disease issues specifically COVID and flu, an update on the work that has been taking place to update the statutory guidance on the 'core offer' for local authorities, and the Director of Public Health Annual Report.

Infectious disease - the national position was generally positive with an initial plateau and a reduction now being seen in the number of COVID cases. The position nationally was starting to be reflected in Lincolnshire, which was generally a few weeks behind.

However, a further wave was expected around Christmas and the vaccine is effective in terms of reducing the severity of disease and numbers of individuals requiring hospitalisation. This reinforced the importance of getting the vaccine.

Omicron currently remains the dominant variant but there were two new variants coming through in Lincolnshire, which are also being seen nationally – B22 October 01 and BQ.1 which is sub-strand of BA5 (Omicron). The vaccine is effective against all variants of Omicron. A further variant called XBB had not yet been seen in the UK. In summary 90% of the cases being seen were either BQ1 or BA5.

An increase in the number of cases of flu were starting to be seen but not at the levels expected when looking at what had been seen in the Southern hemisphere over the Summer.

Professor Ward reiterated the usual measures to prevent COVID and/or flu – hands, face, space and fresh air.

Core offer – Public Health have a statutory responsibility to provide public health advice and support to the NHS (formerly the core offer for Clinical Commissioning Groups). There has recently been some updated guidance issued which the Association of Directors of Public Health had assisted in drafting which is entitled 'Delivering the Quality of Public Health Function in Integrated Care Boards. Work is already taking place to update the core offer for the ICB. A report would be presented to the ICB at a future meeting setting out the details.

Director of Public Health Report 2022 – this was now drafted and focused on the Diverse Communities of Greater Lincolnshire, specifically detailed analysis on four key areas - Urban, Urban Industrial, Coastal Communities and Rural and Market Towns. The report will go through the relevant internal Boards and once that process is complete it will be presented to the ICB Board.

The Board considered the update. Sir Andrew Cash sought clarification in respect of the four areas and whether the report would include demographics in relation to children, young people, adults, older people etc. Professor Ward confirmed that the detail on demographics was included on those four groupings, and they were quite different and stark in comparison across geographical areas.

Healthwatch

Mrs Fletcher advised that in recent weeks Healthwatch had received over 200 patient experiences. The following provided a summary of the key themes.

- Concerns around communication between services and patients was again raised this month, with a focus on communication between hospital services and patients. Patients reported struggling to get answers to queries about their treatment or prognosis, feeling like they were being passed from person to person, as well as struggling to get updates on relatives in hospital. In one particular case an elderly lady with diabetes was in A&E for a number of hours and her family were unable to obtain any feedback/information on her condition. Communication between departments in ULHT had also been flagged as a concern, specifically the impact on individuals. These concerns have been shared with providers and Healthwatch await their response.
- Several individuals shared their struggles of accessing services at Lakeside Stamford. These concerns have been shared with the practice and on a positive note Mrs Fletcher was scheduled to meet later that day with their new Chief Executive.
- Dental services – in one week Healthwatch received a significant amount of experiences shared through their recent survey. A large number of the comments were negative. There were some key themes including improved access for children, NHS practices becoming solely private, and this information not being communicated clearly and a need for improved access across the board.

Mrs Fletcher advised that Healthwatch Lincolnshire continue to raise dental access concerns both locally and nationally. The findings of the survey and report will be shared and directly influence the Lincolnshire Dental strategy 2023-2026 that is currently being put together. This strategy will set out what needs to be done over the next three years to improve NHS oral health services and drive improvements in oral health across the county.

Healthwatch have also been asked to provide patient participation at the Lincolnshire Dental Strategy face to face stakeholders' workshop and as a result of overwhelming interest were now setting up its own focus group to record even more patient experiences. The campaign will next look at feedback from seldom-heard groups: those who are living in deprived and rurally isolated areas, cancer patients, wheelchair users, pregnant women, parents, those with sensory loss as well as the dental workforce themselves. The full report will be published in due course.

Mrs Fletcher advised there were a few further points to raise:

- Healthwatch had received feedback that dosette boxes were apparently being stopped by some pharmacies, which whilst a relatively small change, can have a significant impact on patients, particularly those who are very vulnerable in terms of ensuring they take their medication at the right times. A piece of work would be taking place to ascertain the reasons why these were being stopped.
- Picking up on a point raised earlier by Sir Andrew Cash, Healthwatch have been concerned for some time about concerns raised in respect of cross-border services, particularly in the South of the county. Healthwatch would welcome a piece of work taking place to understand the issues around patient flow, which was noted.
- Healthwatch held an event in October 2022 and a summary of that was currently being produced which would be circulated once finalised.
- Healthwatch were looking to develop an extension of their IMP system (Information Management for Patient experiences), hopefully with the support of the ICS which other systems could potentially feed into. Healthwatch would then be able to provide system-wide intelligence rather than just on an individual organisation basis.

The Board considered the update. Mr Turner advised that he had noted the update provided on dental services and people wanting to participate in the conversation, which was not particularly surprising given the level of interest.

This was a positive step, and it was important for this piece of work to dovetail into the Dental Strategy work being led on by Mrs Williamson within the ICB.

Dr Baker referred to dosette boxes and their removal by pharmacies and welcomed the review being carried out by Healthwatch. This is a really important service in terms of ensuring patients take their medications when they should. This was seconded by Councillor Bowkett. Following a brief discussion it was noted that Mrs Mills would take this forward on behalf of the ICB.

Action: Mrs Mills

The Board agreed to:

- **Note the Public Health update.**
- **Note the Healthwatch update.**

CORE PURPOSE 1: HEALTH INEQUALITIES

22/48 EQUITY AND EQUALITY LINCOLNSHIRE MATERNITY AND NEONATAL SYSTEM (LMNS)

Mrs Williamson introduced Mrs Jarvis, Maternity and Neonatal Programme Manager and advised that as reported at previous Board meetings, part of the ICB Core20PLUS5 approach and the national approach is looking at how to reduce health inequalities. One of the five clinical areas of focus is on maternity and neonatal system and the report included in the pack of papers had been produced to highlight to the Board the partnership work and approach to Equity and Equality across the Lincolnshire Maternity and Neonatal System (LMNS).

Mrs Jarvis expressed her appreciation for being invited to attend the Board meeting and referred to the earlier comments on co-production, confirming this is absolutely embedded into the Maternity and Neonatal programme of work. This has been conveyed on a national stage recently and the LMNS team would be more than happy to support the piece of work referred to by Mr Turner. A further point of note is that the LMNS team are required to develop an Equity and Equality Strategy by March 2023 and this was detailed as part of the next steps in the paper. Public Health colleagues have been supportive in the provision of data to support the development of that Strategy.

Mrs Jarvis provided a presentation which covered the following headings:

- The Lincolnshire Maternity Picture
- National Reports
- Key Statistics
- Smoking in Pregnancy
- Intelligence Informed Approach
- What we have done so far
- Development of Equity & Equality Strategy
- Thank you – what we can do help
- What matters to you – public roadshow events in 2022 and 2023

The Board considered the paper and supporting presentation and commended the work that has taken place to date and proposed next steps.

Mr Fahy advised that this programme of work is about population health management and reducing health inequalities and it was really heartening that a group has been identified with a clear targeted approach who are aware of the challenges yet time and time again have managed to make progress in getting positive outcomes, specifically areas such as smoking cessation. In summary, Mr Fahy wanted to express his appreciation to the team for which he is the Senior Responsible Officer.

Mr Fahy added that there was one further piece of work to be considered in conjunction with NHSE colleagues which relates to adopting one approach in response to national reports. This would be raised with NHSE regional colleagues.

Mrs Kenson referred to smoking cessation and sought clarification on how well the maternity pathway is integrated with general practice and how that works in practice in the community outside of the nine month pregnancy period. Mrs Williamson advised that as referred to in the update there has been a specific ask in terms of the maternity pathway but part of the overall approach working with the Public Health team is around making sure the smoking cessation pathway forms part of every conversation with the public through referrals and engagement in general practice. Mrs Williamson provided a summary of other areas of work taking place with NHSE colleagues and One New Lincolnshire in getting those messages out through Primary Care and PCNs about actively engaging with weight management and other services offered. Work has also taken place on looking at how to best to re-engage and re-connect with the community.

Professor Ward added that this is split into two parts – one is about making sure there is integration between the pathway within maternity services and the stop smoking provider – One New Lincolnshire which is a third sector organisation which also provides other services, such as weight management support, low level alcohol use (it is a wrap-around service). The second part relates to health protection and 0-5 vaccination scheme which is fundamental in tackling health inequalities. Take-up has dropped off during COVID.

Mrs Pomeroy sought clarification on whether it would be possible to bring forward the dates of some of the What Matters to You roadshows. Mrs Jarvis advised that these would take place sooner than indicated where possible but the roadshows do require a lot of resource and planning.

The ICB Board agreed to:

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

CORE PURPOSE 2: HEALTH OUTCOMES

22/49 INTEGRATED QUALITY AND PERFORMANCE REPORT

Performance Section

Mrs Raybould presented the latest Integrated Quality and Performance Report which was split into two sections – Quality and Performance. Mrs Raybould advised that she would cover the Performance section and would take the report as read but wanted to highlight to the Board some key areas of operational delivery.

The Board was advised that Page Four detailed a new high level summary of performance at ICB and where noted Trust level. The format and content of the report continued to be adjusted and evolved and work was on track to deliver a revised report for next year as had previously been agreed by the Board. Mrs Raybould advised that she was happy to receive feedback on the changes to the report to date.

It was recognised that the validated data sets are often lagging but at the Service Delivery and Performance Committee meetings the latest data available, even if unvalidated, is considered. Mrs Raybould would take the opportunity to update the Board on the most recent data as part of the presentation of the report.

Urgent and Emergency Care (UEC) – During September and October there had been a peak in the number of COVID cases, as referred to by Professor Ward under the Public Health update, and the data for that reporting period was included in the report. This had impacted on services and workforce, although not in the same way as had been seen earlier in the year, but as a result performance was below the expected levels in some areas.

However, as a result of a number of interventions by partners November's position is much improved. A couple of examples of this is the work ULHT introduced entitled 'Breaking the Cycle' on the 7th November 2022. At that point Ambulance Handover Delays were around 300 for the Lincolnshire system which includes providers outside of Lincolnshire. In the last week this had reduced to 72 which represented a significant improvement.

One of the national directives in the new Autumn statement and which will come through in the Planning Guidance for 2023/23 relates to Category Two response times; the requirement is to improve ambulance response times for Category Two incidents to 30 minutes on average over 2023-24. For the majority of the last week there had been hardly any handover delays over an hour at ULHT. There had been a slight increase at NWAFT in the last week. They had previously implemented a version of Breaking the Cycle some time ago. Part of this work is to maintain discharge out of hospital, and this was currently a challenge for NWAFT, which was recognised in Lincolnshire; hence ULHT and LCHS were working together to look at Breaking the Cycle Two and that was on-going. A piece of work was also being undertaken to look at the capacity and utilisation of virtual wards.

As referred to at the last Board meeting, the re-setting of the system in terms of available services and access was now starting to demonstrate green shoots. For example Clinical Assessment Service (CAS) Care Homes had seen an increase in calls of circa 25%. There is also the Mental Health Assessment Centre (MHAC) in Lincoln which is seeing 100 patients a month. This should be reflected in next month's Performance Report.

Cancer – as the Board has previously been made aware, the focus has been on colorectal as that represented over 60% of the backlog. The Board will see from the pack this has come down and latest data which was reviewed last week showed a 28% reduction in the backlog for colorectal cancer. This is a result of a wide range of interventions over a five week period, which is really excellent news.

The overall 62 day cancer wait backlog has also come down to 21% which demonstrated the level of work and focus in acute, primary care and a piece of work led on by Dr Sunil Hindocha, Interim Medical Director in respect of the Faecal Immunochemical Test (FIT) pathway, all of which ensures patients who are high risk of having cancer are being prioritised effectively.

Elective – now that 104-week breaches have been achieved focus is upon achievement of the 78-week cohort that need to be treated by the end March 2023. The plan is currently below trajectory overall but there are some challenges in a small number of specialities in achieving that. Mitigation plans are being worked through, but these may have adverse impacts upon the financial position as a result of some potential out-sourcing.

Out-patient recovery at ULHT is behind plan and page eight of the report described the eight week focus actions to increase pace and improve efficiency started at the beginning of the month.

Mental Health - Early Intervention Psychosis (EIP): This was discussed by the Board at its last meeting and whilst the report demonstrates the standard is not being met, it is an improving picture which is reflected in the data. There are some significant workforce challenges in this area, which are not easy to mitigate. In terms of Learning Disabilities Health Checks, the report detailed the current position and work being taken to improve performance.

Winter Plan 2022/23

The Winter Plan has been developed through a real collaborative effort involving all of the ICB's NHS main providers, primary care, national and local regional NHS teams, clinical leaders through the clinical summit and the care sector, Public Health and Adult Social Care.

The Plan has also been influenced by national best practice, guidance issued by NHS England, learning from previous winters within the system and recent peaks in demand whilst experiencing levels of COVID in the community.

The plan is overseen by a Winter Resilience Oversight group made up of executives from health and social care organisations that meet weekly and report into both system Urgent and Emergency Care Partnership Board (UECPB) and Service Delivery and Performance Committee (SDPC). The Plan was discussed at length by the Committee at its meeting held the previous week.

The Winter Plan does not detail core service provision but is designed to supplement the on-going improvements and developments in urgent care as part of normal operational planning. Its purpose is to highlight the predictions for winter demand and set out the planned response, with extra initiatives, capacity and information to manage urgent care and patient flow pressures that the system will inevitably see.

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

The Winter Plan 2022/23 contains a clear ambition for Lincolnshire which will be utilised to orientate and guide decisions during the preparation for and operational delivery over winter months. It sets out the actions and schemes that will be delivered during winter 2022/23 and describes the governance mechanisms to help identify early issues and the need for and tracking of course corrections over the period. One of the new asks for systems is the establishment of Incident Control Centres, which every ICB is required to have set up. This has been established for the system but is not currently sited in one place.

The Board considered the update on the Performance Report and the Winter Plan. Mrs Pratt advised that she was supportive of the format and content of the Winter Plan and specifically wanted to refer to a couple of point – the first of which was the emphasis on ‘Home First’. If that is embedded within the system than this puts the system on the front foot.

The second related to the use of local authority interim beds which is considered best practice and leading edge stuff. This is a really good example of the joint partnership working arrangements that are already in place but with the opportunity to build on that. Mrs Pratt also referred to the system control reflections adding that she hoped this would be able to lead to some benefits realisation through reflection, the documentation of that, ownership and ensuring that is embedded.

Mrs Pratt asked what the position was in response to the recent letter received from NHS England setting out their expectations in relation to elements such as theatre utilisation and whether those would be achieved. Mrs Raybould advised that the letter had been issued to all acute Trust CEOs and the actions identified had been responded to. A copy of the letter and response would be shared with the Board for information. Mrs Raybould added that a number of the actions identified had already been put in place through the Planned Care Board but there are some significant opportunities, specifically in terms of theatre utilisation for some specialities. This has formed part of the focus for the system in terms of recovery in terms of long waiters. Out-patient productivity is also another area for focus where current performance does need to be improved. Both of those areas together will drive better performance.

Mrs Pratt responded by asking whether this benefits realisation will feed into the financial recovery plan. Mr Gaunt advised that the largest component to this is the 122 bed reduction; the feature of removing that completely from the bed base will realise the benefits as referred to.

Mrs Fletcher asked whether there had been any improvements in discharge and long wait numbers in relation to referrals and diagnostics. This was noted to be picked up by Mrs Raybould after other Board Members had made comments.

Professor Ward advised that in terms of performance the focus has to be on the reactive aspects, such as in relation to health protection areas, e.g. C-Difficile and E-Coli, otherwise there will continue be high levels of infections, which are avoidable. The proactive element is included in the Winter Plan such as around the vaccination programme. It is essential to get primary care and community colleagues to understand exactly how important that is in terms of managing secondary care challenges. On a final note, there is a clear need to start the planning for the next winter, and so on – winter comes every year!

Dr Baker advised that the NHS does have a habit of putting interventions in place for winter and then they are stopped at the end of March even when they have had a positive impact from both a financial aspect and patient care. If there are areas which are working well, and which have had a positive impact than they should be continued throughout the year.

Mrs Fosh expressed her appreciation to Mrs Raybould as the Senior Responsible Officer (SRO) along with colleagues involved in pulling together the Winter Plan. As alluded to by Mrs Raybould the Winter Plan is an additionality to that which is already taking place. Learning from the previous year, the Winter Plan will need to be further refined going forward and referring to Dr Baker's point, there will be interventions that should not be stopped and indeed there were some plans implemented the previous year which have carried on throughout the year.

Referring to Mrs Pratt's comments, there is a programme of work for discharge and flow, and it might be helpful to bring a report/presentation to the Board at some stage which highlights the work that has taken place and the proposed next phases of that.

Mrs Connery advised that referring to Dr Baker's point, it was acknowledged that in Lincolnshire there needs to be better evaluation of some of the positive interventions put in place. There are areas of resource available to assist with that evaluation and some examples were provided from the mental health perspective, which was supported and noted.

Mrs Raybould referred back to Mrs Fletcher's question and advised that there is evidence of improvements in discharges, but it has been slow. There are currently no particular issues in respect of most diagnostics, with the exception of Echocardiograms, which has recently experienced some delays which are currently being worked through.

In terms of the Winter Plan going forward, the points identified have already been factored into the planning process. There is also a clear message from NHS England that any monies provided need to be utilised recurrently to get ahead of the situation. This will be factored into the evaluation.

On a final note, testing is being carried out on some areas through a national exercise through emergency planning called 'Artic Willow'. This tests the impact of industrial action, energy changes, adverse weather and winter pressures. This is an on-going exercise which commenced the previous week.

Sir Andrew advised that there would be a short refreshment break at this stage. The meeting was therefore suspended at 10.58 am and recommenced at 11.05 am.

Quality Section

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

COVID Vaccination Autumn Programme: The Autumn booster programme went live on the 5th September 2022 and was due to complete on the 31st December.

The information detailed in the pack demonstrated that performance is on-track and Lincolnshire one of the best performing vaccination programmes in the Midlands region.

This is a really positive position to be in, but work continued to take place to raise awareness about having the vaccine – its never too late to get either the COVID booster or flu vaccination. The Health and Social Care based workforce was now in excess of 56.

Serious Incidents and Never Events: There has been another Never Event reported in relation to Lincolnshire patients in October 2022. The Never Event was reported by ULHT and related to a retained foreign object post procedure. The patient had recovered well. The ICB was working closely with ULHT colleagues to understand the implications.

Mortality metrics: All Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remain on trend for all of the ICB's main providers. Following on from the last Board meeting, work continued with NWAFT to understand their position in partnership with Cambridge and Peterborough ICB and NHS England. Dr Sunil Hindocha, Interim Medical Director met with Dr Fiona Head, Chief Medical Officer / Medical Director for Cambridge and Peterborough ICB to discuss their most recent external review of their issues with SHMI which is now complete, and the draft report has been shared. The review has highlighted that NWAFT do have some coding issues.

Mental Health – this had been primarily covered by Mrs Raybould, but just for noting the ICB had been working with LPFT colleagues in respect of the challenges around the Psychiatric Intensive Care Unit (PICU) and its temporary closure due to patient safety issues. Plans were on track for the unit to open back up as soon as possible.

Learning Disabilities and Autism (Transforming Care): the in-patients programme was slightly off track. The total combined target is ICB 13 + IMPACT which is 27. Current performance is at 28. However, performance had improved significantly from the previous year and the deep dive with NHSE regional colleagues has taken place and the feedback from that was positive, especially around the ICB transformation plans and integrated approach with the local authority.

Health Checks: On plan Delivery Year to Date (YTD) is 943 Health Checks, which is ahead of YTD delivery for 2021/22 and ahead of the plan for 2022/23.

Infection Prevention and Control (IPC) Communicable disease outbreaks: The ICB Health Protection Team continue to work closely with local authority colleagues on a number of areas. The Health Protection team have begun responding to significant Avian Influenza outbreaks which have begun unusually early in the season, and it is the biggest ever recorded to date. There are some very large scale Avian farms in Lincolnshire and working with Public Health Protection Team colleagues has meant staff being on site providing anti-virals to staff who work in those facilities. This has been a significant piece of work.

Care Homes: There are 278 Care Homes in Lincolnshire. There 16 of those rated as outstanding by the Care Quality Commission (CQC) and two further ones have moved up to good since the last report was presented to the Board. There were four homes rated as inadequate but two have moved out of that.

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

Safeguarding: Details of the new structure and recent appointments to key roles within the team were set out in the report.

Special Educational Needs and Disabilities (SEND): The SEND team submitted the fourth Maturity Matrix to NHSE. Lincolnshire ICB is one of the only systems in the Midlands region to be rated as green which is a very positive position.

Primary Care: One practice is rated as inadequate (Hawthorn). Two are rated as Requires Improvement – Lakeside Healthcare, Stamford and Johnson GP Surgery in Spalding.

The Board considered the update on Quality. Councillor Bowkett advised that she had two points to raise, the first of which related to the provision of prescriptions by some practices on the East Coast, which were now only available between certain times in the day. Councillor Bowkett declared that she was a registered patient of the Hawthorn practice and asked that this be noted in the minutes.

The second point related to asylum seekers of which there are currently 220 and they appear to be receiving their health checks in advance of local residents. There is a public meeting taking place on Friday that week which the local MP will be attending.

Dr Baker advised that the number of asylum seekers is an issue in his patch in the South West of the county, but these individuals do generally have a number of significant healthcare needs which need to be addressed but their treatment is clearly diverting clinicians away from other duties.

Mrs Pomeroy referred back to the Winter Plan, of which delivery was based heavily on staff being fit and well, and clearly winter is fast approaching, and asked whether sickness rates were where they would be expected at this time of year. Following on from that what are the take up rates for the flu and COVID booster vaccines.

Mr Fahy referred back to the comments about Hawthorn practice and advised that this would be picked up outside of the meeting.

Action: Mr Fahy

The situation with asylum seekers is reflected across the county. Some of the difficulties and frustrations around this are related to national policy and the general lack of insufficient notice given about these individuals. Mr Fahy had recently fedback to his regional colleagues some of the frustrations associated with lack of advance warning. That aside, as demonstrated only in the last week, the response by the teams involved in getting out to those individuals was really positive and to be commended.

Referring to Mrs Pomeroy's comments, Mr Fahy advised that a focused piece of work had been actioned with his fellow Director of Nursing colleagues recently to raise awareness of having the flu and COVID booster vaccines in the health and social care cohort, and those in leadership roles being seen to have theirs. Performance is currently around 60% for flu and was on target to be at similar levels as per last year. In terms of COVID, this is now not nationally mandated, but Mr Fahy was confident all the right actions were being taken to get people to have the vaccine.

In terms of sickness rates, it was noted this type of information was held by Human Resources, and not included as standard in the Quality and Performance Report. However, it was understood the numbers were around the usual seasonal trend levels.

Mrs Jolly reiterated the positive comments made about the performance in terms of the vaccination programme and quality in Care Homes which was moving in the right direction post COVID. On a separate note Mrs Jolly sought clarification as to why there is not currently the same level of focus on Home Care as there is on Care Homes, which is equally important.

Mr Fahy advised that the ICB does not currently commission a significant amount of domiciliary care, but Mrs Jolly raised a good point, and he would pick this up outside of the meeting with local authority colleagues.

Action: Mr Fahy

The ICB Board agreed to:

- **Note the Integrated Quality and Performance Report.**
- **Note the Winter Plan 2022/23.**

CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY

22/50 FINANCIAL REPORT

Mr Gaunt advised that the paper included in the pack set out the current financial position and the Board would be briefed on the contents. Alongside the report an update would be provided building on some of the work that was shared in the recent Board Development Session around planning and forecasting and developments in the way in which NHSE would like the forecast position to be reported. A few points would then be highlighted from the Chancellor's Autumn Statement as referred to earlier in the meeting.

Mr Gaunt highlighted the following from the financial report:

- The system has a target of £2.9m deficit at month 7, and a plan to breakeven against allocations by the financial year end. The actual position is a deficit of £16.1m which is £13.2m adverse variance to plan.
- As it stands the risk adjusted position (year to date actual plus unmitigated risk) stands at a £35.1m adverse variance to plan; the forecast process will seek to confirm to what extent the risks can be mitigated by further action.
- There are a number of drivers of the year to date position and the forecast outturn position. These are:
    - The continued impact of COVID-19 costs particularly in ULHT.
    - Excess bed costs related to delayed discharges
    - Bank staff and agency volumes and rates of pay mainly within acute settings
    - Delivery on waste reduction and efficiencies reflecting the high level of unidentified improvement schemes against the plan ambition.

A further complexity to this is that whilst there are some shortfalls in financial performance, the difference has had to be made up through non-recurrent funds to improve the position. As a result this has an impact on the financial position for 2023/24 in that this measure cannot be utilised again.

The system continued to firm up understanding the underlying exit rate position for 2022/23 but initial indications showed that the underlying deficit is in the region of £70m. Mr Gaunt along with a number of colleagues across finance and indeed other functions in the system are looking to confirm the picture. The intention is to present an outlook that Mr Gaunt and colleagues would be confident in to the Board on the 20th December and also details on combat measures on how the position can be improved over the next three years. That piece of work commenced a few weeks ago and was on-going. Mr Gaunt and Mr Burnett had recently run a series of planning sessions to support that work.

In terms of the forecast position, this is referred to in the report as the risk adjusted outturn. For the first time there is a protocol for moving away from plan which the ICB will have to enact. With this comes a high degree of scrutiny and a significant amount of work. The work associated with this will be presented through the Finance and Resource Committee and there was a discussion in respect of this at the most recent meeting held last week. There will need to be a clear understanding of the position in respect of areas previously highlighted such as bank agency and work is taking place with ULHT colleagues on this.

There is also a requirement to produce a Financial Recovery Plan to demonstrate how the financial position can be improved. The focus of the work in December will be on the Financial Recovery Plan but in early January attention will need to shift to the forecast and the governance steps of the forecast, which were briefly outlined for information.

Mr Gaunt advised that he had recently written to the NHSE Regional Director of Finance to confirm the intention to enact the protocol and discussions have already commenced with regional colleagues in relation to that.

The Board was advised of some other steps that are currently being undertaken including a piece of work on good financial governance which involved an independent audit being carried out across all Lincolnshire NHS Trust partners and the ICB. The initial results of that piece of work would be available later that week, and that will then be presented to the ICB Audit and Risk Committee and the on-going work on enacting the measures referred to.

In terms of the Chancellor's Autumn Statement this indicated there would be £3.3 billion additional funding made available to the NHS over the course of the next financial year and the year after that. In addition there was already a plan for £5 billion growth from this financial year into the next one. As referred to by Mr Turner, the level of allocation was deemed to be sufficient in the context of the NHS meetings its key priorities and commitments.

On a final note, there had been reference earlier in the meeting to the nature of non-recurrent solutions. The commitment is that this can be considered recurrent and rolled into the baseline and as long as interventions that had been implemented demonstrated that they worked, this should be continued going forward (referring back to Dr Baker's comment).

The Board considered the report and supporting verbal briefing. There were some observations made in terms of the importance to look at the ICB's and wider systems governance and assurance processes to make sure everyone is on the same page in managing the identified risk. There is also a need for cultural awareness and prioritisation of initiatives.

Mrs Mills referred to agency costs and advised that this goes across the board and included primary care and community pharmacies and the capacity and impact on those to sustain services. It is not just related to ULHT.

It was noted that the local government settlement had not yet been received; this was expected to be issued on the 21st December 2022.

The Board agreed to:

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

CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE

22/51 LINCOLNSHIRE SYSTEM GREENER NHS PLAN

Mrs Connery introduced the next item and advised that she is the green Senior Responsible Officer (SRO) for the system. The Lincolnshire System NHS Greener Plan was included in the pack of papers and the Board would be taken through the high level context and some of the statutory duties. Mrs Bunce, Programme Director who had joined the meeting for this item would go through what this means for Lincolnshire, the delivery plan and associated governance arrangements.

A presentation was provided, and the following areas highlighted:

- Greener NHS in Lincolnshire (healthier planet and healthier people) and delivering a net zero NHS.

- The Carbon Footprint of the NHS
- The Lincolnshire NHS Greener Programme and associated workstreams
- NHS Greener Regional and Reporting Assurance (requirements, intentions and what that looks like)
- Delivering Net Zero - Midlands priority deliverables 2022/2023
- Midlands priority deliverables
- Approach and governance structure
- Vision, Objectives and Targets
- The United Nations Sustainable Development Goals
- NHS Lincolnshire Journey to Zero (2022 to 2025)

It was noted that a copy of the presentation slides would be circulated to the Board after the meeting.

Action: Mrs Ellis-Fenwick

The Board considered the contents of the report and reflected on the presentation. Mrs Kenson referred to the embedding of social values and asked how that includes social care, such as carers who have to travel. Mrs Bunce advised that this is a real challenge simply because of the rurality of Lincolnshire. Some examples of areas that could be looked at were outlined, but in reality this was not something that could be directly answered at the meeting; it would need to be considered going forward.

Mrs Connery advised that a key aim through working with partners is to adopt a similar language and tools when measuring social values or environmental aspects, which should then reduce the need to complete a number of impact assessments such as Quality and Environmental across the system.

Professor Ward supported both Mrs Bunce and Mrs Connery's comments adding that this is a significant challenge because of competing parts such as the need to provide care in people's own homes across the county but at the same time seeking to comply with national requirements combined with limited resource in the social care budge. There are no immediate solutions.

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

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

GOVERNANCE

22/52 QUALITY AND PATIENT EXPERIENCE COMMITTEE

Mr Fahy presented the report from the Quality and Patient Experience Committee meeting held on the 13th October 2022 and advised that he would take the report as read but wished to highlight the following areas:

Areas for escalation to the Board:

- Urgent and Emergency Care standards and the concerns that were discussed relating to the delay in delivering the pathways, the committee wants to highlight to board the direct impact this is having on patient safety and it's potential to cause harm to patients, High volumes of A&E attendances can lead to over-crowding, rising pressure on A&E services and poorer experience for patients. Recent evidence points to the link between delays in urgent care pathways does cause harm to patients.

- Acknowledgement of the governance processes and ensuring that the Committee evolves and is fit for purpose.
- The formation and development of a Quality Operational Group to undertake the operational functions whilst the System QPEC Committee focusses on the strategic elements.

The Board considered the report and agreed to:

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

22/53 SERVICE DELIVERY AND PERFORMANCE COMMITTEE

Mrs Kenson presented the report from the Service Delivery and Performance Committee meeting held on the 19th October 2022 and advised that she would take paper as read but was happy to respond to any queries.

The Board was advised that a further meeting of the Committee had taken place on the 16th November and had a robust discussion had taken place on the Winter Plan. The report from that meeting would be presented to the Board in December 2022.

The Board considered the report and agreed to:

- **Note the report.**

22/54 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 19th October 2022 and advised that he would take the report as read but wished to highlight the following areas:

- Spalding Update – the situation was rapidly changing, and developments were moving at pace. Focus on the best interests of the patients will drive the conclusion.
- A report would be presented to the Board in December outlining the latest position.

The Board considered the report and agreed to:

- **Note the report.**

22/55 FINANCE AND RESOURCE COMMITTEE

Mrs Pomeroy presented the report from the Finance and Resource Committee meetings held on the 24th October 2022 and 15th November 2022.

Mrs Pomeroy advised that she would take the report as read but wanted to highlight the following areas:

- NHSE Protocol for Changes to Financial Forecast - The protocol formalises the layers of assurance with individual provider deficits managed at an ICS level and ICS deficits are reviewed and managed by NHS England.
- Forecast Position – the next meeting has been extended to allow sufficient time to look at that in more detail.
- Committee Terms of Reference - Revised version accepted by the Committee with a review date agreed of May 2023.

The Board was asked to note the update and approve the Committee's revised Terms of Reference for inclusion in the ICB Corporate Governance Handbook.

The Board considered the report and agreed to:

- **Note the report.**
- **Approve the Committee's revised Terms of Reference.**

22/56 AUDIT AND RISK COMMITTEE

Mrs Pratt presented a report which provided an update on the discussions that took place at the latest Audit & Risk Committee meeting held on Monday, 14 November 2022.

Mrs Pratt advised that she would take the item as read but wanted to highlight that there was one item for escalation to the Board, which would be addressed in the private session of the meeting.

The Board considered the report and agreed to:

- **Note the report**.

22/57 DATE AND TIME OF THE NEXT MEETING

Sir Andrew Cash thanked everyone for their attendance and advised that the next formal ICB public Board meeting will take place on the 20th December 2022 at 9.30 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.

Post meeting note – the session on the 20th December 2022 was utilised for a Board Development Session. The next formal public Board meeting will take place on Tuesday, 31st January 2023 at 9.00 am.

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Chair Signature **Date**

Question to the Lincolnshire Integrated Care Board - 22nd November 2022

Received from Mr Andrew Nebel

Please may I ask the ICB Management board to address these following questions:
[a] Can the ICB Management board confirm that provision of all primary & secondary healthcare in Stamford is its responsibility to oversee, regardless of the ownership of the facility … and that this includes Stamford & Rutland Hospital?

Yes it is the ICB's responsibility to arrange healthcare for the GP registered population of Lincolnshire and that includes oversight of primary care and hospital services within Stamford but also services in other parts of the county and in some instances outside of the county.

[b] It is aware that Stamford & Rutland Hospital serves a larger area than the town itself and large parts of South Kesteven's patient community receive treatment there? Can it please publish data showing how many Lincs based patients use the hospital and what geographic spread does these data indicate?

The ICB is aware there is a broader population outside of Stamford itself and a piece of work has been completed on the data regarding the use of Stamford Hospital which can be shared if required.

[c] Advise the Stamford and District patient community whether a strategic 4 Counties PCN Healthcare Plan exists, and if not, when one will be available for public view?

The four Counties PCN serves Stamford and includes one of the practices in Stamford and one in Bourne. Primary Care Networks (PCNs) are not statutory organisations and are not legally required or contracted to provide a Strategic Healthcare Plan.

[d] Can the Management Board confirm that it has an active and ongoing dialogue with Leicester, Leicestershire & Rutland ICB to ensure the services provided at Stamford & Rutland Hospital are integrated with the Place Based for Rutland since a substantial proportion of Rutland's patients, particularly in the eastern half, obtain services from it?

The ICB is involved in a number of meetings and has well established relationships and active dialogue with Leicester, Leicestershire and Rutland ICB, NWAFT and Rutland County Council colleagues on a range of matters, including Stamford Hospital. This ensures there is a joined up approach to the planning and provision of services to the population of Stamford and also out of the county for those that use those services.

Not Delivered
In Progress
On Track to Deliver
Delivered

NHS
Lincolnshire
Integrated Care Board

ACTION LOG - PUBLIC

Date of Meeting:	Tuesday, 31st January 2023
Agenda Item:	1 (iv)
Reporting Officer:	Sir Andrew Cash, Interim ICB Chair

Date of Meeting	Minute Number	Item	Action	Lead	Due Date	Progress
22nd November 2022	22/47	Healthwatch update	To look into the issue raised regarding the cessation of dosette boxes.	Mrs Mills	January 2023	Update to be provided at the next meeting.
22nd November 2022	22/49	Integrated Quality and Performance Report	Provision of prescriptions being restricted to certain times of the day.	Mr Fahy	January 2023	Update to be provided at the next meeting.

22nd November 2022	22/49	Integrated Quality and Performance Report	To look into domiciliary care in relation to Home Care rather than just in Care Homes.	Mr Fahy	January 2023	Update to be provided at the next meeting.
22nd November 2022	22/51	Lincolnshire System NHS Greener Plan	To circulate the presentation slides.	Mrs Ellis-Fenwick	November 2022	Delivered.

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Wednesday, 14 December 2022

Sent via email

John Turner
Lincolnshire ICB Chief Executive

Dear John

Re: LINCOLNSHIRE SYSTEM RECOVERY SUPPORT PROGRAMME (RSP) REVIEW MEETING – 08 DECEMBER 2022

Thank you to you and your colleagues for attending the meeting on 8th December to discuss the System's progress towards exiting the national Recovery Support Programme (RSP).

Overview

The Lincolnshire System has been in the national RSP since July 2021 and currently has an agreed exit date of end of Q4 2022/23. The purpose of our meeting was to review System progress against the agreed RSP exit criteria with a view to whether the exit date remains achievable. We discussed that if the outcome of the meeting results in an agreement that the exit date needs to change, this will have to be agreed through regional and national governance structures and will most likely attract attention from the Secretary of State for Health and Social Care Office.

RSP System Progress

It was acknowledged at the outset of the meeting by yourself, on behalf of System colleagues, that the System has not made the required progress against the exit criteria, specifically, demonstrable delivery of the System Financial Improvement Plan. The System is required to evidence significant financial improvement over two consecutive quarters to support exit from the RSP. You also acknowledged that some of the transformation work has not realised the intended benefits, and you informed us that the ownership of the transformation has now shifted from the Provider Collaborative to the ICB under the responsibility of Matt Gaunt, ICB Director of Finance.

You articulated that this is not an acceptable position and that the System ambition is not only to exit the RSP and segment four of the NHS Oversight Framework, but to move to segment two in a sustainable way. We discussed several key successes within the System; for example, ULHT exiting the RSP earlier this year. We also discussed some of the reasons why sufficient progress has not been made; for example, lack of scrutiny of the plans, operational pressures and the pressures of establishing the ICB. From our discussions, we concluded that the System will not achieve the current planned exit date.

Next Steps

You agreed that there will be a reset of the plan and that the System will implement a robust governance regime, informed by the lesson learned to date. You will oversee delivery of the new plan and will ask for evidence of delivery as part of your assurance processes. You also confirmed that both financial and clinical leadership will be aligned, supported by adequate programme management. We recognised that there is a new System Improvement Director in post and that you are confident that this role will bring a new focus to the programmes of work.

We discussed timescales for the reset and you confirmed that the revised plan will go to your System Clinical Reference Group in mid-January 2023, and that this will inform your rationale of a new proposed exit date. The proposal will then be presented and agreed through your System governance architecture as appropriate in the New Year. Once the System has collectively agreed a proposed revised date, the System will then present this to the Regional Recovery Support Oversight Group in February/March 2023 for discussion and agreement. We discussed that a revised exit date could be Q2 2023/24, however we requested that the Region has early sight of your revised plan to enable joint discussions to take place during the proposals. We agreed that you would share the revised plan in early draft form in mid- January 2023.

At the QSRM meeting on the 15 December 2022, a discussion will take place referencing the outputs of today's meeting and the agreed next steps. You and your System colleagues will explore a new exit date; we discussed the importance of a new date being achievable and the potential implications if the new date is not achieved.

I recognised that NHSE oversight needs to improve and I committed to joining your monthly ICB System Review Meetings. My team and I, working in partnership with the National Intensive Support Team, remain committed to supporting the Lincolnshire System to successfully exit the RSP. We discussed the Region supporting you in minimising distractions from delivery of the revised plan, I remain committed to this.

I look forward to seeing the first draft of the revised Lincolnshire Strategic Delivery Plan in the New Year.

Yours sincerely,

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

CC: Matt Gaunt
Andrew Morgan
Sarah Connery
Maz Fosh
Clair Raybould
Jitka Roberts
Sunil Hindocha

Sent via email

John Turner
Lincolnshire ICB Chief Executive

NHS England
Birch House
Ransom Wood Business Park,
Southwell Road West
Mansfield
NG21 0HJ

20 December 2022

Dear John

LINCOLNSHIRE QUARTERLY SYSTEM REVIEW MEETING – Q3- 15 DECEMBER 2022

Thank you to you and your System colleagues for a productive and informative meeting with Regional colleagues on the 15th of December.

Overview

We congratulated you for progress in a number of areas and thanked you for demonstrable improvements in quality since we last met, specifically recognising United Lincolnshire Hospitals NHS Trust's exit from both the Recovery Support Programme (RSP) and Maternity Support Programme, the eradication of 104-week waits and excellent work in Orthopaedics.

We acknowledged the positive dynamic between the system and regional team, and the fact you are open to both support and challenge.

The solid foundations to Health Inequalities work were noted, with a strong relationship with your Director of Public Health, good projects and initiatives based on a Population Health Management approach were noted. We are keen to see this progress.

Within Primary Care, the positives in recruitment and improved face-to-face access generally were acknowledged, as were the variations we know you are committed to addressing.

The most significant issue remains finance. We are committed to supporting you exiting the RSP, though expressed disappointment at the lack of progress which will result in a revised exit date being agreed. Whether this is down to a suboptimal plan, execution or both, we stressed the importance of each constituent organisation within the system contributing to this imperative. You assured us of improved oversight and scrutiny arrangements that have been implemented, and that you are committed to addressing productivity and workforce challenges as examples cost-reducing opportunities.

Operational – Elective Care, Cancer, Diagnostics and Urgent and Emergency Care, including ambulance handover delays

Within Elective Care, we thanked you for the excellent work done to address 104-week waits, provide Mutual Aid and deliver great Orthopaedic services. However, we noted your position in relation to 78 week waits, Cancer and Diagnostics (Echocardiograms).

We explored your plan to address 78-week waits and the pressures that mainly sit in Out-Patients. We were assured that whilst there are risks associated with this, there are mitigations in place to tackle these.

We considered your performance in Cancer services and noted specifically that improvements in the Lower GI pathways appeared to have stalled. We were assured you were sighted on this and that there are actions currently being implemented, supported by strong clinical leadership, that will show demonstrable improvement in the next few weeks. You also recognise the opportunities to deliver the Faster Diagnosis Standard and confirmed the work that has been undertaken in Colorectal services will roll-out to other specialties.

The recent challenges with medical cover in Adult Critical Care were noted. You confirmed these have been addressed and are confident there will be no adverse impact on flow or patient care.

Performance across diagnostic services was acknowledged as being strong, with the exception of Echocardiograms. We asked you eliminate 13-week waits and it was confirmed work is underway to achieve this.

We asked about your Demand and Capacity Plan, as the most recent report is you are below the trajectory for delivering additional beds. It was confirmed this was due to a procurement issue and the situation has now been recovered. We also hope to be able to support the additional capacity at Grantham District Hospital and will follow this up post-meeting.

You made reference to a data quality issue with your Virtual Ward numbers and the workforce challenges you are experiencing. These are being addressed.

We considered the pressure on ambulances services. Some of the admissions avoidance strategies implemented pre-Covid have been re-set and have had an impact with a more recent reduction in numbers. You confirmed MADEs have taken place in the community this week and hospital events are planned for next week. The importance of immediate handovers was stressed, particularly during periods of industrial action, and it was confirmed arrangements are in place.

Health Inequalities

We acknowledged the strong foundations that have been laid to address health inequalities, with a focus on data, analytics and governance. The use of Population Health Management information at PCN-level is positive. We asked how the needs of more deprived coastal communities will be tackled and you confirmed a holistic approach is being taken, citing the approach to CVD and heart failure services. The Clinical & Care Directorate implements the Clinical Prioritisation Framework to ensure services are targeted in the most impactful way.

Primary Care

The restoration of face-to-face appointments to pre-pandemic levels was noted as a significant achievement and we congratulated you for this. You confirmed you are aware of variations in the provision across the system and are addressing these.

You confirmed KPMG is supporting strategic workforce modelling work currently underway. Screening uptake rates are also a focus.

Mental Health, Learning Disabilities and Autism

You confirmed that the Mental Health Investment Standard will not be delivered, whilst also acknowledging that specific service pressures remained, e.g., Improving Access to Psychological Therapies. You confirmed you are currently undertaking detailed reviews of services under pressure, as you recognise the priority to address these.

We asked about the temporary closure of your Psychiatric Intensive Care Unit (PICU) and your assessment of the impact on patients. You confirmed you will not be in a position to share your plan to re-open this service until February/March 2023, adding that you are working closely with Nottinghamshire to ensure patients have access to this provision more locally, if required. You also noted your aspiration to develop PICU for women.

You advised the key challenge being addressed across Mental Health Services is workforce. The provision of new services, (e.g. the Mental Health Urgent Assessment Centre) has increased staff turnover.

Finance, including exit from the Recovery Support Programme (RSP)

A detailed discussion ensued regarding your current financial position and forecast outturn, and the impact this will now have on your exit from the RSP. You summarised your position and explained that further recurrent and non-recurrent options are being explored – to be confirmed later in January 2023.

We discussed your agency expenditure and were told about your Agency Reduction Plan, with its KPIs to assess ongoing impact. You outlined other work that is being undertaken to reduce rates and that this is already realising benefits.

RSP priorities for Quarter 4 of 2022/23 and next year were summarised, to include workforce, productivity, prescribing and bed closures. It was confirmed support is in place, with additional specialists being secured to ensure the revised exit plan is achieved.

We expressed significant disappointment at the position you are in and stressed the need for stronger grip. We confirmed further urgent work will be undertaken. You accepted the current position is unacceptable but provided assurance that the system is committed to a sustainable resolution and has improved governance in place to deliver this.

Summary

In closing, we thanked you for you for a positive meeting and confirmed our collective commitment to supporting you to succeed. You confirmed you are proud of the good work being done, whilst also being clearly sighted on the challenges, and thanked us for the support and challenge.

Thank you once again for your time and transparency of the conversation.
If you have any queries in relation to this letter, please do not hesitate to contact me.

Yours sincerely

Oliver Newbould
Director of Strategic Transformation, Central Midlands
& Director of Intensive Support- Midlands
NHSE

Cc. Andrew Cash - Lincolnshire ICS Chair
Andrew Morgan - Chief Executive, United Lincolnshire Hospitals NHS Trust
Sarah Connery Chief Executive, Lincolnshire Partnership NHS Foundation Trust
Maz Fosh - Chief Executive, Lincolnshire Community Health Services NHS Trust
Pete Burnett - Lincolnshire System Strategy and Planning Director
Hayley Jackson - Deputy Director of Strategic Transformation, NHSE

4 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	4 (i)
Title of Report:	Update on Lincolnshire Dental Strategy
Purpose:	Sandra Williamson Director for Health Inequalities, Prevention and Regional Collaboration
Appendices:	

1.	**Key Points for Discussion:**

The purpose of the report is to provide an update on progress, highlighting the engagement to date and the four core themes for the Dental Strategy for Lincolnshire.

The report has been developed by:

- NHS England - Consultant in Healthcare Public Health
- NHSE Commissioning Team Senior Manager

2.	**Recommendations**

The ICB Board are recommended to note the progress in developing the Dental Strategy for Lincolnshire.

3.	**Executive Summary**

Background and information

NHS England (NHSE) is currently responsible for the commissioning of all NHS dental services, but this responsibility will be delegated to the Lincolnshire Integrated Care Board (ICB) on the 1st April 2023.

From April 2023, Integrated Care Boards will take over the delegated responsibility for commissioning dental services from NHS England.

To support this transition, Lincolnshire ICB approached NHS England to facilitate the co-development of a local three-year Dental Strategy for Lincolnshire to drive improvements in oral health and accessing dental care within the county.

The aim of the Dental Strategy for Lincolnshire is to provide a roadmap for the ICB and its partners of the plan of action needed over the next three years to achieve these improvements. Its production requires a collaborative approach, working with stakeholder colleagues and organisations across Lincolnshire to create a joined-up integrated whole system dental strategy that delivers on better oral health and care for communities across Lincolnshire.

Dental Challenges in Lincolnshire

Oral health is a vital and integral part of health and wellbeing. Despite this, oral disorders consistently feature in the top ten causes of Years Living with Disability (YLD) across England, highlighting the considerable impact that poor oral health has on general health and wellbeing.

Within Lincolnshire, there is evidence of stark oral health inequalities affecting the local population, with the most recent national dental survey of 5-year-old children's teeth (2019) showing that 39.3% of 5-year-olds in Boston experiencing dental decay for example, compared to 15.3% in West Lindsey (against a national average of 23.4%).

As well as the highlighting the link between social deprivation and poorer oral health outcomes, the most recent rapid Oral Health Needs Assessment for Lincolnshire (2022) demonstrates that West/East divide in Lincolnshire in relation to childhood tooth decay, where deprived coastal communities experience poorer oral health and access to care services than their peers who live in the west half of the county.

Lincolnshire is also faced with national challenges, particularly with regards to limited access to NHS dental health services, exacerbated by the impact of the COVID-19 pandemic. Access rates among adults locally were at 29% pre- 2020, dropping to 9.5% in 2020. Whilst rates increased to 19.1% by the end of 2021, there remains high levels of variation across the County with the highest rates seen in South Kesteven and East Lindsey, and the lowest in Lincoln and South Holland and its coastal communities (who already experience poorer oral health). Furthermore, services are faced with the additional workload of reducing the NHS backlog that arose from disruption of normal services during the COVID-19 pandemic.

Progress to date

A working group has been formed to support the shaping of the dental strategy and overseeing its delivery, involving input from a range of stakeholders including:

- NHS England dental commissioners and public health
- Lincolnshire ICB
- Lincolnshire County Council
- Local Dental Network, General Dental Practice teams and the Community Dental Services
- Health Education England
- Wider Primary Care
- Healthwatch Lincolnshire
- University of Lincoln academic partners

The working group meet on a fortnightly basis to ensure that the strategy development is progressing as intended. This section describes further the work that has been undertaken so far. As per the standard Terms of Reference for the working group, participants were invited to extend invitations to additional stakeholders as appropriate.

An important emphasis of developing the strategy was to use a development framework that helped stakeholders to identify not only the key strategic issues and challenges facing dental services and oral health within Lincolnshire, but also explicitly identify the full range of resources and capabilities that exist in the county that might be drawn on, combined and/or utilised in such a way to drive improvement oral health and care: a so-called 'resource-based view of the firm' approach to strategy development.

While Lincolnshire, like many rural/coastal communities, faces some significant challenges in relation to the availability and access to NHS dental services, inequalities, with places and groups with poor oral health, the working group committed early in the process to take an asset-based approached to developing the strategy. This recognised that Lincolnshire has a lot of existing relevant and valuable resource that, either as stand-alone and/or when combined, currently does, or could, make a significant contribution toward improving oral health and dental care.

Such assets include the long-standing multi-stakeholder Oral Health Alliance Group hosted by the Lincolnshire County Council, an engaged Local Dental Network and Committee, dedicated NHS commissioning and workforce team, patient representatives and the health and care workforce, both in dental and wider.

Engagement

To engage with and seek the views of stakeholder partners, two online workshops were held on the 20th and 21st September 2022, with the aim of receiving input from a wide range of partners on what they considered are the key strategic issues and priority areas for a Lincolnshire dental strategy.

Around 40 participants attended both workshops in total. Participants were invited to contribute their thinking to four key themes identified in the 2022-23 Lincolnshire Local Dental Network work plan, with the addition of addressing “Inequalities” as a cross-cutting theme.

We also sought to collect further information about the assets, resources and capabilities that currently exist in Lincolnshire and which present opportunities for improvement in dental care and oral health. These workshops were held online at different times of day to maximise opportunities for attendance, with an open invitation sent out in advance via a range of routes.

The four core themes are described below:

Theme 1: Workforce

It was recognised in the workshop that areas across England are facing workforce issues, and the focus of discussion was on how we can attempt to address this locally. The groups agreed that more could be done to promote and further enhance Lincolnshire as a positive and fulfilling place to work. This could include working with staff to co-design career progression pathways, and to co-produce events and systems that support a sense of community and create a culture of value and respect. The possibility of producing promotional material for prospective job applicants that showcases the benefits of living and working in Lincolnshire was also discussed, though it was highlighted that this has not been effective in other areas and so may need further consideration.

A key subtheme that arose during discussions was that of increasing the number of dental trainees working in the region, as it was recognised that those who have trained locally are more likely to then seek ongoing employment in the area. Steps that could help support this include the creation of local specialist pathways for training, working with other areas in the East Midlands to support training in dental specialities such as Restorative and Paediatric dentistry, and considering how to increase the number of training spaces available in Lincolnshire such as by reviewing the incentives for training practices.

Finally, for any of these approaches to be successful it will be vital that input and engagement is sought directly from the workforce, acknowledging the value of their local insight and the importance of their support for strategy outputs to be successful.

Theme 2: Access

A rapid oral health needs assessment was completed by the Lincolnshire County Council Public Health team in September 2022. This shows that access to dental services fell during the COVID-19 pandemic, and that there is variation in the level of access based on individual demographics and geography.

It was by those attending the workshop that interventions seeking to improve access should be targeted most towards those evidenced who have the greatest need.

It was recognised that access is closely associated with many of the issues covered in the workforce theme, and particularly with regards to unequal distribution of the workforce across Lincolnshire. The Golden Hello scheme that has already been launched by NHS England seeks to go some way towards addressing this issue, but the groups at the workshops noted that it is too soon to say what effect this may be having.

Novel methods of increasing access in rural areas were also discussed. These included creating outreach services whereby dental trainees spend a defined portion of their week in a less urban setting. It was also felt that there should be engagement with the NHS Estates team to identify potential sites for outreach clinics to support service delivery in communities for whom transport may otherwise be a barrier.

Finally, work undertaken by Healthwatch Lincolnshire has shown that improving access to dental services is a priority for patients. It was suggested that we liaise closely as we move forward, to monitor patient experiences on accessing dental services and evaluate whether our interventions are achieving the desired improvements.

Theme 3: Prevention

Both workshop groups agreed on the importance of embedding a prevention approach across the whole life-course, with a focus on targeting the most vulnerable populations. This is particularly important given the current cost of living crisis, with households experiencing severe budgetary constraints. One suggestion offered in both sessions was providing those most at risk with toothbrushing packs and oral health guidance materials, by utilising Making Every Contact Count approaches. It was recognised that this measure would need to be sustainable as toothbrushes have a finite lifespan and so providing these on a one-off basis is likely to have limited impact.

The discussions highlighted several pre-existing strong links with community and patient groups that can be utilised to promote good oral hygiene measures, including children centres throughout the county and community dental teams. It was highlighted that challenging dietary practices could be of benefit, such as by working with schools to move away from providing high-sugar sweets and cakes for celebratory events and working with retail settings to prevent the sale of energy drinks to children.

Adults in care homes were also identified as a key population with a need for oral disease prevention measures, but the barrier of concentrated fluoride toothpaste requiring a prescription was highlighted. Work is currently being undertaken to try and overcome this challenge.

Finally, a novel approach that was offered to support delivery of messaging to young adults was by working with higher education settings, and particularly health and social care courses for which students have community placements. Once taught about basic oral health measures, the students could then deliver these to the patients they work with to help amplify these positive principles.

Theme 4: Integration of Oral Health

It was clear from responses within the workshops that there is a huge amount of fantastic practice already ongoing integrating oral health within the system, that it will be important to both build on and learn lessons from these examples. Of particular note, was the Swallowing, Oral Health and Nutrition Ambassador (SONA) training programme for care homes. There is a real desire to ensure this approach becomes embedded in all Care Homes, via an on-going training package for Care Home staff, and streamlining the pathway into Dental services where necessary.

There was a real appetite amongst attendees to explore opportunities for linking oral health with general (medical) primary care. The example of patients with diabetes was highlighted as an area where there is an established two-way interaction between general physical health and dental health, with opportunities present but not currently utilised to impact the course of disease through linking communication between General Practitioners (GPs) and General Dental Practitioners (GDPs). Barriers of contract lines and indemnity were raised as obstacles to be overcome – however programmes where these have been surmounted were discussed (such as dentists ordering HbA1c blood tests in patients where indicated). It was also noted in the workshop that many of the pressures faced by Dental Practices – such as access and workforce - have been mirrored within General Medical Practices in recent years, with the potential for solutions to be shared. The use of Population Health Management techniques was identified as an opportunity for oral health, as it is currently being utilised within Primary Care Networks (PCNs) and General Medical Practice.

Dentistry was highlighted as one of the key pillars of joined-up primary care in establishing the Integrated Care Board, sitting alongside Medical, Optometry and Pharmacy. This offers a parity of dentistry with these other key areas. A clinical academy has been established to develop combined pathways and tackle unwarranted variation via quality improvement tools, across the whole system.

The cross-cutting theme of inequalities was raised within this theme also. Attendees highlighted the variation in need and in particular unmet needs in vulnerable groups, including those with no fixed abode, those seeking asylum, looked after children etc, and noted the value in linking with the Health Inequalities Forum and within PCNs who are already considering opportunities to access these groups within their workstreams, to see how this may apply to accessing dental care.

<u>Conclusion</u>

It was universally agreed at the strategy workshops that the shift from dental commissioning from regional to local Integrated Care Boards offers exciting opportunities to adopt new and innovative approaches to dental services commissioning that are demonstrably more aligned with local need within Lincolnshire.

While ongoing challenges with the national NHS dental contract and its future reform in better meeting the oral health needs of today's society are out with local control, the system and place-based commissioning of dental services using novel flexibilities in service provider contracts offers a real opportunity to improve dental service provision, addressing

inequalities and inequitable care by focusing on our most disadvantaged and underserved places and people.

Integration of dental services and oral health, firmly embedded as part of the 'four pillars of primary care', with GP, Pharmacy and Optometry as well as integrating oral health in a range of wider care pathways where good oral health provides better general health outcomes, will be a key feature of our developing strategy.

Next steps:

- Final strategy to be developed by 31st March 2023 for approval by the ICB
- Delivery plan with key milestones to be developed

4.	**Management of Conflicts of Interest**

Not applicable

5.	**Risk and Assurance**

To be considered as part of the finalisation of the Dental Strategy and the development of the delivery/ implementation plan

5.	**Financial/Resource Implications**

To be considered as part of the operational planning process with NHSE team and ICB

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

National Policy where NHS England delegated the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the reserved functions

7.	**Health Inequalities implications**

Summary included in the background / context to the report. Addressing Health Inequalities is a cross-cutting theme throughout the Dental Strategy and the development of the delivery/ implementation plan

8.	**Equality and Diversity implications**

To be completed as part of the finalisation of the Dental Strategy and the delivery/ implementation plan

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

Healthwatch are supporting the development of the Dental Strategy.
In addition, Healthwatch have set up small focus group on NHS Dental Services in Lincolnshire following on from recent survey

11.	**Author(s)**

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

Sandra Williamson - Director for Health Inequalities, Prevention and Regional Collaboration
Email: Sandra.williamson6@nhs.net

Item 5 (i) and (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	5 (i) and 5 (ii)
Title of Report:	Integrated Quality & Performance Report – January 2023
Purpose:	This report provides the Board with information on achievement against the ICB's key performance targets and quality standards
Appendices:	None

1.	**Key Points for Discussion:**

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

2.	**Recommendations**

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

3.	**Executive Summary**

Overview

The January integrated performance & quality report incorporating constitutional standards, quality and safety measures and elective recovery activity, presents system performance updated to December where available.

Urgent & Emergency Care

The number of people waiting more than 12 hours in A&E increased to 1,034 from 560 in November.

- Ambulance response times increased to 2 hours 16 minutes for Category Two incidents (18 minute standard) and two hour ambulance handover delays increased at both Lincoln (351 from 132 last month) and Pilgrim (283 from 86 last month).

Cancer

- In December, 512 patients were waiting over 62 days, reducing from 528 in November.
- The number of patients waiting 104 days or more increased in December to 175, from 163 in November.

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals has reduced by 203 to 112,870 in November.
- The number of patients waiting more than 78 weeks increased to 1,251 from 1,019 in November. This was 1.1% of the total list size.

Mental Health

- The Improving Access to Psychological Treatments (IAPT) access rate was 1.68% in October and is not on track to achieve the 33% standard by March 2023.
- The IAPT recovery rate target was 49.3%, also below the 50% standard.

Never Event

- There has been a never event reported in December in relation to Lincolnshire patients. The never event was reported by ULHT and related to a wrong site surgery.

4.	**Management of Conflicts of Interest**

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

5.	**Risk and Assurance**

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

6.	**Financial/Resource Implications**

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

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

Not applicable.

8.	**Health Inequalities implications**

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

9.	**Equality and Diversity implications**

Not applicable.

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

Not applicable.

11.	**Report previously presented at**

Not applicable.

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

Tim Fowler, Associate Director of Contracting and Performance
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Integrated Performance & Quality Report

NHS
Lincolnshire
Integrated Care Board

January 2023

23/01/2023

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Lincolnshire ICB Performance Dashboard

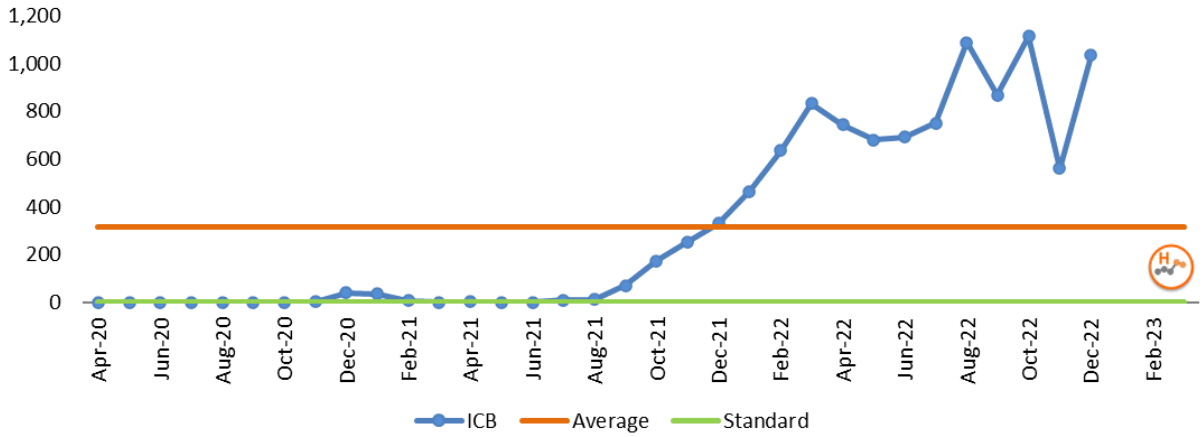
Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Direction	Variation
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	●	95%	Dec-22	70.4%	60.3%	65.0%		↓	L
	A&E attendances- patients waiting over 12 hours (ICB)		0	Dec-22	1034	N/A	N/A		↑	H
	A&E attendances- time to first clinical assessment within 60 minutes (ULHT)		-	Dec-22	38.8%	30.3%	30.3%		↓	L
	Ambulance response times - Mean response time- Category 1 (ICB patients)	●	00:07:00	Dec-22	00:10:54	00:10:01	00:10:57		↑	
	Ambulance response times - Mean response time- Category 2 (ICB patients)	●	00:18:00	Dec-22	02:16:05	01:51:32	01:32:54		↑	H
	Ambulance handover times - number of handover delays of > 2 hours (Lincoln)		0	Dec-22	351	N/A	N/A		↑	H
	Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)		0	Dec-22	283	N/A	N/A		↑	
Cancer	% Suspected Cancer Referrals First Seen Within 14 Days	●	93%	Nov-22	64.8%	81.7%	78.8%		↑	L
	Patients receiving treatment for cancer within 62 days of an urgent GP referral	●	85%	Nov-22	47.8%	49.3%	61.0%		↓	L
	Total 62 Day Backlog (ULHT)		-	Dec-22	512	N/A	N/A		↓	H
	Total 104 Day Backlog (ULHT)		-	Dec-22	175	N/A	N/A		↑	H
	% of patients told cancer diagnosis outcome within 28 days (ICB)		75%	Nov-22	59.7%	68.8%	69.7%		↑	
Planned Care	RTT: % of incomplete pathways within 18 weeks	●	92%	Nov-22	52.2%	55.9%	60.1%		↑	L
	Percentage waiting six weeks or less for a diagnostic test	●	99%	Nov-22	57.5%	63.1%	73.1%		↑	
	Patients waiting over 52 weeks for treatment (% of total ICB waiting list size)		0%	Nov-22	8.2%	7.6%	5.5%		→	H
	Patients waiting over 104 weeks for treatment (% of total ICB waiting list size)		0%	Nov-22	0.01%	0.02%	0.02%		↓	L
	Patients waiting over 78 weeks for treatment (ICB) (% of total ICB waiting list size)		0%	Nov-22	1.11%	1.15%	0.65%		↑	
	Total waiting list size (ICB)		-	Nov-22	112,870	N/A	N/A		↓	H
	Total elective spells (ICB)		10,646	Nov-22	10,693	N/A	N/A		↑	H
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	●	0.8%	Q2 22/23	22.02%	25.3%	21.3%		↓	
Mental Health	IAPT access - people that enter treatment (ICB)	●	2.75%	Oct-22	1.68%	N/A	1.68%		↓	
	IAPT recovery rate (ICB)		50%	Oct-22	49.3%	N/A	49.2%		↓	
	Inappropriate Out of Area Placements for adults per 100,000		-	Oct-22	41.3	137.3	120.3		↑	
	People experiencing first episode psychosis waiting to start a package of care (ICB)	●	60%	Nov-22	73%	77%	71%		↑	L
	Estimated diagnosis rate for people with dementia (ICB)		66.7%	Oct-22	62.1%	62.0%	62.6%		↑	
	People with SMI who have received six physical health checks in the preceding 12 months (ICB)		60%	22/23 Q3	46.4%	-	-		↑	
	CYP with MH disorder receiving treatment (one contact) in the reporting period last 12 months		8,000	Oct-22	7,765	N/A	N/A		↑	H
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	●	95%	22/23 Q2	76.5%	N/A	N/A		↓	
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	●	95%	22/23 Q2	55.9%	N/A	N/A		↑	

Key Performance Updates January 2023

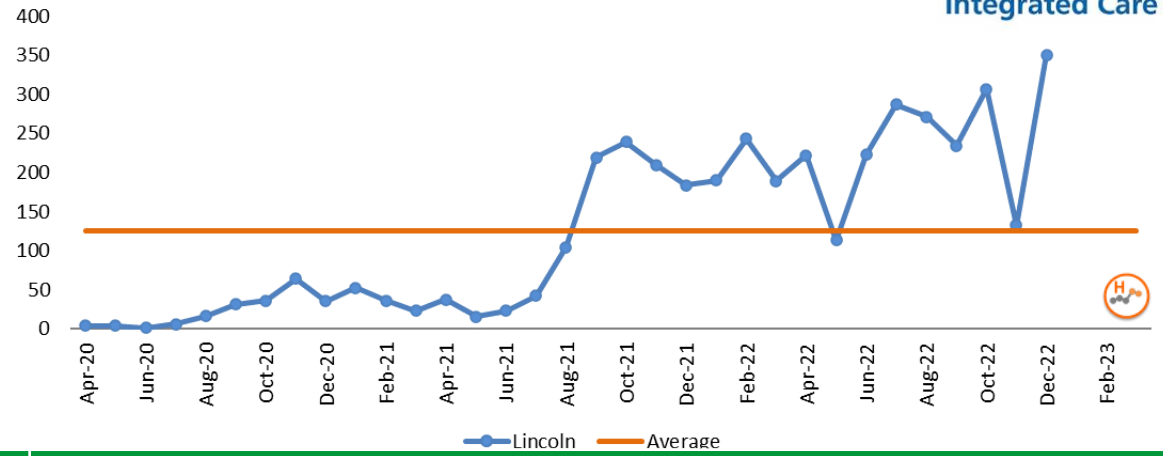
Programme	Indicator	Cause Identified	Actions Being Taken
Urgent Care	Ambulance Handover Delays Over 2 Hours	• Occupancy rates have remained high both in acute and community. This has continued to impact on the level of performance against national indicators and on the ability to release crews who have attended acute sites resulting in further increasing ambulance handover delays. While the December ambulance handover position was worse than the November performance, the early January position looks to be improved.	• Continued development and delivery winter capacity & demand schemes (11 overarching schemes). An additional 3 month plan developed and submitted to NHS England. This sets out the expected acute demand and required discharges. • Plan to utilise the tranche 1 discharge funding and the additional discharge funding for bed capacity both submitted. Further development of additional admission avoidance schemes in development.
Cancer	Cancer 62 day backlog	• We continue to have a significant backlog, position is improving and on trajectory at 484 patients over 62 days. Colorectal continues to account for the largest part of the backlog however last month this was 53% of the overall backlog compared to 48% this month.	• Introduction of 'golden patient' initiative in colorectal initiated this week and working well to highlight patients who could have their next steps expedited. • New Rapid Access Colorectal Pathway working well across the system, Since the roll out referral numbers have dropped by half. Routine and urgent referrals have also dropped in colorectal. Analysis is ongoing.
Planned Care	Patients waiting over 78 weeks for treatment	• Whilst the actual number of patients waiting 78 weeks or more is at it's highest, ULHT are on track to eliminate waits of over 78 weeks by the end of March 2023. Plans include both in-sourcing and out-sourcing patients with alternative Providers to increase capacity. Overall waiting list size has reduced slightly in November.	• The system has received some national funding to continue the Super September initiative whereby the Elective Activity Coordination Hub is contacting patients to check whether an appointment is still required and offer them an alterative provider if clinically suitable. This initiative has been recognised nationally as a 'best practice' scheme.
Mental Health	IAPT Access/ Recovery Rate	• IAPT Access has dipped slightly to 1.68% of patients entering IAPT (people that enter treatment against the level of need in the general population). • IAPT Recovery Rate has recovered, but remains under the 50% target at 49.3% in October. It however, remains just above the England average of 49.2%. This is still seen as a result of increased levels of referrals to the service post Covid.	• LPFT continue to work with commissioners and NHSE colleagues to understand the gap between current workforce and the increased access target – focus will be on seeing as many people as can be scheduled, ensuring waiting times are kept as short as possible and quality is good, rather than outreaching to achieve access and people waiting much longer with reduced outcomes.

Urgent Care

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



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



NHS Lincolnshire Integrated Care Board

Current system pressures

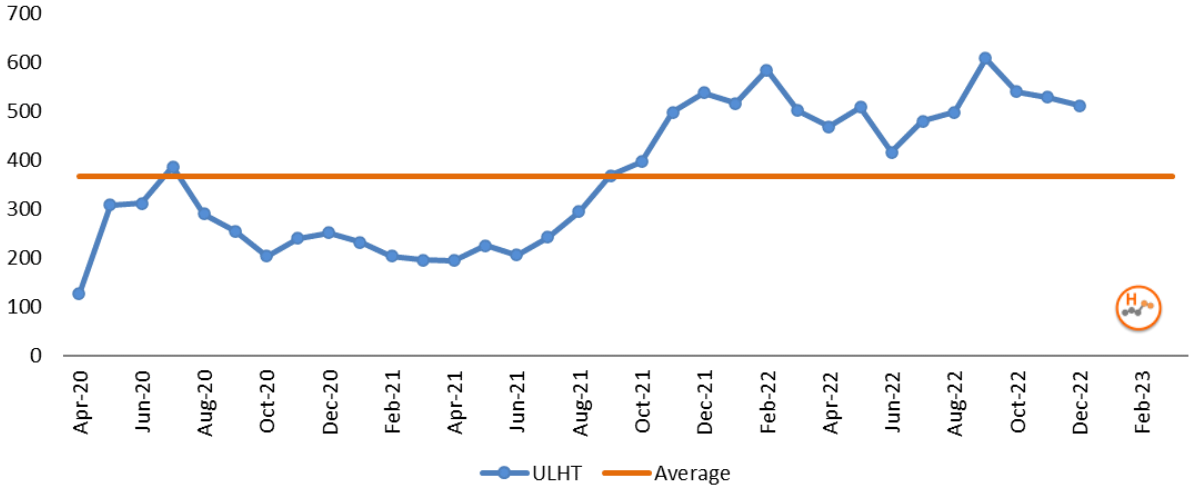
- The Lincolnshire system has remained under significant levels of pressure throughout December and into January, with multiple critical incidents and system level 2 EPRR incidents as well as one BCP incident declared. The system has also collectively managed periods of Industrial action.
- The main challenges faced by the system have been around demand (time profile and acuity), system wide workforce, capacity for supported discharge and flow through all bedded services. Occupancy rates have remained high both in acute and community. This has continued to impact on the level of performance against national indicators and on the ability to release crews who have attended acute sites resulting in further increasing ambulance handover delays. While the December ambulance handover position was worse than the November performance, the early January position looks to be improved.
- Type 1 activity remained high in December, but early January numbers look to have decreased.
- Type 3 activity remains higher than this time last year but is maintaining the 4 hour performance target overall. UTCs are also accepting more ambulances conveying directly to them which increases both acuity and volume within the centres.

Actions to recover

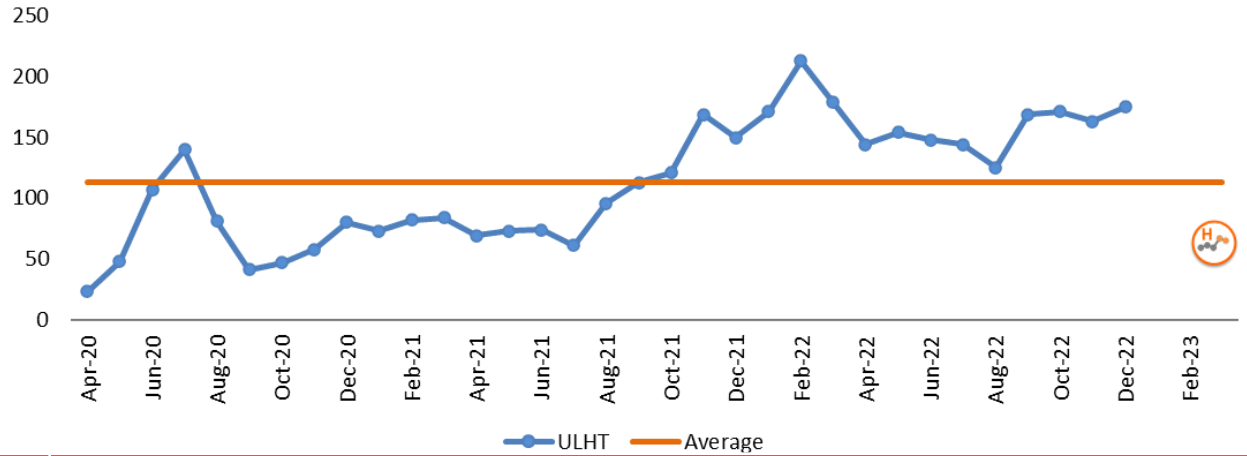
- Continued development and delivery winter capacity & demand schemes (11 overarching schemes). An additional 3 month plan developed and submitted to NHS England. This sets out the expected acute demand and required discharges.
- The ULHT +1 model (Bristol Model) – ‘breaking the cycle’ and ‘breaking the cycle too’
- Plan to utilise the tranche 1 discharge funding and the additional discharge funding for bed capacity both submitted. Further development of additional admission avoidance schemes in development.
- Focus on conveyance avoidance and conveyance to alternative settings.
- Maximising bedded and non-bedded out of hospital capacity.
- The System Co-ordination Centre is now in place to support early escalation and resolution of pressured periods.
- Strategic oversight of the current pressures and development winter mitigations.

Cancer

Total 62 Day Backlog (ULHT)



Total 104 Day Backlog (ULHT)



NHS Lincolnshire Integrated Care Board

Current system pressures

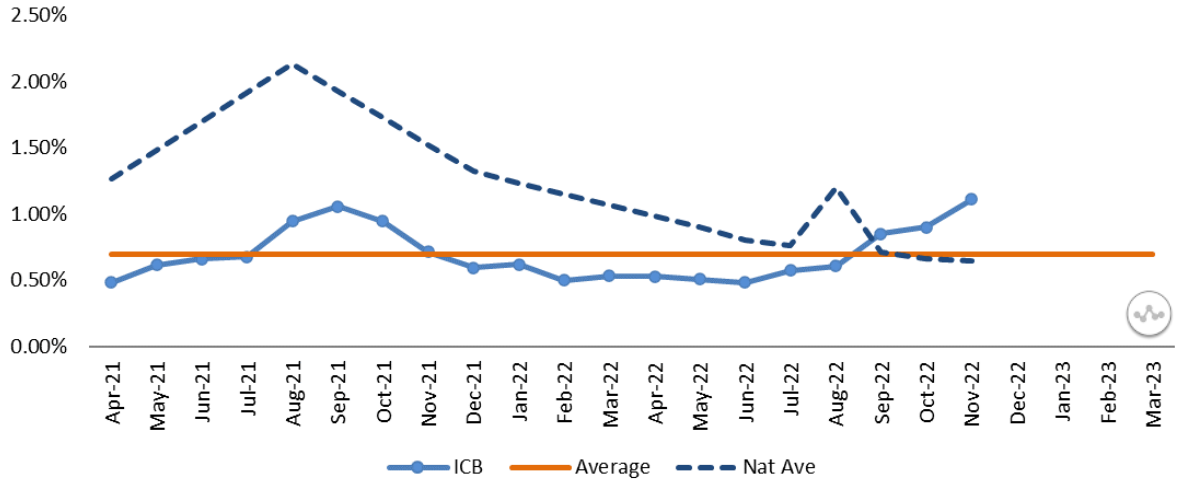
- We continue to have a significant backlog, position is improving and on trajectory at 484 patients over 62 days. Colorectal continues to account for the largest part of the backlog however last month this was 53% of the overall backlog compared to 48% this month.
- Referral rates have been high but have reduced in the last 4 weeks this is typical over Christmas and does not demonstrate a trend.
- Urology backlog has grown significantly in the last 8 weeks, unclear if this is a short term staffing issue.
- Significant reduction in availability of 1st OPAs for lung due to capacity issues.

Actions to recover

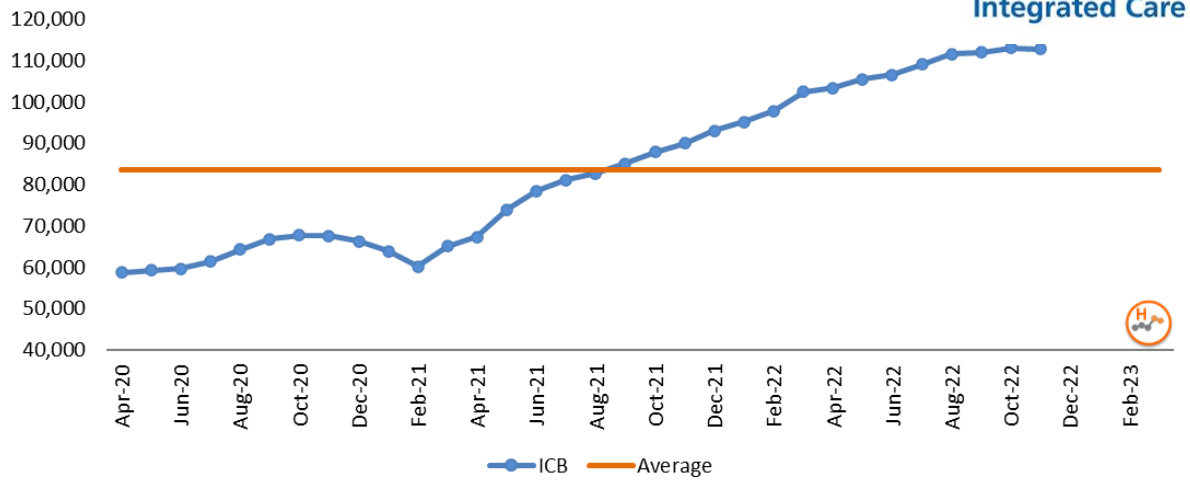
- Colorectal recovery meetings still taking place three times a week. Focus is on reducing number of patients over 62 days.
- Introduction of ‘golden patient’ initiative in colorectal initiated this week and working well to highlight patients who could have their next steps expedited.
- New Rapid Access Colorectal Pathway working well across the system, Since the roll out referral numbers have dropped by half. Routine and urgent referrals have also dropped in colorectal. Analysis is ongoing.
- Working with respiratory team to put in place a new Lung Triage CNS to reduce the demand on the lung service.
- Supporting Upper GI to improve referral practice.
- Urology have agreed to the ICB cancer team undertaking a deep dive into the Prostate Pathway.

Planned Care

Patients waiting over 78 weeks for treatment (ICB)



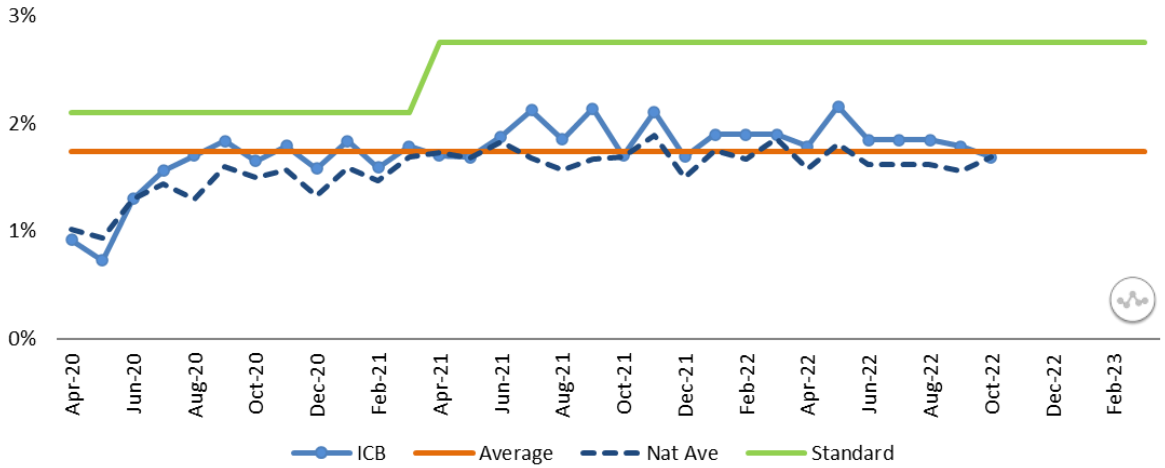
Total Waiting List Size (ICB)



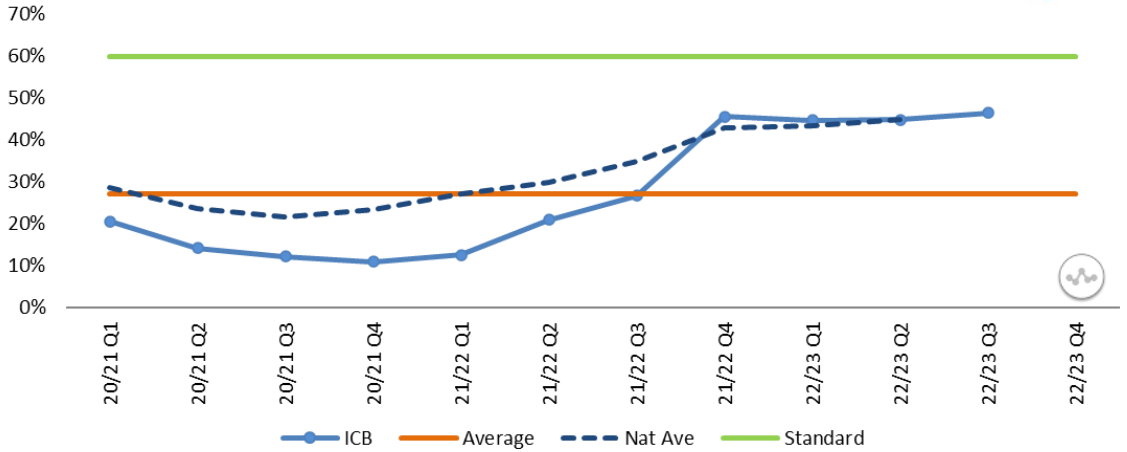
Current system pressures	Actions to recover
• It is important to view and read this in the context of the current National Covid Restore Agenda and the move away from a focus on constitutional standards to the expectation of focus upon cancer and clinical urgency. • This means there is a clinical risk based patient selection process as opposed to selection based upon the longest waits. Within this context it is unlikely that there will be material improvement to statutory RTT performance for some time. • Hospitals continue to experience patients who are reluctant to travel to alternative sites where wait times may be quicker. • Workforce levels continue to be a challenge for Providers • The majority of Providers have eliminated waits of over 104 weeks except where patients have chosen to wait longer. Some Providers outside of Lincolnshire are challenged in meeting the national waiting list targets. The University Hospitals of Leicester had 135 patients waiting 104 weeks at the end of November (this included 4 Lincolnshire patients).	• Whilst the actual number of patients waiting 78 weeks or more is at it's highest, ULHT are on track to eliminate waits of over 78 weeks by the end of March 2023. Plans include both in-sourcing and out-sourcing patients with alternative Providers to increase capacity. Overall waiting list size has reduced slightly in November. • The system has received some national funding to continue the Super September initiative whereby the Elective Activity Coordination Hub is contacting patients to check whether an appointment is still required and offer them an alterative provider if clinically suitable. This initiative has been recognised nationally as a 'best practice' scheme. • There has been a slight decrease in the overall number of patients waiting more than 6 weeks between September and October 2022 for diagnostics. DEXA, ECHO, and MRI remain the systems biggest challenges, and have the largest percentage of patients waiting for more than 6 weeks for their appointments. Additional capacity in all of these modalities has now been planned into future CDC development and a number of funding bids have been submitted to support recovery with additional service provision. Further additional ECHO activity is due to commence later this month, with an additional 3,000 scans being provided by an independent provider at the Grantham CDC. The fire damaged DEXA is now back online at Lincoln County and activity levels have increased accordingly.

Mental Health

IAPT Access (ICB)



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



Current system pressures	Actions to recover
IAPT • IAPT Access has dipped slightly to 1.68% of patients entering IAPT (people that enter treatment against the level of need in the general population). • IAPT Recovery Rate has recovered, but remains under the 50% target at 49.3% in October. It however, remains just above the England average of 49.2%. This is still seen as a result of increased levels of referrals to the service post Covid. **SMI Health Checks** • Performance over the County has remained stable over 2022/23 – the latest data shows an improving position with delivery in the 12 months preceding 1 January 2023 of 46.4% (2,194 patients receiving a full check) • Performance is expected to improved significantly in Q4.	**IAPT** • The new online system is supporting self-referral via the service website. • LPFT continue to work with commissioners and NHSE colleagues to understand the gap between current workforce and the increased access target – focus will be on seeing as many people as can be scheduled, ensuring waiting times are kept as short as possible and quality is good, rather than outreaching to achieve access and people waiting much longer with reduced outcomes. **SMI Health Checks** • Performance data and updates at a practice level are made available through locality Clinical Committees. Guidance on coding SMI HCs was presented to Committees and shared with practices during December. • An incentive scheme to support GP practice delivery in Q4 has been agreed – practices will receive additional funding based on year-end delivery against QOF. • A dedicated post to develop and deliver a community outreach model to support SMI HC delivery is out for recruitment – realistically this won't impact on delivery in year but will support improved performance in 23/24.

Lincolnshire ICB Quality Dashboard

Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Direction	Variation
Incidents	Never events (ULHT)		0	Dec-22	1	N/A	N/A		↑	
	Never events (NLAG)		0	Dec-22	0	N/A	N/A		→	
	Never events (NWAFT)		0	Dec-22	0	N/A	N/A		→	
	Serious Incidents (ICB)		-	Dec-22	34	N/A	N/A		↑	
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)		-	Aug-22	1.0268	1.0424	1.0004		↓	L
	Hospital Standardised Mortality Ratio (HSMR) (ULHT)		100	Oct-22	94.93	N/A	N/A		↓	
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)		-	Aug-22	1.0148	1.0424	1.0004		↓	L
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)		-	Aug-22	1.0837	1.0424	1.0004		↓	
Infection, Prevention, Control	MRSA Cases (ICB 12 month rate per 100,000)		0	Nov-22	0.61	0.56	0.77		→	L
	C-Diff Cases (ICB 12 month rate per 100,000)		0	Nov-22	22.42	25.98	27.17		↓	
	E-Coli Cases (ICB 12 month rate per 100,000)		0	Nov-22	28.18	36.30	37.44		↓	
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICS)		12	Jan-23	0	N/A	N/A		↑	
	Rate per 1000 of people with a learning disability receiving inpatient care (ICB)		-	Nov-22	54	44	41		↑	L
	Cumulative Learning Disability Healthchecks (ICB)		1706	Nov-22	1813	N/A	N/A		↑	
Patient Experience	Patient experience of GP services (ICB)		-	2022	72.2%	70.5%	72.4%		↓	
	Friends & Family Test: A&E Recommended (ULHT)		-	Nov-22	76.2%	72.0%	74.7%		↑	
	Friends & Family Test: Inpatient Recommended (ULHT)		-	Nov-22	89.3%	93.8%	94.3%		↑	
	Friends & Family Test: Maternity Recommended (ULHT)		-	Nov-22	90.9%	93.5%	92.3%		→	
	Friends & Family Test: Community Recommended (LCHS)		-	Nov-22	86.3%	93.5%	92.3%		↑	
	Friends & Family Test: Mental Health Recommended (LPFT)		-	Nov-22	91.1%	84.8%	83.9%		↑	
Primary Care	Primary Care CQC- number of practices rated as 'Inadequate' by CQC		0	Nov-22	1	N/A	N/A		→	
	Primary Care CQC- number of practices rated as 'Requires Improvement' by CQC		-	Nov-22	4	N/A	N/A		↓	H
	GP Appointments- percentage seen by a GP		34.7%	Nov-22	33.8%	N/A	N/A		↑	
	GP Appointments Mode- percentage seen face to face		66.8%	Nov-22	71.1%	N/A	N/A		↓	H
	GP Appointments- time from booking to appointment same day		43.2%	Nov-22	43.3%	N/A	N/A		↑	
	GP Appointments- time from booking to appointment 1-6 days		24.5%	Nov-22	23.7%	N/A	N/A		↑	L
	Enhanced access provision per 1000 of the PCN adjusted population (ICB)		60	Oct-22	73	N/A	N/A		↓	
	The percentage of available GP enhanced access appointments utilised (ICB)		80%	Oct-22	86.5%	N/A	N/A		↑	H

Key Quality Updates January 2023

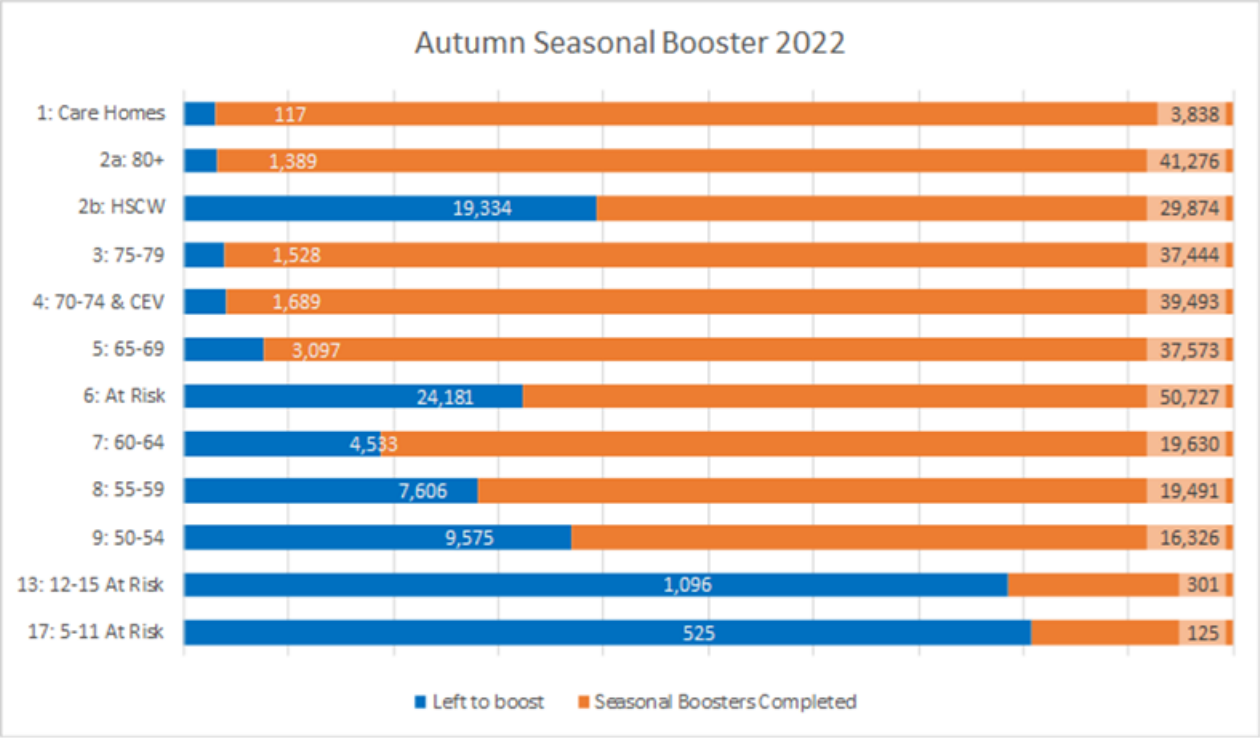
Programme	Indicator	Cause Identified	Actions Being Taken
Never Events	Never Events	• There has been a single never events reported between 3 December 2022 – 10 January 2023, in relation to Lincolnshire patients. The never event was reported by ULHT and related to a wrong site surgery	• Full investigation reports are received by the ICB quality services team which include actions that have been taken as a result of the incident being reported and subsequently investigated. • The completed Never Event Report is taken through the ICB Serious Incident Review Group Meeting. The investigation is reviewed, assurance secured where necessary and closure of the incident agreed – or further action identified (where required).
Infection, Prevention & Control	MRSA/C-Diff Cases	• To date 1 MRSA bloodstream infection case has been reported by ULHT. The total number of ICB cases is 8. • Lincolnshire ICB has been allocated a ceiling trajectory total of 148 C.diff cases for 2022/23. ULHT has a ceiling trajectory total of 56 cases (a reduction of 12 from 2021/22). ULHT have reported 51 cases YTD	• Hospital onset cases are routinely investigated and reported through the Trusts' IPC groups with any lapses in care identified. • 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	• There are currently 19 LDA ICB Inpatients, 7 above the target of 12. • A number of planned discharges have been delayed in Q3 and the ICB inpatient numbers are affected by IMPACT step downs into rehab placements and CYP inpatients becoming adults prior to discharge. Work is progressing with the provider collaborative to redesign the discharge from secure care direct to community pathways.	• Recruitment to community forensic and crisis and home treatment teams with posts readvertised and a number of appointments made • Transforming care Liaison service recruitment 90% completed • Capital bid PID to NHSE in preparation to provide additional complex care community capacity
Primary Care	Primary Care Access	• Access continues to improve generally, however, data consistency is an issue and GP appt data sets are heavily caveated. • GP practices have raised ongoing demand pressures as a significant risk.	• A solution to simplify PCN Enhanced Access reporting has been identified and should improve data.

Covid-19 Vaccinations

NHS Lincolnshire Integrated Care Board

Overview by Dose

All Cohorts	Evergreen 1st Doses	Evergreen 2nd Doses	Evergreen 3rd Doses	Seasonal Booster
Total Completed	623,966	599,452	10,885	302,626
Activity Last 7 Days	37	61	0	0
Difference from previous week	**-2**	**19**	**0**	**-684**

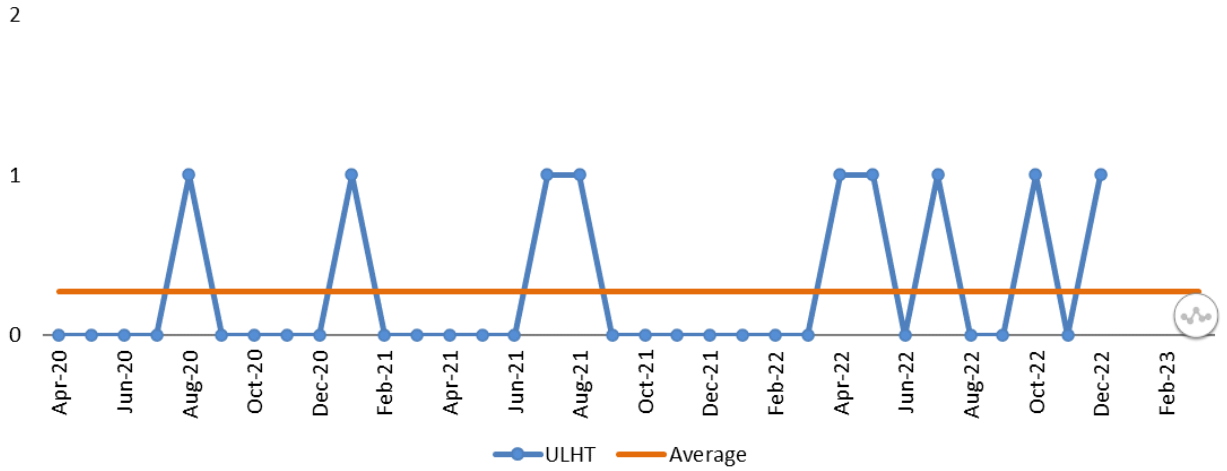


Update

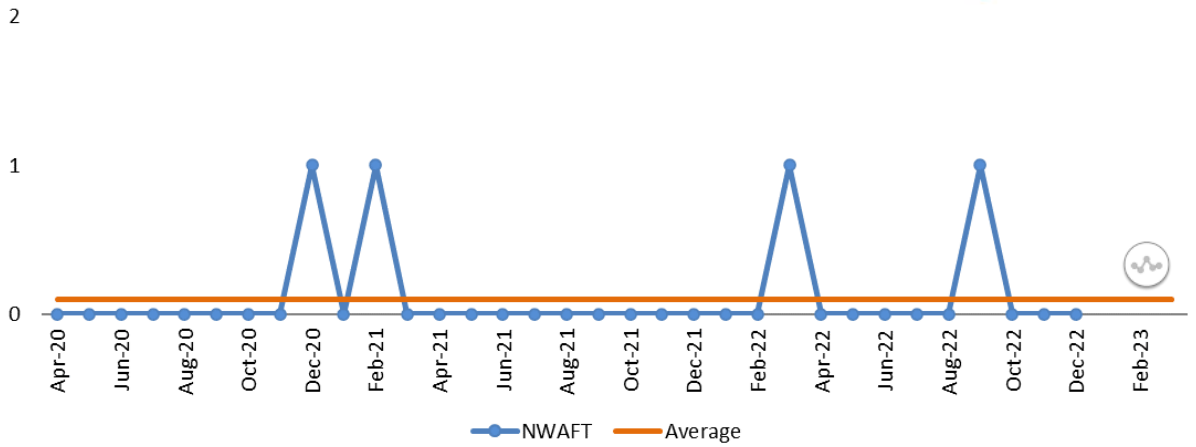
- The Autumn booster programme went live 5th September 2022 with Care Home visits
- All eligible patients are now able to book appointments at vaccination centres
- This will be delivered in partnership by PCNs, the Mass vaccination centres, the Hospital Hub and Community pharmacies, as has been the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

Never Events

Never Events (ULHT)



Never Events (NWAFT)



Lincolnshire Integrated Care Board

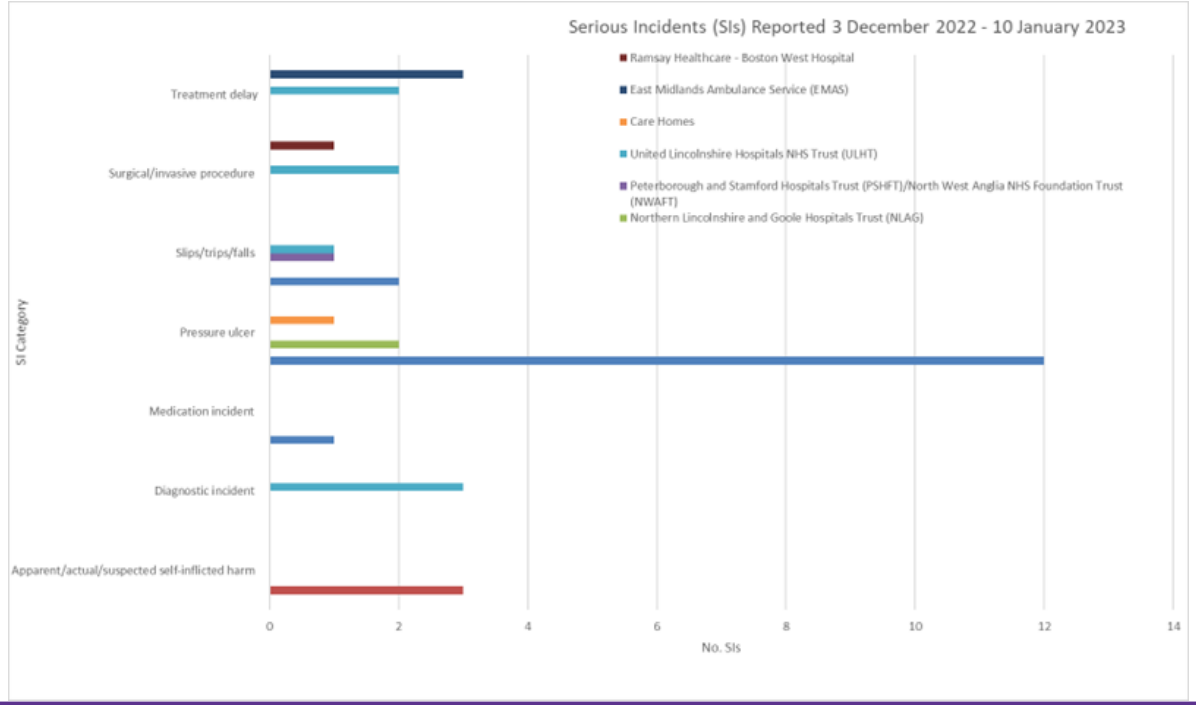
Current system pressures

ULHT

- There has been a single never events reported between 3 December 2022 – 10 January 2023, in relation to Lincolnshire patients. The never event was reported by ULHT and related to a wrong site surgery
- Full investigation reports are received by the ICB quality services team which include actions that have been taken as a result of the incident being reported and subsequently investigated.
- The completed Never Event Report is taken through the ICB Serious Incident Review Group Meeting. The investigation is reviewed, assurance secured where necessary and closure of the incident agreed – or further action identified (where required).

	Administration of medication by the wrong route	*Misplaced naso- or oro-gastric tubes*	*Retained foreign object post procedure*	*Wrong Site Surgery*	*Wrong implant/ prosthesis*	*Ligature – No Collapsible Rail*
April 2022	*ULHT, PHB*					
May 2022				*ULHT, LCH*		
June 2022						
July 2022				*ULHT, LCH*		
August 2022						
September 2022	*HEY NWAFT, PCH*					
October 2022			*ULHT, LCH*			
November 2022						
December 2022				*ULHT, GDH*		

Serious Incidents



Update

• There has been a total of 34 serious incidents reported between 3 December 2022 – 10 January 2023, whilst a slight increase when compared to the last report, is generally in keeping with previous serious incident reporting rates.

• Most serious incident reported continue to relate to services provided by LCHS (n=15), of which (n=12) were identified as category 3 and 4 pressure ulcers. This level of reporting is consistent when compared to the last report whereby (n=14) category 3 and 4 pressure ulcers were reported. In addition, between 3 December 2022 and 10 January 2023 LCH also reported (n=2) slips/trips/falls and a single medication incident.

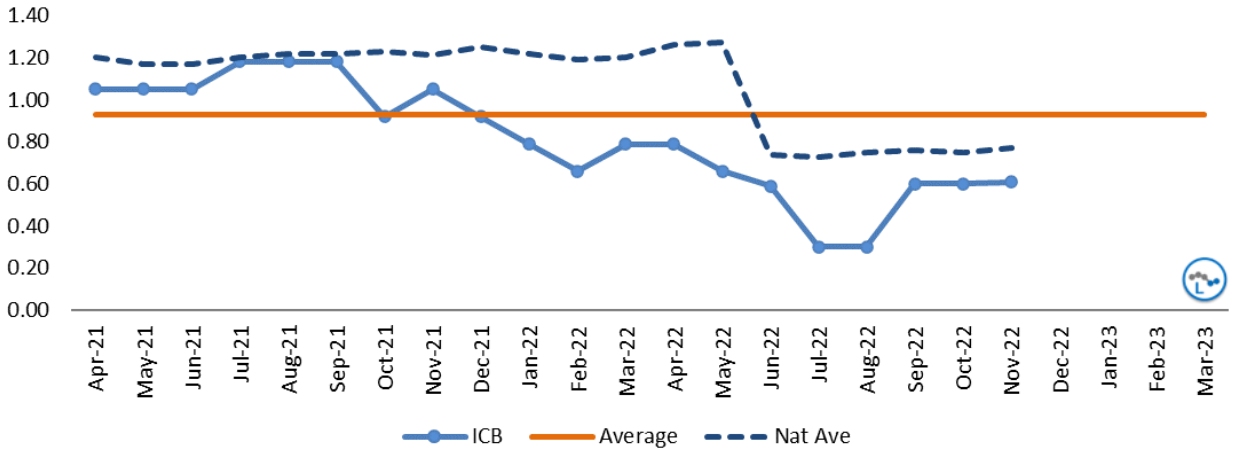
• ULHT reported a total of (n=8) serious incidents in the timeframe referenced; this represents an increase when compared to last month (n=4). The focus of serious incident reporting for ULHT is diagnostic incidents (n=3); surgical/invasive procedure (n=2); treatment delay (n=2) and a single slip trip and fall. It is noted that there had been a single never event reported by ULHT in the timeframe referenced. The never event has been included in the number of surgical/invasive procedure incidents reported; and related to a procedure being undertaken for a patient where it had not been clinically indicated.

• LPFT reported a total of (n=3) serious incidents in the timeframe referenced; this remains consistent with previous SI reporting figures. All three serious incidents reported related to apparent/actual/suspected self-inflicted harm.

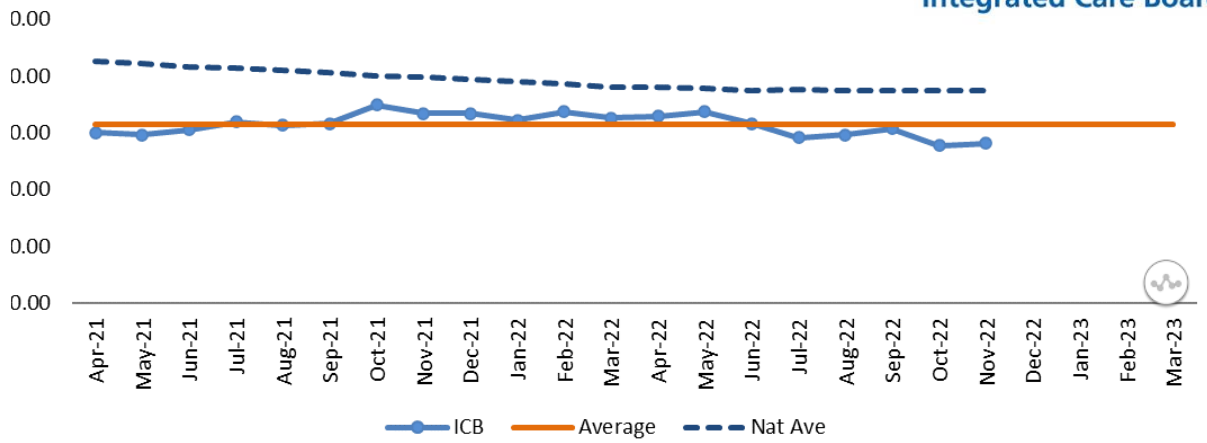
Infection, Prevention & Control

NHS Lincolnshire Integrated Care Board

Infection Prevention & Control- MRSA Cases (ICB)



Infection Prevention & Control- E-coli Cases (ICB)



Current system pressures

MRSA

- To date 1 MRSA bloodstream infection case has been reported by ULHT. The total number of ICB cases is 8.

C.diff

- Lincolnshire ICB has been allocated a ceiling trajectory total of 148 C.diff cases for 2022/23. January figures were unavailable at the time of writing. ULHT has a ceiling trajectory total of 56 cases (a reduction of 12 from 2021/22). ULHT have reported 51 cases YTD. There have been no Periods of Increased Incident (PII) reported this month.

ULHT

- An assurance visit for Q3 took place via Teams due to staff shortage/sickness. Criteria 9 of the Health and Social Care Code of Practice was reviewed. This focusses on policies and guidance relating to IPC. The Trust have effective systems and processes in place to manage this and are compliant with Criteria 9.

LCHS & LPFT

- Q3 Assurance visits to LCHS and LPFT were both postponed this quarter; new dates TBC. The LCHS team is currently affected by unavoidable staff shortage. The LPFT visit was postponed due to a communicable disease response taking priority.

Actions to recover

MRSA

- Each case of hospital onset MRSA bloodstream infection is investigated and managed through the Trusts Infection, Prevention & Control (IPC) group meetings.

C.diff

- Hospital onset cases are routinely investigated and reported through the Trusts' IPC groups with any lapses in care identified.
- 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.

ULHT

- The Health Protection Team will continue to monitor compliance against the Health and Social Care Act Code of Practice by conducting site visits, confirm and challenge and acting upon intelligence from other sources..

LCHS & LPFT

- The ICB HPT are supporting the LCHS team as required e.g. during annual leave periods.

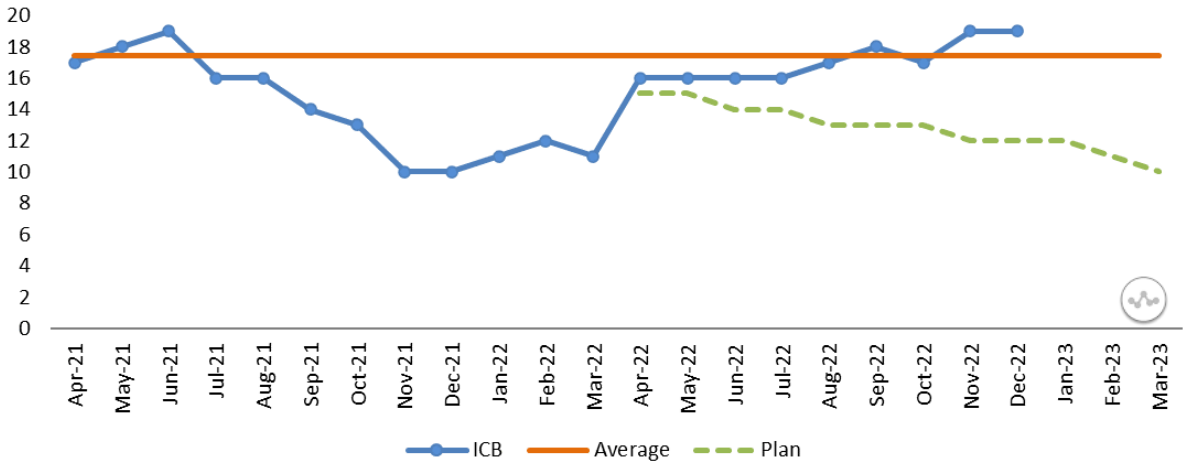
Communicable disease outbreaks

- Antiviral storage has been secured at the UTC's in Boston and Lincoln to allow for 7 day access.

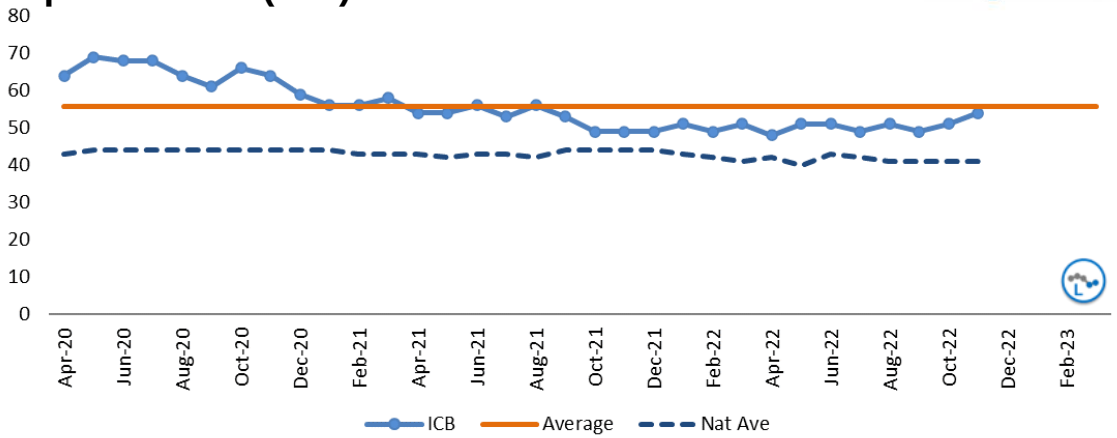
Learning Disability & Autism

NHS Lincolnshire Integrated Care Board

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



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



Current system pressures	Actions to recover
LD Inpatients • There are currently 19 LDA ICB Inpatients, 7 above the target of 12. • There are currently 12 LDA IMPACT inpatients, 1 below target of 13 • There are currently 2 LDA children & young people (CYP), 1 below target of 3 • A number of planned discharges have been delayed in Q3 and the ICB inpatient numbers are affected by IMPACT step downs into rehab placements and CYP inpatients becoming adults prior to discharge. Work is progressing with the provider collaborative to redesign the discharge from secure care direct to community pathways.	**LD Inpatients** • Recruitment to community forensic and crisis and home treatment teams with posts readvertised and a number of appointments made. • Transforming care Liaison service recruitment 90% completed • 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

Care Home Quality

CQC rating December 2022	Outstanding	Good	Requires Improvement	Inadequate
No. of Homes: 276 15 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	185 (2 homes less than last month)	55 (remains the same as last month)	5 (1 more than last month)

CQC rating January 2023	Outstanding	Good	Requires Improvement	Inadequate
No. of Homes: 274 15 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	181 (4 homes less than last month)	58 (3 homes more than last month)	4 (remains the same as last month)

Update

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

Care Homes with high risk issues – under enhanced level of surveillance via ICB/LCC officers: x24 providers which is an increase of 8 providers since last month

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

- One in East, South & South West localities
- Themes include lack of management oversight and governance, inadequate staffing levels, poor quality care plans and safeguarding concerns

There has been a total of 20 Default Notices by Lincolnshire County Council:

- Across all localities
- 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.

January 2023

Safeguarding

Safeguarding Team

- The safeguarding team re-structure is now complete with the final appointment of two Band 7 Lead Safeguarding Nurses for Adults and Children; the successful candidates are due to commence their new roles in February 2023.

Safeguarding Adults / Mental Capacity / Court of Protection

- The ICB continues to wait to receive a definitive outcome of the draft 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.

Safeguarding Issues/Risks

Completion of Initial health Assessments within statutory timescales remains a challenge for Lincolnshire. LCHS continue to work proactively to increase medical practitioner sessions (GPs and contract through ULHT for paediatrician sessions). To mitigate the risk, all Children in Care (CiC) who will not receive their assessment within timescales has a health and wellbeing check (completed by the CiC nurses) to assess health needs and identify issues requiring further action and referral.

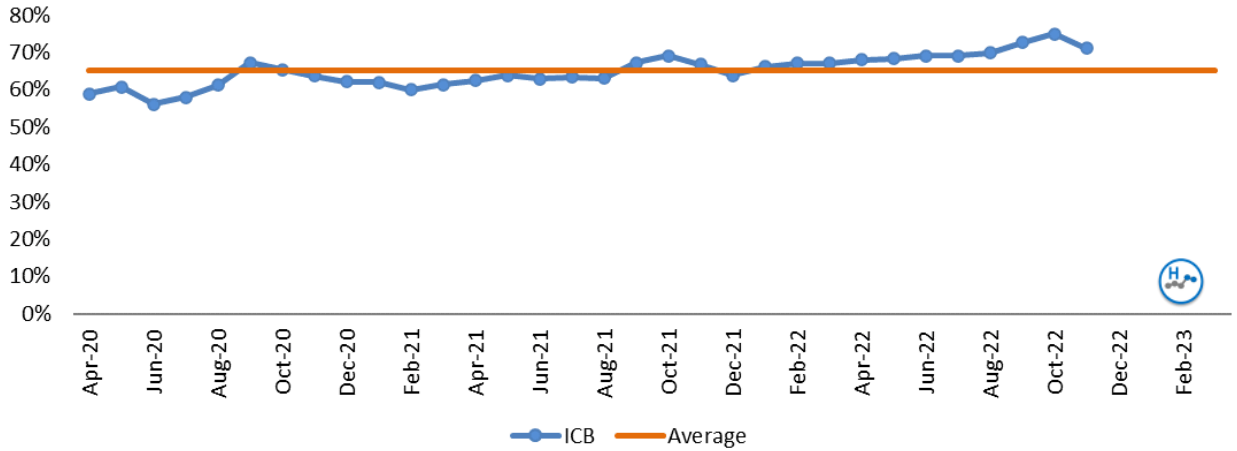
SEND

- The ICB's SEND team will be Peer Reviewed in line with the new Ofsted/ CQC framework in April 23 – therefore the team are in the process to ensure that we are inspection ready buy rewriting the SEF and SEND Strategy in collaboration with the local authority.
- The new Co Chair of Lincolnshire Young Voices has recently commenced in post and we are beginning the second recruitment round for the second Co chair
- The DCO is supporting the National SEND Celebration event later in January
- The DCO and other health provider colleagues are supporting the Lincolnshire Parent Carer Forum Week of SEND event
- Implementation and training programme underway for SEND Clinicians regarding the new cloud based education, health and care plan system

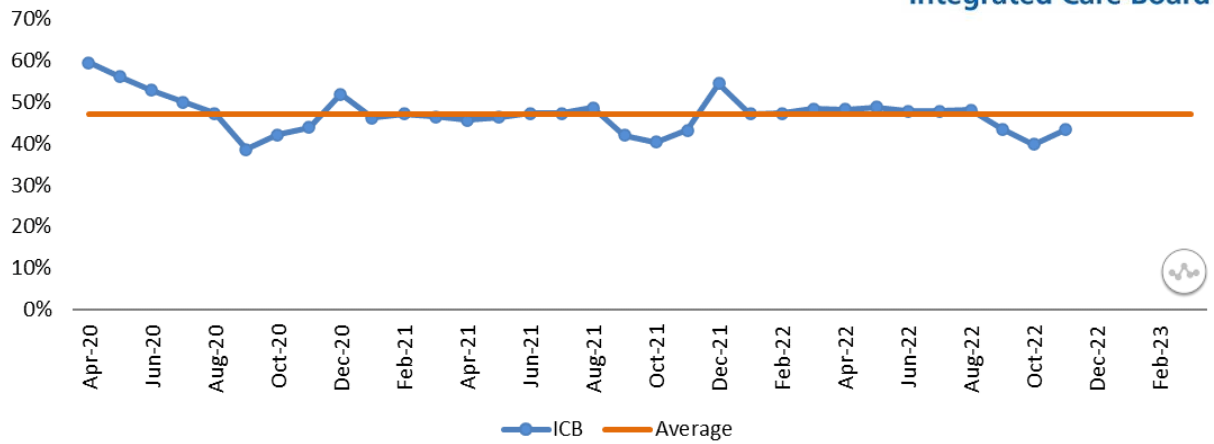
Primary Care

NHS Lincolnshire Integrated Care Board

GP Appointments Mode- percentage seen face to face



Time from booking to GP appointment (Same Day)



Current system pressures	Actions to recover
Quality • No CQC visits have taken place since the last report. • Hawthorn Medical Practice remains rated as Inadequate by the CQC.	**Quality** • ICB teams are supporting practices in addressing the issues identified by the CQC. LMC are also supporting. • ICB Primary Care and Quality teams continue to support practices in improving care quality and patient experience
Access • The development of online triage, new ways of working over the covid pandemic alongside introduction of additional, non-medical roles into primary has changed how people access primary care • Access continues to improve generally, however, data consistency is an issue and GP appt data sets are heavily caveated. • A solution to simplify PCN Enhanced Access reporting has been identified and should improve data. • GP practices have raised ongoing demand pressures as a significant risk.	**Access** • Practice support available through Livi system and LMC. Lantum available to support practice capacity and actively promoted to practices and PCNs • GPAS monitoring practice pressures and reporting through to OPEL system: managed by the LMC. • Primary Care and Performance teams are supporting Enhanced Access reporting and following up with PCNs. • Winter pressures funding is available to support Enhanced Access capacity. .

6 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2022
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	6 (i)
Title of Report:	System Financial Management Report December 2022 (Month 9)
Report Author:	Rebecca McCauley, Senior Finance Business Partner
Appendices:	Appendix 1: System Financial Position Appendix 2: ICB Financial Position Appendix 3: System Risks and Mitigations Appendix 4: ICB Financial Performance Targets Appendix 5: Delivery against System Agency Expenditure Limits Appendix 6: Financial Position of the Better Care Fund

1.	Key Points for Discussion:

This report sets out the financial position of the Lincolnshire Integrated Care System (ICS) and the Lincolnshire Integrated Care Board (ICB) on 31 December 2022 (Month 9).

2.	Recommendations

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

3.	Executive Summary

Summary System Financial Position

This paper shows the financial position of Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care System as it was reported to NHS England. The position reported for the ICS includes financial information from 1st April 2022 to 30th June 2022 (the final 3 months of the Lincolnshire CCG and the first 6 months of the Lincolnshire ICB) to present a complete year to date and forecast outturn view for the ICS as reported on 31st December.

The Lincolnshire ICS position is shown in Table 1, with further breakdown at Appendix 1. The system had a target of £4.0m deficit at month 9, and a plan to breakeven against allocations by the financial year end. The actual position is a deficit of £19.3m which is £15.3m adverse variance to plan. This represents a further £0.6m deterioration in month from, Month 8.

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 enable us 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 this would not be accepted and that this will be required to reduce to c.£20m.

Enacting the protocol to deliver a financial deficit will bring about a rigorous process for moving away from an approved financial plan with formalised layers of key lines of enquiry and monitoring and management of key controls.

Table 1: Lincolnshire system planned and actual net expenditure

Lincolnshire ICS Surplus (+) / Deficit (-)	Year to Date			Forecast Outturn		
	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
NHS Lincolnshire Integrated Care Board (and former CCG)	-6.6	-11.7	-5.0	-3.2	-3.2	0.0
United Lincolnshire Hospitals NHS Trust	0.0	-12.6	-12.6	0.0	0.0	0.0
Lincolnshire Partnership NHS Foundation Trust	2.6	5.0	2.4	3.3	3.2	-0.0
Lincolnshire Community Health Services NHS Trust	0.0	-0.0	-0.0	0.0	0.0	0.0
Total	**-4.0**	**-19.3**	**-15.3**	**0.0**	**0.0**	**0.0**

The reasons for the off-plan expenditure run rate at Month 9 remains consistent with prior months and has been for the same reasons as per previous months Board reports.

Efficiencies

The ICS reported a year-to-date waste reduction value at Month 9 of £30.4m which, against a plan of £36.8m, represents an adverse variance of £6.4m. 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, therefore expecting a £7.8m adverse variance to plan. It should be noted that of the £56.0m forecast only £24.2m is deemed as recurrent efficiencies.

The slippage in the efficiency delivery at ULHT is the principal reason for the £6.4m year-to-date shortfall against the year-to-date target. The forecast for the end of the year is that this under-delivery is fully recovered. However, it should be noted that this is subject to significant system risks which are detailed below which subject to the outcome of the Protocol enactment is expected to be brought into the position in forthcoming reporting months.

Table 2: System Efficiencies

ICS Efficiencies	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m	FOT £m	FOT Variance £m
Lincolnshire Community Health Services NHS Trust	3.4	3.4	0.0	4.7	4.7	-0.0
Lincolnshire Partnership NHS Foundation Trust	6.3	6.0	-0.3	8.4	7.8	-0.6
United Lincolnshire Hospitals NHS Trust	17.9	9.8	-8.1	29.0	29.0	0.0
NHS Integrated Care Board	11.5	11.2	-0.3	26.2	14.4	-11.7
Total Efficiencies	**39.1**	**30.4**	**-8.7**	**68.3**	**56.0**	**-12.3**
Total ICB efficiency impacting providers inside system	2.3	0.0	-2.3	4.5	0.0	-4.5
Total ICS Efficiencies	**36.8**	**30.4**	**-6.4**	**63.8**	**56.0**	**-7.8**

Recurrent / Non-Recurrent Split:						
Recurrent	28.9	6.9	-22.1	51.2	24.2	-27.0
Non-recurrent	7.9	23.5	15.6	12.5	31.7	19.2
Total ICB Efficiencies	**36.8**	**30.4**	**-6.4**	**63.8**	**56.0**	**-7.8**

Risks and Mitigations

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

Appendix 2 provides a summary of the risks. Most notable is the £16.9m attributable to the inability to reduce agency spend due to planned bed closures not materializing; demands within the acute healthcare setting have resulted in a net increase of open beds in year.

The system has £72.8m of risk identified to date, which has been mitigated down to £27.2m. Without further action the system could therefore fail to meet its financial target by £27.2m in year. This position has reduced in month resulting from run rate improvements that have been confirmed in the month.

The Lincolnshire ICB expects to implement an NHSE protocol to move off plan as a result of the risks presented and additional work is nearing completion to confirm the forecast position.

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

ICB Financial Position and Statutory Requirement

Table 1 above shows that the ICB and former CCG combined is reporting a year-to-date adverse variance to plan of £5.0m by delivering a Month 9 deficit against allocation and income of £11.7m against a year-to-date planned deficit of £6.6m.

The ICB is however reporting a forecast to deliver the planned deficit of £3.2m as the combined financial performance across the CCG and ICB in 2022/23. However, in light of the risks faced and discussions with NHSE regarding the financial recovery plan this forecast position is under review.

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

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

Capital

The ICS has utilized £29.4m against its £42.9m year-to-date capital plan therefore reporting a £13.6m variance. It is expected that £56.7m of the full year allocation of £57.9m will be fully utilized by the financial year end resulting in a £1.2m underspend. The reported underspend at Month 8 was £6.6m which shows a £5.4m in-month movement in the position which is explained by the Community Diagnostic Capital spend.

Table 4 Capital Expenditure Summary

Capital Expenditure	Year to Date			Forecast Outturn		
Scheme Summary	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
NHS Lincolnshire Integrated Care Board and former CCG	0.7	0.2	0.5	1.5	1.5	0.0
United Lincolnshire Hospitals NHS Trust	25.0	15.7	9.3	38.4	37.3	1.1
Lincolnshire Community Health Services NHS Trust	2.3	1.5	0.9	3.5	3.3	0.2
Lincolnshire Partnership NHS Foundation Trust	15.6	12.2	3.4	16.0	16.0	0.0
Total	**43.7**	**29.6**	**14.1**	**59.4**	**58.1**	**1.2**

Mental Health Investment Standard (MHIS)

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

There has been a reduction in cost and volume of individual packages of s117 and mental health continuing health care and locked rehabilitation packages relative to prior years. The current estimate is c.£7.5m which equates to a 5.3% shortfall against target.

The ICS is continuing discussions with NHS England to understand the parity of Mental Health services for Lincolnshire against national targets and benchmarks. For Month 9 the ICS has continued to report delivery of the MHIS target but with a £7.5m risk of required investment to achieve the standard, mitigated by the potential of non-delivery of the target.

Underlying Position

The latest calculations of the underlying exit rate position for 2022/23 shows that the underlying deficit is in the region of £70m. This is before the application of the historic former CCG deficit brought forwards. This continues to be assessed and will be incorporated into the 2023-25 financial planning.

Next Steps

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

1. Conclude discussions with NHSE to enact the protocol to move off plan.
2. Finalise the 2022/23 full year forecast position with partners.

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

APPENDICES

Appendix 1 – Lincolnshire ICS Financial Position

System I&E Summary	System I&E Summary							
	Plan YTD £m	Actual YTD £m	Variance YTD £m	Variance YTD %	Plan Year Ending £m	Forecas Year Ending £m	Variance Year Ending £m	Variance Year Ending %
System Revenue Resource Limit	(793.5)							
ICB Net Expenditure								
Acute Services	419.5	426.8	(7.4)	(1.8%)	630.4	631.2	(0.8)	(0.1%)
Mental Health Services	93.4	90.7	2.7	2.9%	143.8	138.6	5.1	3.6%
Community Health Services	78.9	80.0	(1.1)	(1.4%)	121.2	121.8	(0.7)	(0.6%)
Continuing Care Services	32.0	28.7	3.3	10.2%	47.7	44.0	3.8	7.9%
Primary Care Services	90.8	93.5	(2.7)	(3.0%)	134.6	138.2	(3.5)	(2.6%)
Other Commissioned Services	3.6	3.0	0.7	18.0%	5.7	4.6	1.1	19.0%
Other Programme Services	3.8	3.5	0.3	8.1%	5.5	5.1	0.3	6.3%
Reserves / Contingencies	(9.3)	0.0	(9.3)	100.0%	(20.6)	(6.7)	(13.9)	67.6%
Delegated Primary Care Commissioning	73.3	72.4	0.9	1.2%	109.3	111.4	(2.1)	(1.9%)
ICB Running Costs	7.2	6.7	0.6	7.9%	11.4	11.2	0.2	1.9%
Total ICB Net Expenditure	**793.1**	**805.1**	**(12.1)**	**-1.5%**	**1,188.9**	**1,199.5**	**(10.6)**	**-0.9%**
Adjustment for reimbursable items	0.0	0.0	0.0	0.0%	0.0	3.6	0.0	0.0%
CCG M1-3 Surplus / (Deficit)	(7.0)	0.0	7.0	1.9%	(7.0)	0.0	7.0	1.9%
TOTAL ICB + CCG Surplus/(Deficit)	**(6.6)**	**(11.7)**	**(5.0)**	**-0.4%**	**(3.2)**	**(3.2)**	**0.0**	**0.0%**
ICS Providers I&E - Adjusted Financial Performance								
Income	(695.8)	(728.7)	32.9	(4.7%)	(930.3)	(975.0)	44.7	(4.8%)
Pay	471.8	505.4	(33.6)	(7.1%)	633.7	674.7	(41.0)	(6.5%)
Non-Pay	213.9	225.9	(12.0)	(5.6%)	283.5	290.6	(7.1)	(2.5%)
Non Operating Items (exc gains on disposal)	7.4	4.9	2.4	33.1%	9.9	6.5	3.3	33.9%
TOTAL Provider Surplus/(Deficit)	**2.6**	**(7.6)**	**(10.3)**	**1.5%**	**3.3**	**3.3**	**0.0**	**0.0%**
TOTAL ICS Surplus/(Deficit)	**(4.0)**	**(19.3)**	**(15.3)**	**-1.3%**	**0.0**	**0.0**	**0.0**	**0.0%**

Appendix 2 – ICB Financial Position

Lincolnshire ICB Position (from Month 4)	Year to Date			Forecast Outturn		
Allocations	Planned £m	Actual £m	Variance £m	Planned £m	Actual £m	Variance £m
Total Allocations	**793.5**	**793.5**	**0.0**	**1,192.7**	**1,192.7**	**0.0**
Expenditure						
Acute Services	419.5	426.8	-7.4	630.4	631.2	-0.8
Community Health Services	78.9	80.0	-1.1	121.2	121.8	-0.7
Mental Health Services	93.4	90.7	2.7	143.8	138.6	5.1
Continuing Care Services	32.0	28.7	3.3	47.7	44.0	3.8
Primary Care Services	73.3	72.4	0.9	109.3	111.4	-2.1
Primary Care Co-Commissioning	90.8	93.5	-2.7	134.6	138.2	-3.5
Other Programme Services	-1.9	6.5	-8.4	-9.4	3.1	-12.5
Running Costs	7.2	6.7	0.6	11.4	11.2	0.2
Total Expenditure	**793.1**	**805.1**	**-12.1**	**1,188.9**	**1,199.5**	**-10.6**
Operating Surplus/Deficit	**0.4**	**-11.7**	**-12.1**	**3.8**	**-6.8**	**-10.6**
Adjustment to position for ICB	0.0	0.0	0.0	0.0	3.6	3.6
Net Surplus/Deficit Position (ICB)	**0.4**	**-11.7**	**-12.1**	**3.8**	**-3.2**	**-7.0**

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

Net Surplus/Deficit Position (ICB & CCG)	**-6.6**	**-11.7**	**-5.0**	**-3.2**	**-3.2**	**0.0**

Appendix 3 – System Risks and Mitigations

Figures are forecasts for the full year 2022/23.

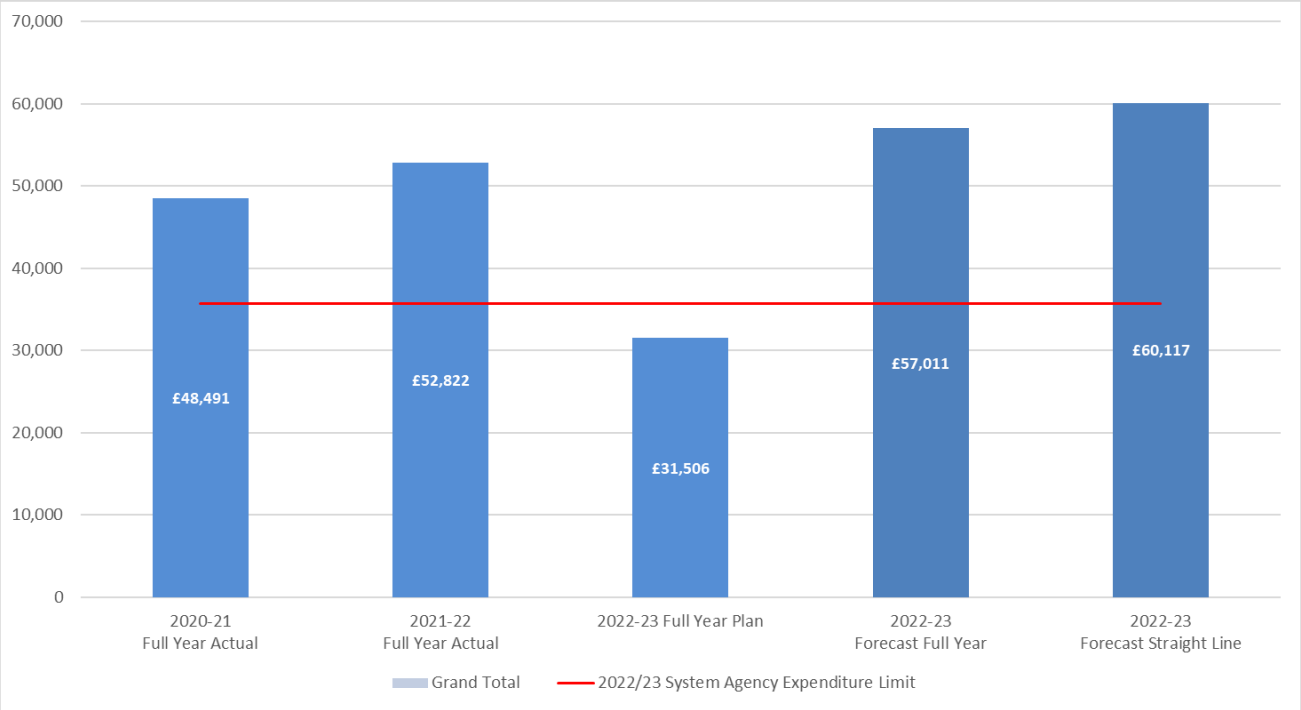
Org / System Wide	Description of risk	Likelihood	Potential Financial Impact before mitigations £m	Description of mitigating actions being taken by system	Potential Financial Impact after mitigations £m
System Wide	Delivery of waste Efficiency schemes	High	-19.9	ICB commissioned expenditure run-rate underspend	-1.7
United Lincolnshire Hospitals NHS Trust	Delivery of waste Efficiency schemes	High	-11.7	Efficiency and Productivity review within ULHT	-1.4
United Lincolnshire Hospitals NHS Trust	COVID-19 costs	High	-5.8	Efficiency and Productivity review within ULHT	-5.8
System Wide	Reductions in agency spend via escalation bed closures	Medium	-16.9	Creation of out of hospital capacity in community and social care to enable the discharge of hospital patients who are either on Pathway 1 or Pathway 0 to enable bed closures.	-16.9
System Wide	Risk of the return of the funding received to address the elective backlog.	Medium	-9.6	Non clawback of ESRF funding	0.0
Lincolnshire ICB	Demand pressures in Ambulance services	Medium	-1.4	Efficiency and Productivity review within ICB	-1.4
System Wide	Further investment required to meet MHIS.	Low	-7.5	Mitigation to be confirmed	0.0
Grand Total			**-72.8**		**-27.2**

Appendix 4 – ICB Financial Performance Targets

Overview – Key Targets	Limits	Year To Date	Forecast year end position	Comments
Revenue resource (programme cost) must not exceed the amount specified in directions	£1,192.7m revenue resource limit (including Running Cost allowance) based on current ICB allocations (6 month period).	Red	Red	The ICB is planning a £3.25 million deficit, so it will be exceeding the revenue resource limit.
Revenue administration resource (running cost) used must not exceed the amount specified in directions	£11.4m 2022/23 Running Cost allowance based on ICB allocations (6 month period).	Green	Green	The year end forecast outturn is within the Running Costs allocation.
Capital resource used must not exceed the amount specified in directions	£1.478m capital allocation for GP IT has been allocated to the ICB.	Amber	Green	The ICB has plans in place to spend all GP IT capital allocation in year although this is underspent year-to-date.
To manage cash payments within the annual cash drawdown requirement (ACDR)	£1.19bn 2022/23 9 month cash drawdown requirement	Amber	Green	At Month 9 (66.7% of the 9 month period), the ICB has utilised 66.9% of the annual cash requirement.
Period end cash balance is less than 1.25% of drawdown value	No more than 1.25% of the drawdown value	Green	Green	November cash balance was £2k (0.0% of drawdown), so within tolerance. Target delivered every month.
Better Payment Practice Code: 95% of NHS and non-NHS invoices by value and volume paid within 30	95% of invoices paid within 30 days of receipt	Green	Green	All targets achieved cumulatively.

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

The chart below shows the in-year increases of agency expenditure across the system and the distance from the prescribed agency expenditure limit of £35.7m; the current forecast is that spend will exceed the target by £21.3m. The forecast has reduced by £4.4m relative to Month 8.



Appendix 6 – Better Care Fund (BCF)

The tables below detail the financial position of the Better Care Fund on 31st December 2022. This is forecast to overspend by £2.3m. This has shown a deterioration in recent months relating to Learning Disabilities, ICES and CaMHS.

	CCG/ICB Contributions £m	LCC Contributions £m	Total Pooled Budget £m
Annual Value Contribution (Plan)			
Proactive S(75)	27.9	51.7	79.6
LD S(75)	26.7	61.5	88.2
CAMHs S(75)	11.9	0.7	12.7
ICES S(75)	3.7	3.1	6.8
Total - Agreement	**70.2**	**117.0**	**187.3**
Non pooled budget items			
Surge capacity	0.2	0.0	0.2
Staffing	0.1	0.1	0.2
Total - Adjustments In Year	**0.3**	**0.1**	**0.4**
Other			
Adult Mental Health	74.5	14.5	89.0
Transitional Beds	1.8	1.0	2.8
Total - Variations	**76.3**	**15.5**	**91.7**
Planned Total	**146.8**	**132.6**	**279.4**
In Year Variations to Plan (Penalties, Under/Over spends, Separate Agreement)			
CAMHS S(75) Pay award	0.2	0.0	0.2
CAMHS S(75)	0.9	0.0	0.9
LD S(75)	0.7	0.0	0.7
ICES S(75)	0.5	0.0	0.5
Total - Variations	**2.3**	**0.0**	**2.3**
Grand Total	**149.0**	**132.6**	**281.6**

Item 7 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	7 (i)
Title of Report:	Lincolnshire's Interim Integrated Care Strategy
Report Author:	Peter Burnett – Director of Strategic Planning, Integration and Partnerships
Appendices:	Interim Integrated Care Strategy

1.	**Key Points for Discussion:**

The Health and Care Act 2022 requires the Lincolnshire Integrated Care Partnership (ICP) 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.

This paper details the process to develop Lincolnshire's interim integrated care strategy and the proposed future engagement with the public. The deadline for agreeing and publishing the strategy is the end of March 2023.

2.	**Recommendations**

The NHS Lincolnshire ICB Board is requested to note:

- The process and the steps taken to develop the interim integrated care strategy,
- The content of the interim strategy document, its ambition, aims and priority enablers
- 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.
- The proposed engagement exercise with the public which will commence in quarter one of 2023/24.

3.	**Executive Summary**

1. Background

1.1 Context

The Health and Care Act 2022, requires the Lincolnshire ICP to prepare and publish an interim Integrated Care Strategy. The strategy must set out the direction for the system, detailing how commissioners in the NHS and Lincolnshire County Council (LCC), working with providers and other partners, can deliver more joined-up, preventative, and person-centred care. A report summarising the guidance issued by the Department of Health and Social Care (DHSC) on the preparation of integrated care strategies was published in July 2022.

The guidance acknowledges that 2022–2023 is a transitional period, and that ICPs will need to refresh and develop the integrated care strategy further during 2023, as ICS arrangements develop and mature. The ICP was initially required to publish an interim strategy in December 2022, however the this has now been pushed back until 31 March 2023. The purpose for the initial publication date in the guidance was in order for the strategy to influence the first, 5-year NHS Lincolnshire ICB Joint Forward Plan.

As the Lincolnshire ICS area is coterminous with the Lincolnshire Health and Wellbeing Board, 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. The agreed approach was to connect the strategies, avoiding duplication, or gaps, between the two. Each will maintain their own identity with the JHWS focusing on "what" the identified needs are; and the integrated care strategy setting "how" we collectively prioritise and address identified needs, as a system.

1.2 Engagement

Despite time constraints, a number of engagement opportunities to gather the views of partners and stakeholders were put in place.

a) Planning and Development Workshop

On 2 November 2022, a strategy, planning and development workshop was held with members of the ICP; HWB; district councils; representatives of primary care networks; and members of the voluntary and community sector. The purpose of the session was to ensure that every representative had:

- a high-level understanding of the health of the population in Lincolnshire;
- the opportunity to input into the ambition for the ICS to 2030, and the aims to 2025;
- clarity on the next steps in developing the integrated care strategy for December;
- an opportunity to discuss the transition into action and delivery.

Stakeholders feedback on the emerging ambition for the Lincolnshire system:

- People agreed that **health outcomes are driven by social factors and the wider determinants of health**. We need to pivot into preventions – knowing that skills, education, employment, housing, crime etc. are key factors.
- People want this group to address the **long-term strategy** and act. But acknowledged, we cannot tackle it all at once -there is a need to focus on key priorities.
- The categorisation of children and young people; working age adults and older people was the best way of ensuring we prioritise each group with a targeted approach.
- At the moment, **the health and care system focusses on symptoms, not causes.**
- People recognised the correlation between **areas with the poorest health outcomes** and **the greatest challenges delivering services**
- It was agreed, whatever the priorities, we **must engage the public** and do so as a partnership.

The workshop identified the following as key enablers for the Lincolnshire system:

- **Workforce is a critical enabler for all** and must be prioritised now and in the long term. Growing Lincolnshire's own, starting in schools, in communities; and working to retain talent already in the system.

- The **importance of intelligence and data.** At both an organisational, and at individual level, this allows people to make better decisions, better use of resources, and avoid duplication.
- **Communities must be at the core of any approach taken**. Shared outcomes and ambitions, with a shared language. We need strong empowered communities that exhibit self-help and self-responsibility. Education and wellbeing are key. Covid-19 brought communities together, we need to harness that.
- Underpinning this are effective **communication, engagement,** and **involvement** of residents, in the vision and creation of what good health outcomes and health and care services looks like, long term and shift the relationship and conversations between people, professionals and the health and care system to one which focuses on people's strengths and assets and 'what matters to them'.

b) Integrated Care Partnership Strategy Involvement Group

A Strategy Involvement Group was established and is meet monthly from October through to December. The group provided support for the development of the strategy with a focus on providing direct advice and input to help shape the strategy by facilitating wider engagement, involvement, and input, across the member's own networks.

The group comprises membership from:

- Lincolnshire Voluntary Engagement Team
- Lincolnshire Care Association (Linca)
- Lincolnshire County Council
- Lincolnshire District Councils
- Primary Care Committees
- Lincolnshire NHS organisations

c) Enabler Leads

Within the national guidance on the preparation of integrated care strategies a number of proposed enablers are identified as possible areas of focus for the strategy. Key strategic officers were engaged to support the provision of content for the enabler sections of the strategy. Engaging with enabler leads ensures alignment of interests for the ICS.

d) JHWS Priority Leads

Meetings with the JHWS Priority leads have taken place to ensure alignment between the JHWS and the emerging integrated care strategy. This work involves JHWS governance arrangements to be reinvigorated and strengthened to ensure appropriate mechanisms are in place that provide assurance to both the HWB and ICP.

2. Interim Integrated Care Strategy

The Interim Integrated Care Strategy has been added as an Appendix to the document however the key elements of the Strategy are as follows:

<u>Ambition and Aims</u>

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 our ambition, the strategy defines four aims that set our 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 our progress against them.

The shared aims are:

- To focus on prevention and early intervention
- To tackle inequalities and equity of service provision to meet population needs
- To deliver transformational change in order to improve health and wellbeing
- To take collective action on health and wellbeing across a range of organisations

Priority Enablers

The ICP strategy sets out the priority enablers the Lincolnshire health and care system and its partners will focus their integration efforts on to deliver these aims and overarching ambition. These were identified at the workshop at the start of November and continued to be refined as the strategy developed.

The priority enablers are:

1. Population Health and Prevention is the 'golden thread' that runs through the strategy and underpins the focus on improving health and wellbeing and tackling inequity.
2. Workforce and Skills is a critical enabler but there is an existing and growing demand that cannot be met by the current working age population.
3. Personalisation and Personalised Care, greater integration provides an opportunity to enhance choice and flexibility for people who use health and care services, and the people that provide them.
4. Community Engagement and Involvement will play a vital role in enabling communities to flourish and to ensure that residents are able to be healthy and live well.
5. Information and Information Systems will be key in supporting behaviour change by informing and support the delivery of care, decision making and enabling better outcomes for people.

3. Timescales and Next Steps

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.

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.

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

The risk of not meeting our legal duties to have developed and published an Integrated Care Strategy by March 2023.

5.	Financial/Resource Implications
None identified	

6.	Legal, Policy and Regulatory Requirements
The Health and Care Act 2022 requires the Lincolnshire Integrated Care Partnership (ICP) 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.	

7.	Health Inequalities implications
A key aim of the strategy is to address health inequalities in Lincolnshire	

8.	Equality and Diversity implications
An Equalities Impact Assessment is being conducted on the process for developing the strategy	

9.	Patient and Public Involvement (including Communications and Engagement)
The next step in the development of the Strategy is to engage with the public and key stakeholders during 2023. The plan for this engagement will be presented at the Integrated Care Partnership meeting in March 2023.	

11.	Report previously presented at:
Not applicable	

12.	Sponsoring Director/Partner Member/Non-Executive Director
John Turner NHS Lincolnshire ICB, Chief Executive and ICP Vice Chair of the Lincolnshire Integrated Care Partnership Councilor Sue Wooley, Chair of the Lincolnshire Integrated Care Partnership	

Lincolnshire COUNTY COUNCIL

NHS Lincolnshire Integrated Care Board

Better Lives Lincolnshire

Integrated Care Partnership Strategy

January 2023

Contents

Foreword

There is a long history of joint working in Lincolnshire between the Local Authority, the NHS, and wider partners. We have worked hard to build the relationships needed to support the people of Lincolnshire to enjoy the highest quality health and wellbeing for themselves, their families, and their communities. We are pleased with the progress we have made and are confident we have developed the right principles and values to guide us.

However, we know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. We also know that to have the best chance of achieving this we need to think and work differently with each other and with our communities.

To help guide us in our work we have developed a shared ambition…

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

Underpinning our ambition, we have defined four aims. These have been set out within this document, aligning with those defined nationally for Integrated Care Systems. However, they are specific to Lincolnshire as they were identified through the engagement process led by the Lincolnshire Health and Wellbeing Board to develop its Joint Health and Wellbeing Strategy.

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

We encourage you to adopt and use this strategy in whatever way you can to further improve the health and wellbeing of the people of Lincolnshire.

Cllr Sue Woolley
Chair of the Lincolnshire
Integrated Care Partnership

John Turner
Vice-Chair of the Lincolnshire
Integrated Care Partnership

Introduction

The Lincolnshire Integrated Care Partnership (ICP) is a joint committee of Lincolnshire County Council and NHS Lincolnshire Integrated Care Board (ICB), and includes representatives from the District Councils in Lincolnshire, NHS provider organisations, Healthwatch Lincolnshire, voluntary and community sector, higher education, Lincolnshire Police and Crime Commissioner, Greater Lincolnshire Local Enterprise Partnership (LEP), Lincolnshire Police and NHS England.

The Lincolnshire ICP is the forum for the organisations that make up the Lincolnshire Integrated Care System (ICS), known as 'Better Lives Lincolnshire', to come together as equal partners to plan actions in support of the delivery of integrated health and care, and overall ambition and aims of the system.

Lincolnshire County Council is still required to maintain the duty to have a Health and Wellbeing Board (HWB) as a committee of the council, with responsibility for the Lincolnshire Joint Health and Wellbeing Strategy (JHWS). Therefore, as a health and care system with only one HWB and one ICS, the functions of the Lincolnshire ICP with the Lincolnshire HWB are aligned wherever practicable.

Together, the organisations of Better Lives Lincolnshire have developed Lincolnshire's first integrated care strategy, with an approach focused on 'connecting' it to the JHWS, avoiding duplication or gaps between the two. Each will maintain their own identity with:

- **The Joint Health and Wellbeing Strategy**
  The JHWS for Lincolnshire continues to focus on 'the what' i.e. the priority areas the health and care system will focus on in light of the Joint Strategic Needs Assessment (JSNA); and
- **The Integrated Care Partnership Strategy**
  The ICP Strategy sets out 'the how' i.e. the key enablers the health and care system will focus integration efforts on to support delivery of the JHWS and its priorities, and the system's overarching ambition and aims.

The first two chapters of this document provide an overview of health and wellbeing in Lincolnshire together with an overview of Better Lives Lincolnshire's ambition and aims. The remainder of the document then focuses on the priority enablers which, together with the priorities set out in the JHWS, will underpin their delivery.

When reading this strategy, it should be acknowledged that 2022 to 2023 is a transition period for our ICP, and we expect that we will want to refresh and develop this strategy as our arrangements evolve. However, in order to influence the Lincolnshire NHS ICB's first 5-year forward plan (to be published before April 2023) we are required to publish an interim strategy.

The level of engagement for this interim strategy is therefore reflective of this timescale, and it is fully expected that engagement will increase as the Lincolnshire ICP matures and the strategy develops.

Health & wellbeing in Lincolnshire

Population overview

- Lincolnshire is the fourth largest county in England covering an area of 5,921 sq. km.
- It is predominately rural, with no motorways, little dual carriageway and 80km of coastline.
- Residents are dispersed across the city, market towns, rural and coastal areas

Population

Lincolnshire is a largely rural county with a resident population of 768,400 (Census 2021), with a 49% male and 51% female breakdown. Lincolnshire has an ageing population with 23% of residents over the age of 65. It has an older population than a lot of other authorities (27th out of 174 upper tier local authorities), and the highest level of care homes in England (293).

The diversity of the population has increased in recent years as a result of new and emerging communities. In the 2021 Census, 89% of residents identified themselves as White British and a further 6.7% as White Other - this is primarily made up of Eastern European communities.

Deprivation

In 2019, the Index of Multiple Deprivation (IMD), which shows overall deprivation, ranked Lincolnshire 91st out of 151 upper-tier local authorities in England, where 1st is the most deprived. Levels of deprivation vary across the county, which has an influence on health and wellbeing needs.

The general pattern in deprivation across Lincolnshire is in line with the national trend, in so much that the urban centres and coastal strip show higher levels of deprivation than other parts of the county. The Lincolnshire coastline, particularly the towns of Skegness and Mablethorpe, are the most deprived 10% of neighbourhoods in the country.

Health

The Director of Public Health Annual Report 2019 (lincolnshire.gov.uk)

Ischemic heart disease (IHD) is by far the highest cause of death in Lincolnshire, followed by lung cancer, stroke, chronic obstructive pulmonary disorder (COPD) and Alzheimer's. The main conditions that result in death have remained largely unchanged in the last 30 years, with the exception of Alzheimer's disease, which has increased and been in the top five conditions from 2002 onwards.

The number of years people are living with a disability in Lincolnshire has increased over the last 30 years, and Lincolnshire's rate is increasing more quickly than regionally and nationally. The main causes of living with a disability in Lincolnshire are low back pain, headache disorders, depressive disorders, neck pain and age-related hearing loss. These top five conditions have remained unchanged since 1990.

Disability adjusted life years (DALYs) compare the overall burden of disease, viewing death and disability in equal measures. The greatest causes of these in Lincolnshire are IHD, low back pain, COPD, stroke and lung cancer. These top five causes have remained unchanged for the last 30 years; however there have been decreases in lung cancer, stroke and IHD. Increases have been seen in low back pain and COPD.

For the overall burden of disease, the majority of Lincolnshire's risk factor exposure and attributable 'risk' is classified as 'behavioural' at just over 50%. This is important in shaping prevention and intervention activities.

Whilst life expectancy has increased for the people of Lincolnshire, those extra years of life are not always spent in good health. An increasing proportion of people are living with multiple long term conditions, some for decades. The combination of an older and further ageing population, rural geography and areas of high deprivation defines the specific challenge of delivering high-quality and effective health and care across the county.

Education, employment and skills

Greater Lincolnshire Local Skills Report_January 2022.pdf (greaterlincolnshirelep.co.uk)

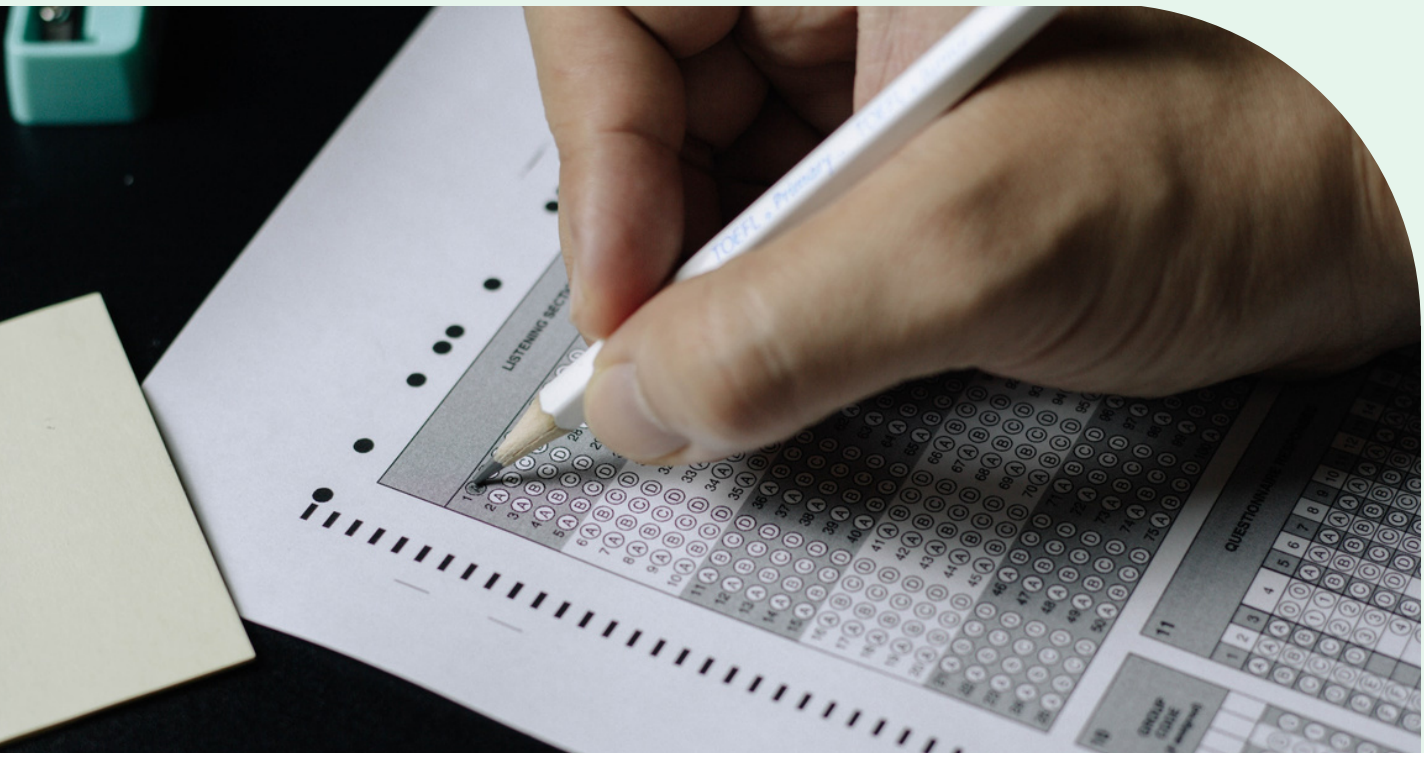
Education, employment and skills levels are key determinants of social-economic outcomes and can play a pivotal role in a person's health and wellbeing. They can influence social mobility, economic independence, housing and income levels.

Lincolnshire's school level attainment is broadly in line with national figures, and above regional figures at GSCE level, and above both national and regional figures at 'A' level. School leaver and graduate retention locally is known to be a challenge with the perception of more opportunities in larger cities within easy reach of the local area such as Peterborough, Nottingham, Sheffield and Hull.

Within certain groups (aged under 25 and over 50) in Lincolnshire unemployment rates remain high and despite progress, skills gaps still persist. Rurality and access to employment opportunities are barriers in some parts of Lincolnshire.

The proportion of residents aged 16-64 who have no qualification is slightly above the national average, with areas with the highest proportion of residents with no or low qualifications being concentrated to the East. More than 30% of residents in Skegness and Mablethorpe have either no qualification or are qualified to NVQ level 1. Some of these patterns are observed hyper locally within small pockets across the county.

The proportion of residents of working age qualified at NVQ Level 4+ is around 10% lower than that nationally, however the proportion of residents aged 25-39 with a level 4 qualification or above is around 20% lower than that nationally.



Housing

Lincolnshire Homes for Independence.pdf (research-lincs.org.uk)

Lincolnshire has 333,600 households. It is estimated that of the private housing stock 18% have a serious hazard likely to cause illness or harm, 17% are low-income households, 10% have fuel poverty, 9% have falls hazards and 9% have excess cold.

Lincolnshire has high rates of fuel poverty, particularly in deprived areas where the quality of the housing tends to be poorer and in rural areas where properties are often not connected to mains gas. Poor quality, cold or overly hot housing can cause or exacerbate acute and chronic health issues leading to increased visits to GPs, hospital admissions or reliance on medications.

There is a shortage of housing for older people, and a significant shortage of housing for sale or shared ownership compared to those for rent. There is also a shortage of housing with care, both for rent and for sale, including extra care / 'assisted living' schemes with 24/7 care available on-site and housing schemes that offer bespoke care services, even if these are not full on-site 24/7 care.

There are also around 200 caravan sites, and nearly 25,000 static caravans on the Lincolnshire coast (the largest concentration in Europe) with a permanent population of over 6,000 people. It is estimated c.30% of local caravan residents live with long-standing illness, disability or infirmity and nearly a quarter have health issues affecting mobility.

Overview of needs assessment

The diagram below provides an overview of the Lincolnshire Joint Strategic Needs Assessment (JSNA).

Our ambition and aims, and how we will deliver them

We want the people of Lincolnshire to enjoy the highest quality health and wellbeing for themselves, their families and their communities, and we are dedicated to working with them to achieve this. We are changing the ways we are working together and are committed to becoming one of the better health and care systems in the country.

The emerging shared ambition for Better Lives Lincolnshire, by 2030, is a simple one…

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

Underpinning our ambition, we have defined four aims that set our strategic direction up to 2025. For each of these aims a set of measures has been defined to demonstrate our progress against them.

These aims are:

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

The approach to developing this ICP strategy for Lincolnshire has been to 'connect' it to the JHWS, but with each maintaining its own identity:

- The Joint Health and Wellbeing Strategy continuing to focus on 'the what'.
- The Integrated Care Partnership Strategy setting out 'the how'.

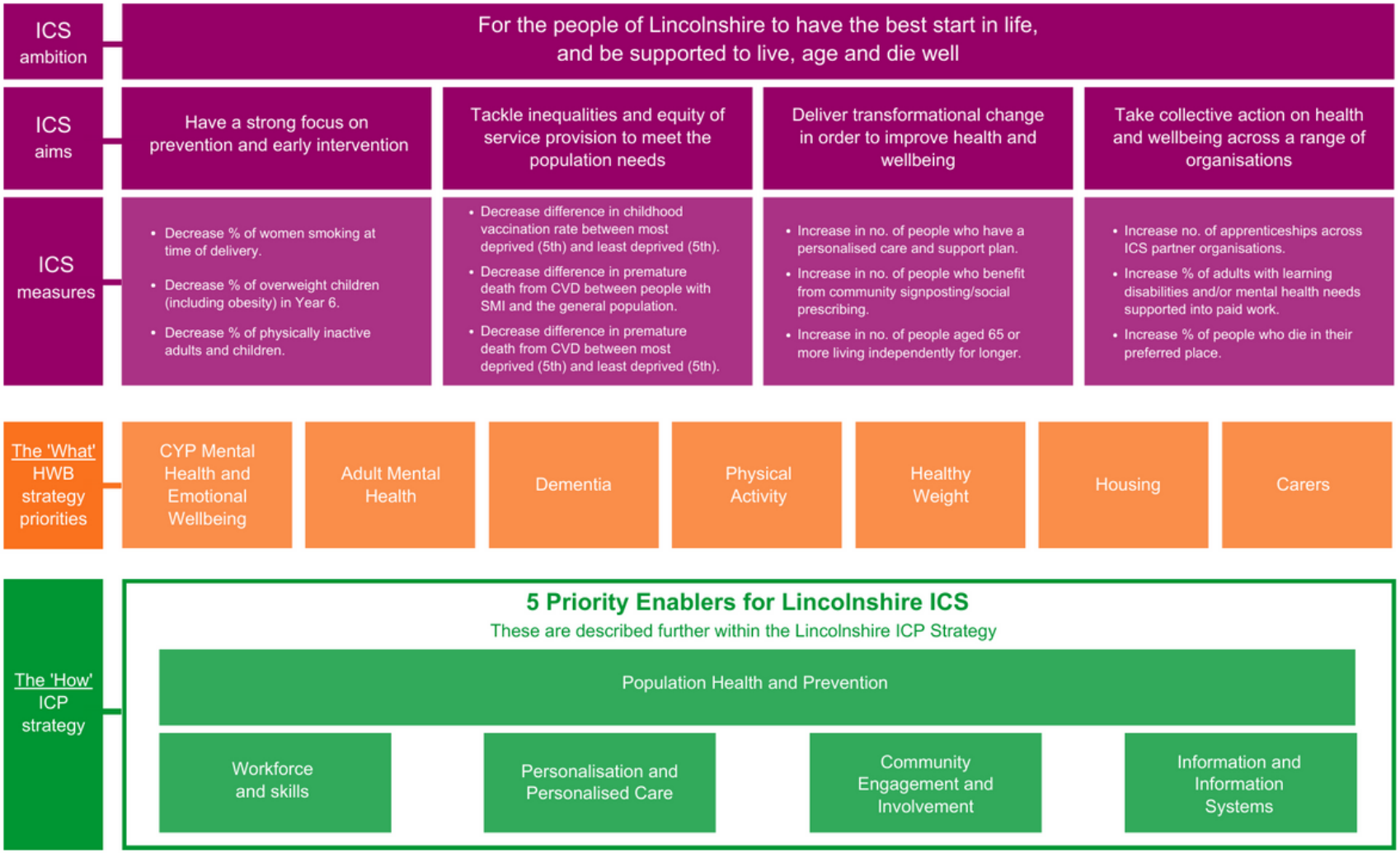
Together these two strategies set out the approach we will take to deliver the ambition across our system. This ICP strategy sets out the priority enablers the Lincolnshire health and care system and its partners will focus their integration efforts on to deliver these aims and overarching ambition.

These priority enablers are:

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

The Better Lives Lincolnshire 'Strategy Map', which reflects this approach, is set out on the following page.

Better Lives Lincolnshire 'Strategy Map'



Priority enabler 1: Population health and prevention

Population health and prevention is the 'golden thread' that runs through the Better Lives Lincolnshire strategy and underpins its focus on improving health and wellbeing and tackling inequity.

A person's physical and mental health and wellbeing are influenced throughout life by a diverse range of social, economic and environmental factors, known as the wider determinants of health. Addressing the wider determinants of health will help improve overall health by helping to improve the conditions into which people are born, live and work. Addressing these determinants throughout the life-course allows us to consider the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

This life-course approach underpins how we plan to deliver the priorities set out in the JHWS, recognising that:

- There are a wide range of protective and risk factors that interplay in health and wellbeing over the life span.
- By altering policies, environments, and societal norms, inequalities affecting the life course trajectory can be reduced, which could benefit the whole population now and in the future.

This means taking action:

- To protect and promote health during important transition periods early and appropriately across the life course.
- To create healthy environments and improve conditions of daily life together as a society.
- To reduce health inequalities throughout the life-course.

In line with the life course model, our delivery of this enabler will focus around four themes:

Theme 1: Preconception, infancy and early years (0 - 5)

Theme 2: Childhood and adolescence (5 - 19)

Theme 3: Working age (16 - 64)

Theme 4: Ageing well

Theme 1: Preconception, infancy and early years (0 - 5)

What happens during pregnancy and the first few years of life influences physical, cognitive and emotional development in childhood and may influence health and wellbeing outcomes in later life. In addition to the critical events that shape an individual's health trajectory, the number and sequence of exposures to risk and periods of increased susceptibility, some of which occur before birth or are genetically inherited, are also crucial.

The preconception period presents an opportunity for professionals to encourage women and men to adopt healthier behaviours in preparation for a successful pregnancy and positive health outcomes for both themselves and their child. We will therefore focus on interventions such as:

- Being aware of screening before or during pregnancy.
- Being up to date with all vaccinations before and during pregnancy.
- Taking folic acid supplements.
- Eating a healthy diet and being physically active.
- Giving up smoking, and reducing or stopping alcohol consumption.
- Expanding oral health promotion activities.

The earliest years of life set the tone for the whole of the lifespan. There is strong evidence that intervening in the first 1,001 days of a child's life can make a difference over their whole lifetime. During this period the brain displays a remarkable capacity to absorb information and adapt to its surroundings.

Positive early experience is therefore vital to ensure children are ready to learn, ready for school and have good life chances. It is shaped by several factors such as sensitive attuned parenting, effects of socio-economic status and the impact of high-quality early education and care.

Improving children and young peoples' mental wellbeing will have a positive effect on their cognitive development, learning, physical health, and their mental health, social and economic prospects in adulthood. It is known that poor social and emotional well-being in young children can lead to behaviour and developmental problems and, later in childhood, severe depression, anxiety, self-harm and other poor mental health outcomes.

The areas we will focus interventions on include:

- Improve speech, language and communication skills in the under 5s.
- Prioritise early intervention through additional investment in children's centres and family hubs.
- Increase uptake of childhood vaccinations.

Theme 2: Childhood and adolescence (5 - 19)

Children and young people face many new challenges and experiences as they grow and develop; part of growing up includes experimenting and trying new things, but adolescence can be a very difficult time for some. We know that approximately 1 in 7 young people experience at least one mental disorder, and emotional disorders – such as anxiety and depression – can be commonplace. If left unaddressed, these problems often persist into adulthood.

Adolescence, defined as the transitional phase between childhood and adulthood, is a time when young people begin developing habits that will carry over into adulthood. Healthy behaviours initiated in childhood, such as physical activity and healthy nutrition, should be maintained during adolescence.

In light of this we will focus our interventions in the following areas:

- Tackling vulnerabilities and adverse childhood events (ACEs) and safeguarding children.
- Supporting young people's mental health and emotional wellbeing.
- Improving educational attainment.
- Tackling tobacco, alcohol and drug use.
- Increase the motivation, confidence and physical competence in relation to physical activity.
- Reducing the number of teenage pregnancies and improving outcomes for young parents and their children.
- Increase uptake of school-age vaccination.

Theme 3: Working age (16 - 64)

Emphasis on a good start in life does not mean that actions at later stages of the life course are not important. Adulthood is an important time for building assets, reducing risks and intervening early.

This stage is crucial as it is a time of significant opportunity to build resilience for later life, to reinforce the improvement in skills and individual empowerment provided by a good start but also to achieve greater health equity among the existing adult population. In particular, it is essential to reduce stress at work, reduce long-term unemployment through active labour-market programmes and address the causes of social isolation. Throughout this period, professionals can ensure that they make every contact count and use everyday interactions with people to support them in making positive changes to their physical and mental health and wellbeing, as well as promoting services such as the NHS Health Check.

The NHS Health Check offers an opportunity to assess the top 7 risk factors driving premature death and disability in England among 15 million people in midlife. This includes pulse rhythm, blood pressure and cholesterol. They are also supported to understand their risk of Cardiovascular Disease (CVD) and make positive behavioural changes that can prevent and delay the onset of CVD. For example, everyone having an NHS Health Check should benefit from personalised support and where appropriate access to services, such as stop smoking, weight management, physical activity, alcohol support and diabetes prevention.

We will therefore focus on interventions such as:

- Working with employers to grow a healthier, highly skilled workforce.
- Improving wellbeing and mental health.
- Preventing musculoskeletal (MSK) conditions by helping people stay fit, active & healthy.
- Improving uptake of screening 7.

Theme 4: Ageing well

There has been a steady increase in average life expectancy in recent decades, albeit increases have slowed considerably since 2011. This is a public health success story. Longer lives are a benefit to society in many ways, including financially, socially and culturally, because older people have skills, knowledge and experience that benefit the wider population. There is an opportunity to utilise this increased longevity as a resource, whilst challenging ageism and the view that retirement is about 'sitting more and moving less'.

The older a person is, the more likely they are to experience chronic diseases and disabilities of both the body and brain. As life expectancy rises, we must promote the concept of productive healthy ageing; improved health and wellbeing, increased independence and resilience to adversity, the ability to be financially secure through work and building resources, engagement in social activities, being socially connected with enhanced friendships and support, enjoying life in good health.

The areas we will focus interventions on include:

- Improving access to good employment.
- Protecting health through improving housing and the built environment.
- Increasing awareness and uptake of vaccinations.
- Maintaining functional ability: brain and body health.
- Preventing falls.
- Preventing loneliness and social isolation.

Priority enabler 2: Workforce and skills

Public sector employment, including health and care, underpins the local economy in Lincolnshire. The health and care sector is vital for employment locally, and we know through work led by the Greater Lincolnshire LEP there is an existing and growing demand for workforce and skills levels that cannot be met by the current working age population.

Occupations reporting the highest volume of vacancies in 2020 were nurses and care workers (5.9% and 5.7% of job postings respectively). Data for 2021 shows nursing and care occupations continuing to report the highest number of vacancies and a recent, but increasingly frequent issue reported by employers is the lack of care staff with the ability to drive. Data in January 2022 suggests caring occupations continue to be one of the toughest roles to fill.

Pre-COVID, long term forecasts indicated that nationally health and social work will be an employment growth sector, with health and social care associates, health professionals, and caring personal service occupations the top three growth occupations. This presents future opportunities at a range of skill levels including occupations requiring degree level education. However, 'replacement' demand is likely to be the biggest challenge faced in the coming years.

An ageing and retiring population across Lincolnshire is projected to account for approximately 90% of replacement demand over the next decade, with the remainder being the result of new positions being created. Additionally, new technologies are shifting the demand for labour towards higher skilled occupations – especially in terms of digital skills. In order to stay competitive in the labour market,

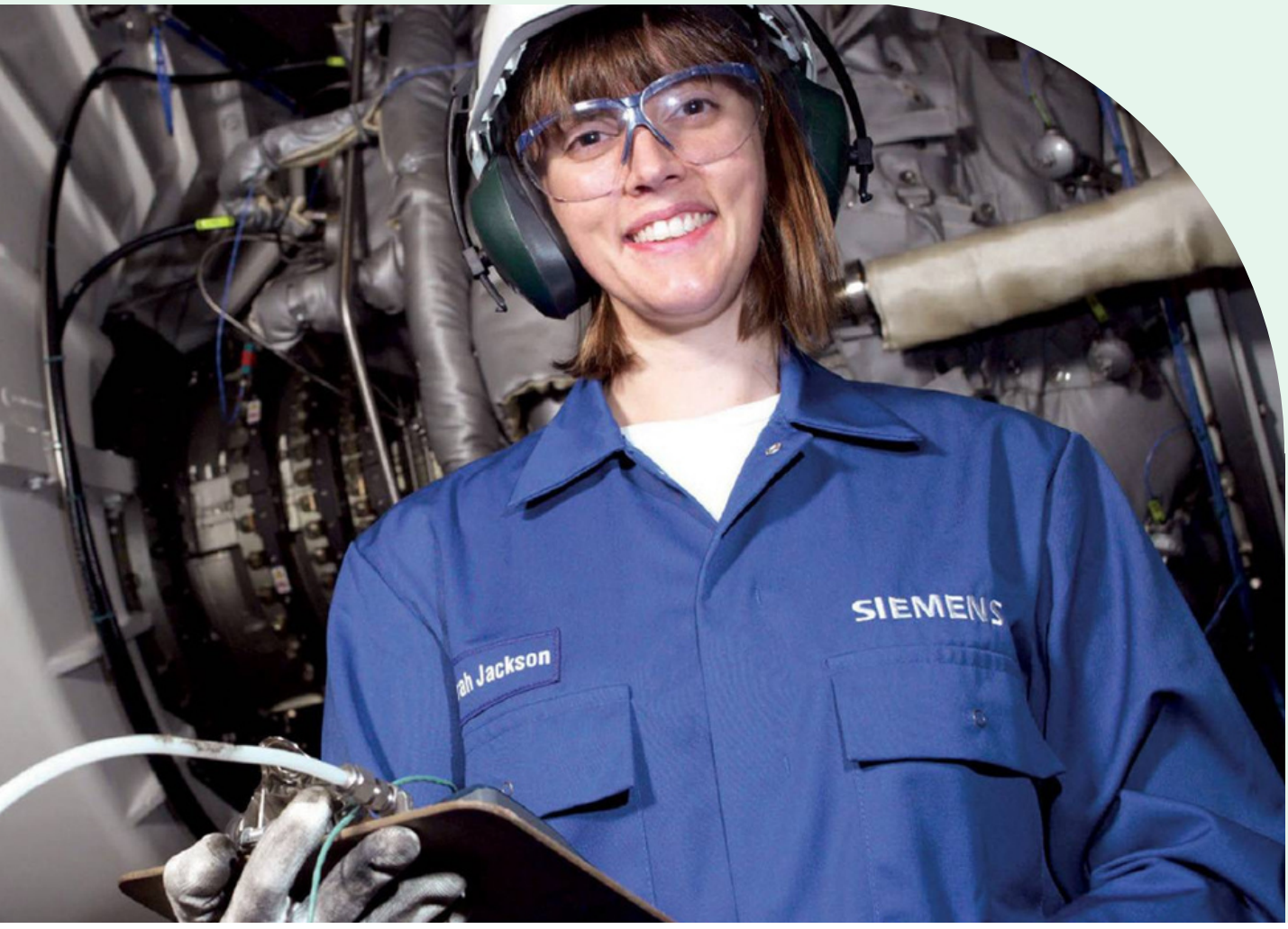
residents will need to retrain and upskill more often. Equally, working conditions and salaries will also need to be attractive to people to work in the health and care sector.

Our approach as an ICP to tackling these issues and delivering this priority is to integrate it with the work being led by the Greater Lincolnshire LEP Employment and Skills Advisory Panel, which identified two main skills themes:

Theme 1: To inspire and support young people to stay and work in the area

Theme 2: To train and support people who are already working, or seeking jobs, so they gain the skills needed to take up future job vacancies.

In addition to these themes the Lincolnshire health and care system People Board will also drive improvements specifically in health and care organisations, covering challenges such as recruitment and retention. This sits outside the direct scope of the ICP, however connections will be made as necessary to ensure work remains aligned, with particular consideration given to the Rural & Coastal Transformation Programme 'Developing health, care and communities through workforce, education and training'.



Theme 1: To inspire and support young people to stay and work in the area

The challenge of graduate and young-people retention is driven, in part, by a perception that the health and care sector within Lincolnshire does not offer sufficient career growth opportunities. The health and care sector is currently not understood sufficiently to inspire younger people about the career opportunities available on their doorstep. This can also lead to long-term worklessness due to a lack of awareness about local opportunities.

To meet the high replacement demand by health and care services within Lincolnshire, younger people (starting with primary school age children) need to be informed about the occupations, careers, and growth opportunities Lincolnshire can offer. As part of this, the links between the sector and jobseekers need to be supported and strengthened.

To support the delivery of this, working with partners, we will:

- Continue the expansion of the Enterprise Adviser Network across Lincolnshire - this will include ensuring Enterprise Advisers fully understand the careers and opportunities in the health and care sector so they feed into schools' career programmes, as well as looking to increase the number of Enterprise Advisers from the health and care sector who are able to showcase these organisations and opportunities to the local community.
- Use the Greater Lincolnshire Careers Hub to promote opportunities and careers in the local health and care system – this will include careers fairs, facilitating links between schools and the sector, organising experiences such as visits to the Lincoln Medical School and improving information held about local jobs and careers so young people can access it and feel informed.

Theme 2: To train and support people who are already working, or seeking jobs, so they gain the skills needed to take up future job vacancies

With job vacancies increasing locally and a shrinking workforce there is an immediate focus to support the health and care sector employers find new staff and retain those already in the workforce, in a wide range of occupations and at different levels.

Literacy and numeracy skills in Lincolnshire are below those seen nationally. With fewer jobs available for people with fewer basic qualifications, upskilling these people will allow them to participate more fully in the local health and care system labour market.

Apprenticeships provide an important route into skilled employment for young people, and so it's vital the local health and care system builds on the recent Apprenticeship Strategy and address the decline in numbers. This includes maximising the impact of apprenticeship budgets, including flexible apprenticeships, new levy transfer mechanisms, and incentives to increase apprenticeship opportunities for people of all ages.

Although digital skills have long been seen as crucially important, the need for such skills to avoid social and labour market exclusion has been emphasised by the COVID pandemic. There has been an increased preference for working, learning and engaging remotely on digital platforms.

To support the delivery of this working with partners we will:

- Develop skills priority statements for the local health and care sector that maximise future opportunities for local people and focus on upskilling and retraining workers.
- Raise awareness locally and nationally of the priorities from the recently published Apprenticeship Strategy, that are particularly relevant to the health and care sector, and take the actions forward.
- Ensure a quality online offer is available to maximise the uptake and delivery of this approach.
- Encourage businesses to develop workforce and skills strategies and implement them.
- Build on the recommendations of the Digital Skills Workshop to develop a plan specifically for the health and care sector e.g., finding new ways to bring learning to people and target intergenerational groups and create a digital skills strategy for the health and care sector.

Priority enabler 3: Personalisation

Personalisation is rooted in the belief that individuals want to have a life, not a service. It's a way of working that changes the conversation from 'what's the matter with you?' to 'what matters to you?'

There are three key messages that shape why Personalisation is so important and should be seen as a key foundation of our ICP:

- Our relationships - the balance of power between people and health and care professionals.
- Empowerment - respecting a person's right to lead their own health and wellbeing.
- Mindset - a way of working that changes the conversations and focuses on what matters to you.

Our aim is to shift the relationship and conversations between people, professionals and the health and care system to one which focuses on people's strengths and assets and 'what matters to them', providing a positive shift in power and decision making that enables people and those who are important to them to have more choice and control to be able to live their best, and healthiest life - the life that is important to them and their loved ones.

Central to this aim is working with people to co-produce a 'Shared Agreement' that describes an evolved relationship between our health and care system and the people of Lincolnshire that is rooted in partnership, personalised care and shared decision-making.

Our approach to delivering this priority is focused around three key themes:

Theme 1: Shared decision-making and 'What matters to you?' conversations

Theme 2: Supported self-care and self-management

Theme 3: Wellbeing, social prescribing, and community-based support

Theme 1: Shared decision-making and ‘What matters to you?’ conversations

As the complexity and uniqueness of the needs of individuals and carers have changed, and expectations towards health, care and wellbeing have evolved, we need to work together to ensure people have relevant information that’s meaningful to them and they are supported to make informed decisions.

Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a professional supports a person to reach a decision about their care.

The conversation brings together:

- The professional expertise such as care options, evidence, risks and benefits; and
- What the person knows best: their preferences, personal circumstances, goals, values and beliefs.

We need to work together to understand people’s strengths, their assets and their potential and support them to realise this by collectively working together to set realistic outcomes and goals, reducing a reliance on services and ensuring the right support goes to the right people at the right time.

To support this way of working, we are extending our approach to Personalised Care and Support Planning across the ICS. It is an umbrella term that covers the planning approaches that we use to have ‘What matters to you?' conversations with people.

We must also ensure the rights of the people we support are respected, and their wishes should always be at the forefront of our thinking. Intervention to safeguard and protect should be proportionate to the risk presented and sensitive to the need, where appropriate, for people to make their own decisions, even when that involves some risk.

'What matters to you?' conversations are a series of proportionate discussions that explore a person's whole life and family situation at any relevant point in time. Asking 'What matters to you?' aims to discover what's important to the person and their carers and to explore their strengths, wants, wishes and goals to live their best life.

Together, shared decision-making and 'What matters to you?' conversations can create a new relationship between people and professionals based on partnership and enable people to be central in making decisions about their own health, care and wellbeing.

To achieve this we will:

- Drive a change in the current culture and systems across the ICP towards shared decision-making and 'What matters to you?' conversations, working with people to make this happen.
- Prepare and support the people of Lincolnshire to feel confident in embedding personalised care and shared decision-making.
- Ensure strong professional and executive leadership, and that all relevant organisations ensure strength-based personalised care is an integral part of their recruitment, induction and training.
- Ensure a sustainable workforce programme in strength-based personalised care approaches that is accessible and tailored to the range of health, care and Voluntary, Community and Social Enterprise (VCSE) professionals across the system.
- Include personalised care and shared decision-making in local incentives, delivery and improvement plans, pathway redesign and assurance.
- Ensure everybody who wants a personalised care and support plan has one that they can view and that they can contribute to their own plans digitally.

Theme 2: Supported self-care and self-management

We will work with people to encourage, support, and empower them to manage their own physical and mental health conditions themselves.

Our vision is for everyone in Lincolnshire with an ongoing physical or mental health condition or conditions to be empowered to live their best lives.

Supported self-management is a way of working with people that uses approaches and tools to proactively identify the knowledge, skills and confidence people have to manage their own health, care and wellbeing, and to help them grow their expertise and confidence to be more independent.

We will do this through:

- A range of staff such as Health and Wellbeing Coaches, establishing one-to-one partnerships with individuals in their care and wellbeing. They will take a supportive and non-judgemental approach

to help people to become advocates for their own care so that they can achieve their health and wellbeing goals.

- Care Coordinators who work with people and their carers to ensure what's important to and for them and their personal goals are addressed, and that appropriate support is identified by creating a single personalised care and support plan. Care Coordinators bring additional skills, expertise and capacity into Primary Care settings, enabling the person to have more time to explore what really matters to them.
- Peer support, provided through a range of approaches, through which people with similar health and care experiences can support each other to better understand their recovery or self-management.
- Working with people to educate or train them to help develop the knowledge, skills and confidence they need to manage their own health and wellbeing effectively. This may be done independently or in partnership with the health and care system.
- Use of range of tools to have a better understanding of the individual's level of skills, knowledge and confidence to be able to better look after their own health and wellbeing.

Theme 3: Wellbeing, social prescribing and community-based support

Recognising that people's health and wellbeing are significantly influenced by a range of social, economic and environmental factors, through social prescribing and community-based support we will work with people in a holistic way and aim to support them to take greater control of these wider determinants of health and wellbeing.

We will enable health and care professionals to link the people they see with someone who will take the time to explore 'what matters to them'. Social Prescribing Link Workers are employed to support people to access non-medical services, including the diverse range of groups and support provided by the local community, voluntary and social enterprise sector.

We will ensure Lincolnshire has a sustainable and resilient social prescribing offer through jointly commissioning and supporting our voluntary and community sector. We will do this through Social Prescribing Lincolnshire, which is a group of social prescribing service providers that includes Voluntary Centre Services (VCS), Lincolnshire Community and Voluntary Service (LCVS) and Primary Care Networks (PCNs) that employ Social Prescribing Link Workers, with support from Lincolnshire Voluntary Engagement Team CIC (LVET). We will involve people with lived experience at every stage of development to co-design services and information.

We will work in an integrated way alongside other commissioned services such as healthy lifestyle support, carers service and Lincolnshire's Wellbeing Service. We will identify opportunities and take action to enhance community-based provision, digital development and support a diverse VCSE sector to thrive and flourish.

Priority enabler 4: Community engagement and involvement

Delivering the priorities set out in the JHWS cannot be done by the individual member organisations of the Lincolnshire ICP on their own.

Community support networks can play a vital role in enabling communities to flourish and play a vital role in ensuring that our residents are able to be healthy and live well.

Communities are usually best placed to solve the specific challenges they face. We can help to ensure that the right support and facilitation is in place. We want to see our communities being better able to bring about the changes they want to see.

This means we need to be clear how we will work with communities to:

- Remove unnecessary obstacles and bureaucracy; and
- Direct limited resources where they can have the biggest impact.

Our approach to delivering this priority enabler mirrors that set out in Lincolnshire County Council's 'Stronger Communities: Lincolnshire's Community Strategy', which consists of five themes. These are:

Theme 1: Consultation, engagement and collaboration

Theme 2: Community networks

Theme 3: Volunteering

Theme 4: Funding for our communities

Theme 5: Tools and data

Theme 1: Consultation, engagement and collaboration

We want to develop new ways of engaging and collaborating with our residents, communities and their representative groups.We want to make sure they have a strong voice at the table, the independence to act and solve problems and the ability to thrive. We will enhance our approach to engagement and involvement to make it even easier for people to share their views to ensure we can be more confident that what we are doing has the backing of our communities and taken into account a broad range of needs. To achieve this we will:

- Have more commonality around the way we work with our communities to hear their views and keep them up to date with the improvements that we are making.
- Have more community-based conversations. This will enable people to become more empowered and closer to the decisions that have the biggest impact on them.
- Be clear where we do not need to play an active role in decision-making. We appreciate that some decisions sit better with our communities and representative groups, but we will be able to provide expertise where necessary.
- Develop our relationships with community groups to influence our decisions and enhance the community voice in all that we do.
- Ensure our decision makers have access to more current and meaningful data about our communities and their wishes and aspirations.

Theme 2: Community networks

Enabling everyone to enjoy life to the full requires strong community networks. We know there are examples of where the local community and health and care system work really well together. We will:

- Set out and utilise a clear framework for engaging with community networks that represent adults, children and the places in which we live, work and play.
- Use these examples to shape the way we deliver services and improve the offer to communities.
- Do even more to develop our connections with, learn from and understand communities so that we have a shared understanding across the system.
- Develop clear engagement plans so that people know what we are working on and how they can get involved.

We will also work with communities to understand where our help and support can be best directed and what we jointly want to achieve. We will work with our partners and community groups to develop solutions in relation to prevention and health and care, and develop strong relationships to modernise the way our services are delivered.

Throughout the pandemic, we have seen amazing examples of communities working together to support each other, both in person and through innovative digital solutions We want to build on this to:

- Help communities become even stronger and more self-sufficient.
- Develop a better understanding of where communities are well placed to meet needs.
- Understand where gaps in provision exist.
- Be able to access community level expertise to help us to make informed decisions and better design our services.

We want people to know what is available and to be able to access it when they need it, irrespective of who the provider is. By working with communities we will be better able to develop solutions together that will improve the quality of life for our residents.

Theme 3: Volunteering

Volunteering has never been more valuable to Lincolnshire and our way of life. Nationally, in 2019, 19.4 million people engaged in volunteering activities through groups, clubs or other organisations. In 2019 and 2020, volunteer centres in Lincolnshire were able to attract over £1.5m of funding with 2,787 people supported to access volunteering. Through increasing the level of community participation we can help communities to become more self-sufficient and sustainable. We want to work with others to promote opportunities to volunteer and the benefits that volunteering brings.

We recognise people will volunteer for lots of different reasons, whether to gain new skills or simply to give something back. We want to work with those closest to communities to improve opportunities for skills development through volunteering.

This is often a really effective way of helping somebody to:

- Take the first steps into employment.
- Gain the confidence and experience that they need to thrive.

We will develop more robust arrangements by working across sectors to support training, personal development, and volunteering opportunities to help our communities to thrive.

We also know that those working within Lincolnshire's health and care system often volunteer within their local communities. They utilise their time, skills and expertise to help others. We want to celebrate and support this amazing contribution and encourage more to come forward. As part of this we will encourage our partners to get involved and support community initiatives.

Theme 4: Funding for our communities

One of the ways that we invest in communities is through grants to groups and organisations. These often provide valuable support to our residents at a time of need or crisis. Recently we've seen an increased need for these services due to the impact of the pandemic on people's health and wellbeing.

We will work collectively to review the effectiveness of our current approach by looking at how funding to voluntary sector infrastructure bodies is used to identify opportunities to learn from best practice, deliver better outcomes for our communities, and get the best use of the Lincolnshire pound.

We will engage nationally and aim to attract more money into Lincolnshire, and look for opportunities to target funds to those most in need and achieve the maximum impact. We will enhance the content of the Lincolnshire funding portal and work with groups to ensure they:

- Are aware of the funding that is available to them from others.
- Can access the help that is available on how to secure additional financial support.
- Can evidence the social value that grant funded activities deliver within Lincolnshire.
- Are able to demonstrate scalable solutions that tackle the challenges faced in different parts of the county.

Theme 5: Tools and data

We know communities increasingly want more open dialogue with us through a range of mechanisms. To achieve the ambitions set out above, we need to invest in our teams so they have the right tools to support high quality engagement and are able to capture data and analyse it to share meaningful insights. We will continue to train and develop our teams so that they can apply best practice techniques and advise others on how to gain the maximum benefit from engagement activities.

This, together with the new technologies, will enable us to:

- Embed new approaches to engagement.
- Improve information sharing practices to ensure improved insight and shared understanding of needs or views.
- Standardise our approach and increase the number of people to participate in dialogue with us.
- Support us to develop policies and practices that have the voice of communities at their heart.

Priority enabler 5: Data and Information Systems

The plans and actions of the Lincolnshire ICP will bring about significant changes in the way individuals receive care. Service users together with those organisations involved in the provision and delivery of health, care and wellbeing will all need to behave differently to achieve the improvements to which we aspire.

Data and Information Systems will be key in supporting behaviour change by informing and supporting the delivery of care, decision-making, and enabling better outcomes for people.

Our focus on information and information sharing falls into two themes:

Theme 1: Supporting people

Theme 2: Supporting health and care professionals

A comprehensive integrated data set, which pulls together information from partners across the Lincolnshire ICS, is required to underpin both of these themes.

Theme 1: Supporting people

There is significant potential for the transformation of health and social care through better widespread use of digital technologies. This includes a growing role for technology in supporting people to monitor and manage their own health and wellbeing and also enhancing people's experience of accessing services.

Access to own care record and care plan

To truly be empowered, people will require access to their own care record and care plan, containing a summary of their care information from their care coordinator and the providers they have come in contact with. The individuals themselves might also contribute to their care record and care plan by adding information.

Self-management

Digital health provides the ability to offer a personalised approach to self-management via digital tools that support people to live well in their communities and enable access to the right support and services tailored to the individual's needs. Teams supporting people can also interact with patients through the same digital service, allowing them to deliver new care pathways and better meet people's needs.

Communication and engagement with professionals

To help individuals take more ownership in their care and rely less on in-person interactions with care professionals it is useful to send them reminders and updates via e-mail, text message or mail at appropriate times. It is also helpful for users to have an effective way to communicate remotely with care professionals, particularly their Care Coordinator. While such interactions could happen via telephone, more sophisticated online approaches need to be considered.

Access to information online

People might need to get information on topics such as information and advice, services available and activities and events.

Theme 2: Supporting health and care professionals

New and more integrated ways of providing care will require local health and care professionals to act and behave in different ways. This will include working with local people, carers and their families so they are more empowered to set their own care goals and manage their own wellbeing, being part of a multi-disciplinary team and delivering more responsive and proactive care.

Population analytics

To be as effective as possible in their role, health and care professionals require a thorough understanding of the needs and activity of their population as well as the costs associated with it.

Population segmentation

A core part of having a good understanding of the population is to have an effective approach to group the population, to support care for specific groups. We will therefore ensure health and care professionals are able to segment the Lincolnshire population and understand health, care and wellbeing needs, activity, outcomes and costs for each group defined.

Performance analytics

We will establish approaches to enable health and care professionals to monitor the performance of the local health, care and wellbeing providers (and associated networks, collaborations and alliances) that care for the local population in an integrated way, in particular monitoring the outcomes delivered as well as other agreed indicators and parameters.

Service user identification

Local care teams will be required to support specific population groups and we will support them to employ a granular approach, such as risk stratification, to identify specific service users that they will need to focus more attention on.

Service user registry

To support an effective and truly integrated delivery of care, we will make sure local care teams have access to an accurate summary of information for each individual in their care, with input from all providers of health and care services, as well as service users themselves.

Care planning

We will make sure local Care Coordinators have the ability to create a care plan and review progress and results. This care plan will shape the integrated care that the individual will receive, ensuring its appropriateness and timeliness. As part of the care planning process, access to a library of care protocols will be made available to support decision-making and ensure that the care plan being created is in line with relevant guidelines and best practices.

Intervention management capability

We will ensure local care teams are alerted to relevant events so they can respond to the specific needs of individuals in a timely fashion. This could include alerts issued when an individual requires an intervention (e.g. vaccination reminders), based on recent events (e.g. discharge from hospital) or on a "care gap analysis".

Delivery analytics

We will make sure local care teams are able to regularly monitor and review the care they are delivering multiple times a week so the progress and impact of the care delivered to specific individuals and groups is fully understood. These types of reviews will need to be informed by ad hoc analytics that track metrics tied to specific care plans and models and are therefore different from the higher level outcome and service standard indicators determined by commissioners or the provider organisation.

Remote monitoring capability

In line with our objectives to support user empowerment and the ability of individuals to receive appropriate care in their home and, where appropriate, to self-manage, we will ensure local care teams have the ability to monitor certain service users remotely.

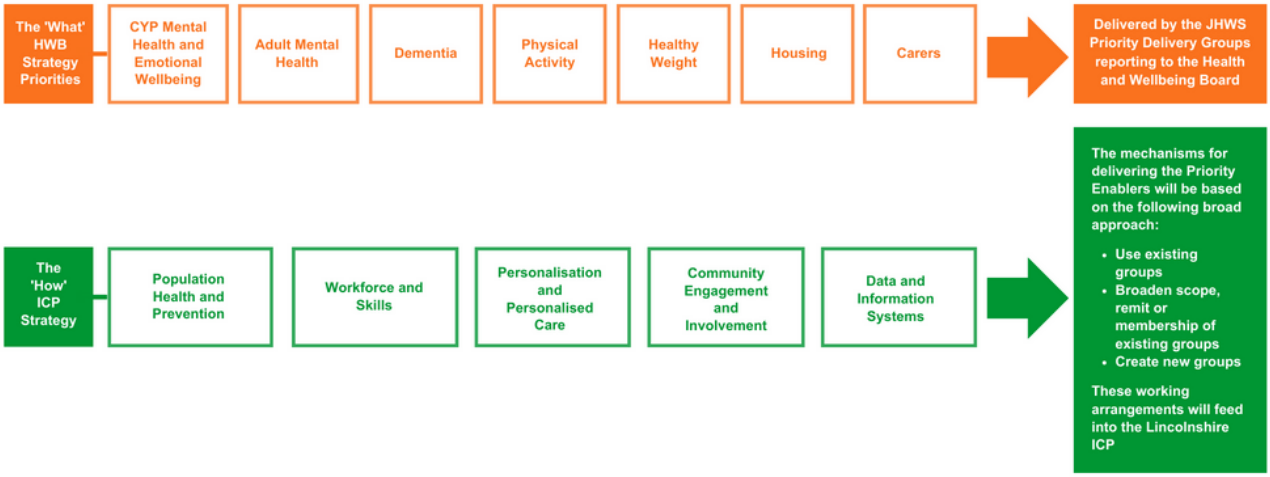
Delivering the strategy

This strategy is not intended to serve as an action plan. The Lincolnshire ICP will have oversight for the delivery of this strategy as a whole including establishing next steps, objectives and targets, results anaylsis and the appropriate governance arrangements to assure upon the delivery.

Three broad approaches will be used to initially establish the priority enabler working groups to deliver this interim strategy:

- Use existing groups.
- Broaden the scope and/or remit and/or membership of existing groups.
- Create new groups.

An overview of the governance and delivery arrangements for the JHWS and ICP Strategy are set out below.



Given 2022 to 2023 is a transition period for our ICP, we expect that we will want to refresh and develop this strategy and its delivery arrangements as our plans and thinking evolve.

Once the JSNA is republished in March 2023, further engagement and development will take place to refresh the JHWS for Lincolnshire and inform further development of the Integrated Care Strategy. Both strategies will be produced by December 2023.

Appendix 1: Joint Health and Wellbeing Strategy for Lincolnshire priorities

Mental Health – Adults

A significantly high number of adults are affected by poor mental health, ranging from anxiety through to more severe forms of mental illness. Data demonstrates need is worse in some areas when compared to regional and national data (depression rates, self-reported wellbeing). There is a worsening trend, exacerbated by the pandemic, with a high level of need making mental health a priority both locally and nationally. There is strong evidence of the impact of preventative action in terms of improvement in health outcomes (wider determinants, homelessness, substance abuse, etc.) and/or delaying or preventing the need for other services. Treatment and recovery outcomes improve with early intervention.

Mental Health & Emotional Wellbeing - Children and Young People

Prior to the pandemic, 1 in 10 children and young people were affected by emotional/mental health issues, as well as the effects on the wider family/population at large. The pandemic was challenging for children and young people and has increased needs (Source: Director of Public Health Report 2021). Comprehensive evidence exists showing the benefits of a preventative approach to supporting the Mental Health and Emotional Wellbeing of children and young people. It includes both benefits on an individual level (positive health outcomes of early/preventative action) and in terms of service savings/reduced costs of early intervention.

Dementia

Evidence shows that the early detection and management of dementia reduces the escalation of health and care needs. Whilst there is no evidence that preventative action can stop dementia from developing, risks can be identified, and action taken (e.g. exercise and reducing alcohol intake) so that onset is delayed. There are improvements in terms of quality of life if dementia diagnosis and management is at an early stage. Dementia is a strategic priority locally and nationally. Trend data suggests that it is a growing problem and with an ageing population in Lincolnshire, dementia diagnosis, management and support is a clear priority for the HWB given that age is the main determining factor for dementia.

Healthy Weight

Being overweight or obese is associated with increased disability, reduced quality of life and chronic diseases such as type 2 diabetes, heart disease, stroke, liver disease and some cancers. Childhood

obesity presents immediate and long-term effects on a child's physical, social, educational and mental wellbeing. Poor diet and excess calorie intake are the main cause of adult and childhood obesity. There is very strong evidence that preventing obesity will significantly improve an individual's health and prevent or reduce the need for future healthcare services. Estimates value the annual national cost of obesity at £27 billion, including £13.3 billion for obesity medication and £6.1 billion in NHS costs. This cost is expected to rise to £50 billion by 2050 (Source; NICE). Obesity rates in Lincolnshire for both children and adults are higher than the national rates.

Physical Activity

A strong evidence base exists that demonstrates the importance of physical activity in maintaining and improving health and preventing and/or reducing the use of healthcare services. Physical inactivity is the fourth greatest risk factor for premature mortality so preventative measures are needed. The JSNA presents significant evidence of geographic and population-based inequalities, affecting multiple groups of individuals. This includes disabled people, those with learning difficulties, gender differences, low levels of physical activity in areas of deprivation and age-related differences. There are noted geographical variations, too. Given that Lincolnshire has lower than average physical activity participation rates relative to national rates, with a gradual worsening trend in all districts, apart from West Lindsey, prioritising physical activity is a key priority for the HWB.

Carers

In Lincolnshire it is estimated there are 88,000 unpaid family carers and, given the county's ageing population, this number is predicted to increase further and at a faster rate. The value of the labour of Lincolnshire's unpaid carers is estimated to be worth £1,766 million but they exist mostly unnoticed as a 'hidden army'. The impact of a caring role on a carer's own health and wellbeing can be significant, therefore supporting carers is both a national and local priority. Carers need support; their quality of life often decreases when they become a carer with worsening physical and mental health. Receiving support, having a social network, and reducing isolation greatly improves the quality of life for the carer and the cared-for.

Housing

Living in poor conditions or in an unsuitable home can have a negative effect on mental and physical health. Therefore, improving people's housing circumstances can improve health and wellbeing, and delay or prevent the use of some healthcare services. This priority area is broad and includes fuel poverty, vulnerable individuals and families, housing need, condition/housing stock, and includes the unmet housing needs of various demographic groups. Inequalities are evident, with the population groups most affected including: older people, low income families with children, those with disabilities/learning difficulties, those with mental health issues, and the homeless or vulnerably housed.

Item 7 (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	7 (ii)
Title of Report:	Lincolnshire's Joint Forward Plan
Report Author:	Peter Burnett – Director of Strategic Planning, Integration and Partnerships
Appendices:	Guidance on Developing the Joint Forward Plan

1.	**Key Points for Discussion:**

The Health and Care Act 2022 requires the Lincolnshire Integrated Care Board (ICB) and their partner trusts to prepare a first Joint Forward Plan (JFP) before the start of the financial year.

For the first year, ICBs are required to publish and share the final plan by 30 June 2023. NHSE have developed and published guidance to support the ICB and partner trusts in undertaking this work. It sets out a flexible framework for JFPs to build on existing system strategies and plans, in line with the principles of subsidiarity.

NHS England 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.

The guidance makes it clear that each system significant flexibility to determine their JFP's scope as well as how it is developed and structured. At a minimum, it should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's needs.

2.	**Recommendations**

The NHS Lincolnshire ICB Board is requested to note:

- The requirements to develop a Joint Forward Plan with our partner Trusts.
- NHS have published guidance which sets out a flexible framework for the development of the JFP.
- The planned process for developing the Lincolnshire JFP
- NHS England 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.
- Each systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured.

3.	Executive Summary

1. Background

The Health and Care Act 2022 requires the Lincolnshire Integrated Care Board (ICB) and their partner trusts to prepare a first Joint Forward Plan (JFP) before the start of the financial year.

For the first year, ICBs are required to publish and share the final plan by 30 June 2023. NHSE have developed and published guidance to support the ICB and partner trusts in this exercise. It sets out a flexible framework for JFPs to build on existing system strategies and plans, in line with the principles of subsidiarity.

NHS England 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. The guidance doesn't explicitly reference Primary Care, but we recognise the importance of their involvement throughout the development of the document.

2. Requirements

ICBs and their partner trusts have a duty to prepare a first JFP before the start of the financial year 2023/23 – i.e. by 1 April. For this first year, however, NHS England has specified that the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023.

In developing the JFP, ICBs have a statutory duty to have regard to the integrated care strategy, Joint Local Health and Wellbeing Strategies (JLHWBSs) and Joint Strategic Needs Assessments (JSNAs) when exercising any relevant functions. The JFP will also outline how objectives in the government mandate regarding the ambitions in the NHS Long Term Plan and NHS planning guidance will be addressed.

In developing the JFP the ICB are expected to work with their ICPs; primary care partners; local authorities; the voluntary, community and social enterprise sector; NHS collaboratives, networks and alliances; and people and communities.

ICBs and their partner trusts must review the JFP and either update or confirm it annually before the start of each financial year.

3. Guidance

The guidance was published by NHS England on the 23 December 2023. **It outlines that each systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured.** At a minimum, it should 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 guidance includes a summary of legislative requirements that the JFP must meet and also outlines the statutory framework relating to the JFP and its relationship with other strategies and plans.

The three principles describing the JFP's nature and function are:

- Fully aligned with the wider system partnership's ambitions.
- Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
- Delivery focused, including specific objectives, trajectories and milestones as appropriate.

4. Planned Approach in Lincolnshire

The aim in to produce a 5-year NHS plan that describes our vision for the NHS in Lincolnshire and how we will delivery that. The 5-year plan sist alongside and complements the ICP Strategy which lays out how we will work together to improve the health of the population in Lincolnshire.

The intention is to go through an open process people and communities of Lincolnshire, NHS partners, and wider system partners to the JFP identifies how NHS services will meet the population's physical and mental health needs over the next five years.

The ambition is for this document to be c.30 pages in length and be easy to read and understand.

To develop this document the intention is to:

- Establish a Steering Group made up of leads from the ICB, NHS partners and residents.
- Run Workshops to agree the NHS system strategic priorities and commitments for the next five years (aligned to agreed ICS ambition and aims).
- Establish Working Groups to develop the priorities and core commitments further (e.g. direction statements, measures, targets).

The expectation is that the main public facing document will be underpinned by several key documents as follows:

- Delivery Plans
    - 5-year transformation and improvement roadmap for all key programmes, articulating the proposed future state, benefits and outcomes
- Activity, Workforce, Financial and Capital Plans
    - 5-year projections for activity, workforce, finance and capital, including demand & capacity modelling
- Legal Duties and Responsibilities
    - Clarifying how the legal duties are met within the system and who is responsible for them

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 HWB will take place. Feedback from these processes will inform the final document which will be shared with NHSE and presented at the ICB Meeting at the end of June.

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
The risk of not meeting our legal duties to have developed and published a Joint Forward Plan by June 2023	
5.	**Financial/Resource Implications**
None identified	
6.	**Legal, Policy and Regulatory Requirements**
The Health and Care Act 2022 requires the Lincolnshire Integrated Care Board (ICB) and their partner trusts to prepare a first Joint Forward Plan (JFP) before the start of the financial year.	
7.	**Health Inequalities implications**
A key aim of the JFP is to address health inequalities in Lincolnshire	
8.	**Equality and Diversity implications**
An Equalities Impact Assessment will be conducted on completed JFP.	
`	**Patient and Public Involvement (including Communications and Engagement)**
The aim is to co-produce the document with the public and communities and lead an engagement exercise in May on the JFP	
11.	**Report previously presented at:**
Not applicable	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
John Turner NHS Lincolnshire ICB, Chief Executive	

Classification: Official

Publication approval reference: PR1940

Guidance on developing the joint forward plan

Version 1.0, 23 December 2022

Contents

1. Introduction

This guidance supports integrated care boards (ICBs) and their partner NHS trusts and foundation trusts (referred to collectively in this guidance as partner trusts) to develop their first 5-year joint forward plans (JFPs) with system partners. The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts[1] to prepare their JFP before the start of each financial year.

This guidance sets out a flexible framework for JFPs to build on existing system and place strategies and plans, in line with the principle of subsidiarity. It also states specific statutory requirements that plans must meet.

It should be read alongside guidance on NHS priorities and operational planning which can be found here. Specific JFP supporting resources will be available here.

1.1 Action required of integrated care boards (ICBs) and their partner trusts

ICBs and their partner trusts have a duty to prepare a first JFP before the start of the financial year 2023/23 – i.e. by 1 April. For this first year, however, NHS England is to specify that the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023. We therefore expect that the process for consulting on a draft (or drafts) of the plan, should be commenced with a view to producing a version by 31 March, but recognise that consultation on further iterations may continue after that date, prior to the plan being finalised in time for publication and sharing by 30 June.

ICBs and their partner trusts must consult with those for whom the ICB has core responsibility[2] and anyone else they consider appropriate. This should include the ICP and NHS England (with respect to the commissioning functions that have been

[1] The ICB's partner NHS trusts and foundation trusts are named in its constitution
[2] People who are registered with a GP practice associated with the ICB, or unregistered patients who usually reside in the ICB's area (as described in the ICB constitution).

and will be delegated to ICBs). A draft JFP should be shared with the relevant ICP and NHS England; see section 4.1.

ICBs and their partner trusts must involve relevant HWBs in preparing or revising the JFP. This includes sharing a draft with each relevant HWB, and consulting relevant HWB's on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy (JLHWS); see section 4.1.

ICBs and their partner trusts should agree processes for finalising and signing off the JFP. The final version must be published, and ICBs and their partner trusts should expect to be held to account for its delivery – including by their population, patients and their carers or representatives – and in particular through the ICP, Healthwatch and the local authorities' health overview and scrutiny committees. JFPs must be reviewed and, where appropriate, updated before the start of each financial year; see section 4.2.

1.2 Purpose of the joint forward plan

Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. However, we encourage systems to use the JFP to develop a shared delivery plan for the integrated care strategy (developed by the ICP) and the JLHWS (developed by local authorities and their partner ICBs, which may be through HWBs) that is supported by the whole system, including local authorities and voluntary, community and social enterprise partners.

As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments[3], address ICSs' four core purposes and meet legal requirements[4].

1.3 Relationship with NHS planning

ICBs and their partner trusts will continue to separately submit specific operational and financial information as part of the nationally co-ordinated NHS planning

[3] For the purposes of this guidance, universal NHS commitments are those described in the annual NHS priorities and operational planning guidance and NHS Long Term Plan.
[4] This includes the National Health Service Act 2006 and the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010.

process. We will work with systems to avoid duplication and ensure alignment between NHS planning submissions and the public-facing JFP.

2. Principles

Three principles describing the JFP's nature and function have been co-developed with ICBs, trusts and national organisations representing local authorities and other system partners.

Box 1: JFP principles

Principle 1: Fully aligned with the wider system partnership's ambitions.

Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.

Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.

3. Legislative requirements

Statute describes the purpose of the JFP, the NHS mandate, the integrated care strategy, JLHWSs, joint strategic needs assessments (JSNAs) and system capital plans. For the relationship between the various requirements, see Appendix 1.

Appendix 2, Table 1 describes each statutory requirement the JFP must meet.

4. Developing the joint forward plan

4.1 Consultation

Close engagement with partners will be essential to the development of JFPs[5]. This includes working with:

- the ICP (ensuring this also provides the perspective of social care providers)[6]
- primary care providers[7]
- local authorities and each relevant HWB
- other ICBs in respect of providers whose operating boundary spans multiple ICSs
- NHS collaboratives, networks and alliances
- the voluntary, community and social enterprise sector
- people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives, in accordance with the requirement to consult described below.

Where an ICB and its partner trusts are developing their JFP or revising an existing plan in a way they consider to be significant (see section 4.2 for revision of plans), there is a statutory duty to consult:

- people for whom the ICB has core responsibility: i.e. those registered with a GP practice associated with the ICB or unregistered patients who usually reside in the ICB's area (as described in the ICB constitution)

[5] This relates to the general duty of ICBs to involve the public (s14Z45 of the NHS Act 2006), the duty of NHS trusts to involve the public (s242 of the NHS Act 2006) and the ICB duty to consult with the public and other relevant persons when developing the JFP (s14Z54 of the NHS Act 2006).
[6] See guidance on adult social care principles for ICPs; this advises on how ICPs and adult social care providers should work together.
[7] This includes the full breadth of primary care services, including general practice, community pharmacy, optometry and dental services.

- anyone else they consider it appropriate to consult: e.g. specific organisations with an interest in the plan or whose views it would be useful to obtain, and out-of-area patients who receive treatment funded by the ICB.

The approach should be determined by the ICB and its partner trusts but could involve working with people to understand how services can better meet local needs, developing priorities for change and gathering feedback on draft JFPs.

As JFPs will build on and reflect existing JSNAs, JLHWSs and NHS delivery plans, we do not anticipate their development will require full formal public consultation, unless a significant reconfiguration or major service change is proposed.[8]

Previous local patient and public engagement exercises and subsequent action should inform the JFP. The ICB and its partners will need to consider how this is managed to maximise the benefits from engagement and fulfil these statutory duties efficiently.

The JFP must be reviewed and either updated or confirmed annually before the start of each financial year. For consistency and to avoid duplication of effort, we recommend ICBs and their partner trusts develop a standard approach to consulting on the JFP, while recognising this may need to change over time.

In developing the JFP, ICBs and their partner trusts should consider other relevant duties: e.g. seeking the views of underserved groups (such as inclusion health and vulnerable populations) as part of the duty to reduce inequalities. They must also show they have discharged their legal duty under the Public Sector Equality Duty (s.149, Equality Act 2010).

ICBs and their partner trusts must include in their JFP a summary of the views expressed by anyone they have a duty to consult and explain how they have taken them into account.

Further guidance on public engagement and consultation for ICBs is on our website.

[8] See also Cabinet Office guidance on consultation principles and Local authority health scrutiny guidance (which provides guidance on service reconfigurations and scrutiny by health overview and scrutiny committees).

NHS England's role

We will support ICBs and their partner trusts to develop JFPs – please engage early with us. This will be of particular importance, for example, in relation to the services that we will delegate in future to ICBs.

We will review and comment on the draft JFP, and we recommend this is done in parallel with the review by HWBs (see below). This will not be a formal assurance process but an opportunity to support ICBs and their partner trusts to develop their plans.

Separately we will continue to conduct formal assurance of the information submitted in operational planning returns.

Role of health and wellbeing boards

In preparing or revising their JFPs, ICBs and their partner trusts are subject to a general legal duty to involve each HWB whose area coincides with that of the ICB, wholly or in part. The plan itself must describe how the ICB proposes to implement relevant JLHWSs.[9]

ICBs and their partner trusts must send a draft of the JFP to each relevant HWB when initially developing it or undertaking significant revisions or updates. They must consult those HWBs on whether the draft takes proper account of each JLHWS published by the HWB that relates to any part of the period to which the JFP relates. A HWB must respond with its opinion and may also send that opinion to us, telling the ICB and its partner trusts it has done so (unless it informed them in advance that it was planning to do so)[10].

If an ICB and its partner trusts subsequently revises a draft JFP, the updated version should be sent to each relevant HWB, and the consultation process described above repeated.

The JFP must include a statement of the final opinion of each HWB consulted.

[9] A joint local health and wellbeing strategy (JLHWS) is defined as a strategy under section 116A of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Care Act 2022.

[10] We may discuss this opinion with the ICB and its partner NHS trusts and foundation trusts.

4.2 Revision of joint forward plans

Annual updates

ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary.

We recognise that 2022/23 is a transition year for ICSs and that it will require time and extensive engagement to fully develop integrated care strategies. The annual refresh of JFPs allows plans to be iterated and provides the opportunity for further engagement and collaboration, as well as the opportunity to continue to reflect the most appropriate delivery mechanisms and partners' actions.

Where an ICB and its partner trusts update the JFP, in a way they consider to be significant, the same requirements regarding engagement and consultation apply.

Available support

Supporting resources providing further content recommendations will be available soon.

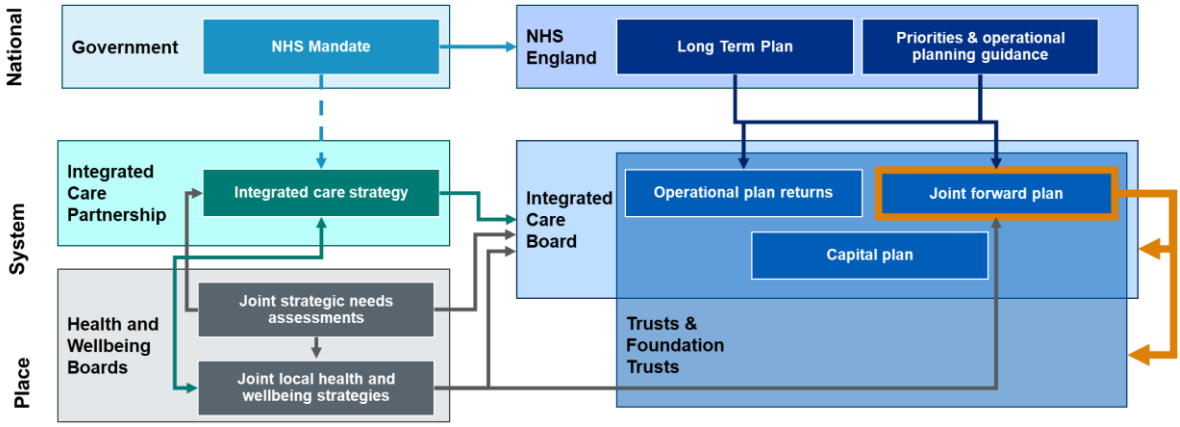
NHS England regional teams can offer support and advice and should be engaged early.

Please direct any technical queries to england.nhs-planning@nhs.net.

Appendix 1: Legislative framework – further detail

Figure 1 shows the statutory framework relating to the JFP. Please note, it does not show interaction with wider system partners.

Figure 1: Relationship of the JFP with other strategies and plans[11]



NHS mandate

The government's mandate to NHS England sets out our objectives, revenue and capital resource limits. This informs both our guidance on priorities and planning requirements and the integrated care strategy.

The JFP will address objectives in the government mandate regarding the ambitions in the NHS Long Term Plan and NHS planning guidance. It will also deliver on the integrated care strategy, which must have regard to the mandate.

Integrated care strategy

The Department of Health and Social Care has issued guidance on the development of integrated care strategies.

[11] In some systems, HWBs' geography is coterminous (or nearly coterminous) with the system footprint and therefore the relationships may be different.

The Local Government and Public Involvement in Health Act 2007, as amended by the Health and Care Act 2022, requires the ICP to produce an integrated care strategy. This should describe how the local population's assessed needs will be met through the exercise of functions by the ICB, local authorities and NHS England. It must address integration of health and social care and should address integration with health-related services.

In addition, the ICP must have regard to the NHS mandate in developing the integrated care strategy. As such, it should reflect both NHS priorities described in the mandate and the local population's assessed needs.

The ICB has a statutory duty to have regard to the relevant integrated care strategy in exercising its functions. The JFP is expected to set out steps for delivering the integrated care strategy.

Capital plan

Before the start of each financial year, ICBs and their partner trusts must set out their planned capital resource use. We will publish separate guidance on preparing capital plans.

The content of the JFP should be consistent with this capital plan.

Joint strategic needs assessments (JSNA)

JSNAs, developed by each responsible local authority and its partner ICBs, assess needs that can be met or be affected by the responsible local authority, its partner ICBs or NHS England. These include the local community's current and future health, care and wellbeing needs, as well as the wider determinants of health which affect those needs, to inform local decision-making and collaboration on development of JLHWSs and the integrated care strategy.

The ICB has a statutory duty to have regard to JSNAs when exercising any relevant functions. The JFP is expected to describe delivery plans to meet the population health needs of people in the ICB's area.

Joint local health and wellbeing strategies

Each responsible local authority and its partner ICBs will have produced a JLHWS. This is a strategy to meet the needs identified in JSNAs and is unique to each local area. The ICP is expected to build on the JLHWS, which may be facilitated by shared membership across HWBs and the ICP.

Each responsible local authority and its partner ICBs are required to consider whether JLHWSs need to be updated in response to any new or updated integrated care strategy.

The ICB has a statutory duty to have regard to JLHWSs in exercising any relevant functions. The steps that the ICB proposes to take to implement any JLHWS must be described in the JFP.

Appendix 2: Legislative requirements – further detail

Table 1: Summary of legislative requirements

Legislative requirement	Description	Implications for the JFP
Describing the health services for which the ICB proposes to make arrangements	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	The plan should set out how the ICB will meet its population's health needs. As a minimum, it should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet the physical and mental health needs of their population.
Duty to promote integration	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would: • improve quality of those services • reduce inequalities in access and outcomes.	Plans should describe how ICBs will integrate health services, social care and health-related services to improve quality and reduce inequalities. This could include organisational integration (e.g. provider collaboratives), functional integration (e.g. non-clinical functions), service or clinical integration (e.g. through shared pathways, multidisciplinary teams, clinical assessment processes).

Legislative requirement	Description	Implications for the JFP
		This must include delivery on the integration ambitions described in the relevant integrated care strategy and joint local health and wellbeing strategies (JLHWSs).
Duty to have regard to wider effect of decisions	In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the 'triple aim' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.	The plan should articulate how the triple aim was considered in its development. It should also describe approaches to ensure the triple aim is embedded in decision-making and evaluation processes.
Financial duties	The plan must explain how the ICB intends to discharge its financial duties	The plan must describe how the financial duties under sections 223GB to 223N of the NHS Act 2006 will be addressed. This includes ensuring that the expenditure of each ICB and its partner trusts in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year,

Legislative requirement	Description	Implications for the JFP
		and complying with NHS England financial objectives, directions and expenditure limits. It should also set out how the efficiency and productivity of NHS services will be improved in line with the core purpose to 'enhance productivity and value for money'. This should include the key actions the ICB will take to ensure that the collective resources of the health system are used effectively and efficiently. This could include specific plans to support the effectiveness of financial governance and controls; address unwarranted variation; strengthen understanding of the cost of whole care pathways; maximise consolidation and collaboration opportunities across corporate services; unlock efficiency through capital investment; and improve use of NHS estate.
Implementing any JLHWS	The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	The plan must set out steps the ICB will take to deliver on ambitions described in any relevant JLHWSs, including identified local target outcomes, approaches and priorities.

Legislative requirement	Description	Implications for the JFP
Duty to improve quality of services	Each ICB must exercise its functions with a view to securing continuous improvement in: • the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness • outcomes including safety and patient experience.	The plan should contain a set of quality objectives that reflect system intelligence. It should include clearly aligned metrics (on processes and outcomes) to evidence ongoing sustainable and equitable improvement. Quality priorities should go beyond performance metrics and look at outcomes and preventing ill-health, and use the Core20PLUS5 approach to ensure inequalities are considered. Plans should align with the National Quality Board principles.
Duty to reduce inequalities	Each ICB must have regard to the need to (a) reduce inequalities between persons with respect to their ability to access health services and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities. The duty to promote integration requires consideration of securing integrated provision across health, health-related and social	The plan should set out how the ICB intends to deliver on the national vision to ensure delivery of high-quality healthcare for all, through equitable access, excellent experience and optimal outcomes. ICBs must also be mindful of, and comply with, the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010.

Legislative requirement	Description	Implications for the JFP
	services where this would reduce inequalities in access to services or outcomes achieved.	
Duty to promote involvement of each patient	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment.	The plan should describe actions to implement the Comprehensive model of personalised care, which promotes the involvement of each patient in decisions about prevention, diagnosis and their care or treatment.
Duty to involve the public	ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided.	The plans should describe how: • the public and communities were engaged in the development of the plan • the ICB and partner trusts will work together to build effective partnerships with people and communities, particularly those who face the greatest health inequalities, working with wider ICS stakeholders to achieve this • activity at neighbourhood and place level informs decisions by the system and how public involvement legal duties are met and assured.

Legislative requirement	Description	Implications for the JFP
Duty to patient choice	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	The plan should describe how ICBs will ensure that patient choice is considered when developing and implementing commissioning plans and contracting arrangements, and delivering services. The plan should also describe how legal rights are upheld and how choices available to patients are publicised and promoted.
Duty to obtain appropriate advice	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.	The plan should outline the ICB's strategy for seeking any expert advice it requires, including from local authority partners and through formal governance arrangements and broader engagement.
Duty to promote innovation	Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).	The plan should set out how the ICB will promote local innovation, build capability for the adoption and spread of proven innovation and work with academic health science networks and other local partners to support the identification and adoption of new products and pathways that align with population health needs and address health inequalities.

Legislative requirement	Description	Implications for the JFP
Duty in respect of research	Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.	The plan should set out how the ICB will facilitate and promote research, and systematically use evidence from research when exercising its functions. This could include considering research when commissioning, encouraging existing providers to support and be involved in research delivery, recognising the research workforce in workforce planning, and supporting collaboration across local National Institute for Health and Care Research (NIHR) networks. Plans should address the research needs of the ICB's diverse communities.
Duty to promote education and training	Each ICB must have regard to the need to promote education and training[12] so as to assist the Secretary of State and Health Education England (HEE)[13] in the discharge of the duty under that section.	The plan should describe how the ICB will apply education and training as an essential lever of an integrated workforce plan that supports the delivery of services in the short, medium and long term. The plan should articulate the role of education and training in securing healthcare staff supply and

[12] This duty relates specifically to persons mentioned in section 1F(1) National Health Service Act 2006. They are "persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England".

[13] Subject to the parliamentary passage of the required Regulations, it is intended that HEE will merge with NHS England in April 2023.

Legislative requirement	Description	Implications for the JFP
		responding to changing service models, as well as the role of trainees in service delivery.
Duty as to climate change, etc	Each ICB must have regard to the need to (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets), and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	The plan should describe how the ICB and its partner trusts will deliver against the targets and actions in Delivering a 'Net Zero' NHS , including through aligning the JFP with existing green plans.
Addressing the particular needs of children and young persons	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	This could include using data and gathering insights to ensure the plan identifies and sets steps for delivery of the longer-term priorities and ambitions for the ICB's population of children, young people and families.
Addressing the particular needs of victims of abuse	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the	This should include related health inequalities and access to, and outcomes from, services. The plan should also cover the needs of staff who are victims of abuse.

Legislative requirement	Description	Implications for the JFP
	provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions.	This should include the use of data and lived experience to ensure the plan identifies and sets out steps for the delivery of longer-term priorities and ambitions for supporting victims, tackling perpetrators and the prevention of abuse, including through the commissioning of services.

Other content

Table 2: Other recommended content

Content	Brief description
Workforce	Evidence-based, integrated, inclusive workforce plans that ensure the right workforce with the right skills is in the right place to deliver operational priorities aligned to finance and activity plans.
Performance	Specific performance ambitions with trajectories and milestones that align with NHS operational plan submissions and pay due regard to the ambitions of the NHS Long Term Plan, as appropriate.
Digital/data	Steps to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. These actions should contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care. This could include reducing digital inequity and inequalities and supporting net zero objectives.
Estates	Steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them. This should align with and be incorporated within forthcoming ICS infrastructure strategies.
Procurement/supply chain	Plans to deliver procurement to maximise efficiency and ensure aggregation of spend, demonstrating delivery of best value. This could include governance and development of supporting technology and data infrastructure to align or ensure interoperability with procurement systems throughout the ICS.

Content	Brief description
Population health management	The approach to supporting implementation of more preventative and personalised care models driven through data and analytical techniques such as population segmentation and financial demand modelling. This could include: developing approaches to better understand and anticipate population needs and outcomes (including health inequalities); using population health management approaches to understand future demand and financial risk; support redesign of integrated service models based on the needs of different groups; and putting in place the underpinning infrastructure and capability to support these approaches.
System development	How the system organises itself and develops to support delivery. This could include: governance; role of place; role of provider collaboratives; clinical and care professional leadership; and leadership and system organisational development.
Supporting wider social and economic development	How the ICB and NHS providers will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing. This could include their role as strategic partners to local authorities and others within their system, as well as their direct contribution as planners, commissioners and providers of health services and as ‘anchor institutions’ within their communities.

Item 8 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

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

1.	**Key Points for Discussion:**

The purpose of this paper is to provide the Board with a summary of the ICB Service Delivery & Performance Committee meetings held in November & December 2022.

2.	**Recommendations**

The Board is asked to note and consider this report.

3.	**Executive Summary**

November 2022

The meeting received information and background on:

Mental Health Update
Discussions regarding workforce highlighted the difficulty of recruitment, particularly to Clinical Psychologist roles, although it was acknowledged this was a national problem.

Recruitment for the Peer Support Worker roles had been successful. For the East Coast area there was a need to build the capacity for volunteering and there was also a need for sustainable funding to be able to offer payment for roles undertaken.

The Learning Disabilities and Autism programme (formerly known as Transforming Care Programme) nationally focused only on a number of standards and trajectories – inpatient numbers across both NHSE/Specialised Commissioning/CCG and Annual Health Checks.

The ICB mental health team had recently attended an assurance summit with NHSE where the focus was much more on the quality of the inpatient experience, the level of information that the ICB has on those individuals and the planning process towards discharge.

There was also a greater focus on community provision. Metrics are now starting to come through with regards to Autism waiting times, the number of care/treatment reviews undertaken in the community and the number of those that convert into an admission avoidance, as well as the use of dynamic support registers.

The ICB has to complete 6-8 weekly visits on its cohort of patients in hospital. In the future the Lincolnshire system will have an enhanced review process that works in tandem with the Host and Placing commissioner guidance.

The ICB, through lessons learned from Safe and Well Reviews and closure of the local LDA hospital, will be taking actions and learning points and building these into additional methodology for the 6-8 weekly visits. Incorporated within this new process will be building in a mixture of clinical and non-clinical staff visiting, to develop a more holistic and blended view on current hospital placements and to proactively identify any issues in relation to quality, care, and treatment, ensuring any lessons learned are built into future visits. This includes where patients could be discharged from a hospital setting if there were appropriate services in place and care could be provided within the community.

Following the reviews, it was confirmed that the ICB did not have any Providers where it was found that there were immediate risks or concerns regarding the quality of care.

LDA Community transformation
Currently the system provides face to face or telephone consultations. In the future patients will be able to communicate from their own home or place of safety and receive a virtual consultation (e.g., video consultation) through the use of an e-consultation platform. This will reduce stress in attending clinics, reduce travelling to their appointments and increase patient choice and experience. Work was underway to have this in place by the end of the financial year (April 2023).

CYP Autism diagnoses – additional investment through the CAMHS S75 has greatly improved the autism diagnosis waiting time and post diagnosis offer. Work has now commenced on the peri diagnostic support offer through a working group with allocated resources for 2023/24.

Whilst additional capacity has been put in place with independent Providers for adults with autism, there was still a high number of referrals being submitted from Primary Care.

The mental health team was also looking at working with LPFT on the advocacy offer. The safe and well reviews have highlighted that a number of Providers have inhouse advocacy only, this gives rise to potential issues over the level of independence and autonomy that the advocacy service has. The team were, therefore, looking at a service called Speak Up to provide independent advocacy.

An all-age autism strategy/pathway was to be put in place, a paper has been presented to the Contract Partnership Board and a draft service specification was in place. This will deliver an all-age autism diagnostic pathway and would also include ADHD, Tics and Tourette's. It was planned that the pathway would be in place by 1st April 2023, subject to going through the LPFT governance process.

Efficiency gains from repatriating patients back into Lincolnshire was discussed and plans were being developed to ensure Providers from outside of Lincolnshire were not utilising all the available spaces within homes in Lincolnshire.

The Transforming Care agenda had now ceased to exist, however, the related targets would still be observed, especially in response to Winterbourne, as these were still felt to be relevant.

Winter Plan
The proposed Winter Plan and Capacity Overview was presented for review and recommendation of approval to the ICB. It was felt that the communication to the general public should focus on this being 'One Lincolnshire Voice', to emphasise that it was a joint

Health and Social Care approach. It was agreed that the plan needed to be agile, and the aspiration of the system was to have a robust Lincolnshire-wide operational plan which included a winter surge.

One of the areas of concern was around workforce and the fact that this could have a limiting factor, but there was a high degree of confidence in terms of recruitment that was already underway.

Forward Plan
The Forward Plan of the Committee's work was discussed, noting the breadth of agenda items. It was agreed that:

- Key portfolios (Planned Care, Cancer, MH/LDA, Integrated Community & Primary Care) would be presented to the Committee every other month.
- The Winter Plan would be a standing item on each monthly agenda until March 2023 and would also include UEC.
- UEC portfolio would fall into every other month cycle from April 2023.
- Digital, People Plan, Health Inequalities and the Provider Collaborative would attend every fourth month.
- Green Plan and Estates would attend every fifth month.

Next Steps on Elective Care for Tier One and Tier Two Providers
ULHT have undertaken and submitted the NHSE required self-certification. From a Lincolnshire perspective, ULHT was not in either Tier 1 or 2 for Elective Care although potentially bordered Tier 1 for a period of time, but it was apparent that all systems across the country were struggling to deliver the 62-day cancer target. Whilst ULHT is in Tier 2 for Cancer, NHSE have recognised the excellent work that is underway with regards to Colorectal.

Cancer
The focus has remained on the 62-day backlog and Lincolnshire remains in Tier 2. Mid-August there had been a threat of moving into Tier 1 but a number of actions were put in place and subsequently a whole programme of work had developed from this.

Colorectal makes up approximately 60% of the backlog and in August there was a total backlog of 575 patients waiting over 62 days for treatment. A recovery cell was established with daily recovery cell calls with the operational and ICB teams, this resulted in a change of focus. From 21/09/22 through to the 28/10/22 there was a 21% overall reduction in the backlog across all pathways and, significantly, a 28% reduction in Colorectal which is a significant achievement.

There are six priority areas remaining: - Lower GI, Head and Neck, Gynaecology, Prostate, Upper GI, and Lung. All of the pathways have a best time practice pathway which has to be implemented. The pathways give milestones that patients should achieve in 28 days.

Workforce capacity remains a significant concern within the divisions due to operational pressures, and particularly administrative staff.

Planned Care
The headlines reported were:

- ULHT and NLAG had eliminated waits of over 104 weeks except where patients had chosen to wait longer.
- ULHT are on track to eliminate waits of over 78 weeks by the end of March 2023 although there are some challenges expected within a few specialties.
- ICB specialist advice usage remains above the national target of 16% of first outpatient appointments.

- All High Volume Low Complexity specialities at ULHT have had their gateway reviews with the national teams. Lincolnshire are the only system that have completed the initial reviews and are on track with action plan development and follow up check ins.
- Theatre productivity review at ULHT has been completed by Foureyes and an action plan developed.
- A waiting list validation Provider has been commissioned and a programme of technical, administrative and clinical validation has started at ULHT.
- The system continues to use and liaise with the independent sector Providers to ensure maximum capacity for Lincolnshire patients for both elective and diagnostic activity.
- A business case to expand the community diagnostic centre at Gonerby Road, Grantham was approved by the national team at the beginning of November.
- Admitted waiting list – patients that need a procedure whether it is a day case or an admitted procedure - the focus is on the need to have more efficient use of the theatres.
- Outpatients are the biggest challenge within the waiting list and workforce capacity was causing issues. These are the staff who answer the phone, book appointments etc..
- There has been a delayed start in relation to outpatient recovery but there was now some pace behind it and we are in the middle of an 8 week focussed period to ensure that all clinics are full.
- Achieving Advice and Guidance target, Lincolnshire was currently at 30% so was achieving above the national target.
- Patient Initiated Follow-ups – Previously patients would automatically be given a follow up appointment but this has been changed to allow patients to make the decision as to whether they need a follow up appointment or to be discharged.
- Capacity – Utilising weekends and the Elective Activity Coordination Hub (EACH). The EACH team receive all the referrals from general practice and they call the patients in order to ascertain as to where the patient wishes to be seen. The patients are also triaged in order to ensure that they are referred to the correct place. 30% of patients who have been contacted no longer needed an appointment, 15% were moved to independent sector Providers. In September a two week sprint was put in place and 2,000 patients were called. NHSE Midlands Region have recognised that this scheme in Lincolnshire was excellent and have put this forward to the national team as a best practice process. This is continuing and two weeks ago authorisation was given for some extra funding from Region in order to increase resources.
- In-sourcing/Out-sourcing of activity to Providers: ENT, Gastroenterology and Respiratory are being reviewed in order to ascertain as to what was needed to bring additional resource in to support these specialities.
- Diagnostics – Lincolnshire was the first in the East Midlands to set up a Community Diagnostic Centre. Grantham officially opened at the end of April 2022 but the funding had also been used to put on additional evening and weekend clinics across the other sites. This has resulted in being able to provide additional capacity for Lincolnshire patients for diagnostics. A business case has recently been approved for the expansion of Grantham (additional £10m).

December 2022

The meeting received information and progress updates on:

Planning

The Committee received an update in relation to system planning.

- The refreshed National Long-Term Plan and the Joint Forward Plan were not expected to be released until 20th December 2022, as is guidance for the 2023-25 Better Care Fund cycle. The delays would not impede progress with planning work.

- There will be a focus on specific areas such as UEC, Elective Recovery, Primary Care Access, and Ambulance Handovers.

Phase 1

- Groundwork has commenced in order to review the current status of existing plans to identify where these need to be progressed further and to look at proposed new plans which would be undertaken collectively as a system.
- Reviewing service portfolios across all providers, with a self-assessment in terms of sustainability, demand, and capacity issues, financial and value for money concerns, and system efficiency plans.
- Reviewing themes, identifying interdependencies and prioritisation.

Phase 2

- January to March – detailed planning in terms of prioritises to be undertaken covering underpinning activity, workforce, and finance plans.
- The governance is complex and there is a need to ensure a balance with regards to both system and organisational needs.

Winter Plan Delivery

An in-depth update was provided:

- Rapid scaling up of Virtual Wards – Progress has been made and the system has 102 beds available with 82% occupancy. The aim by the end of December was to have 133 as a stretched target.
- Breaking the Cycle – Ambulance handover position and the flow through hospitals. Since the last committee meeting the Adult Social Care Discharge fund has been received and a plan has been agreed by the Health & Wellbeing Board and was being worked through currently. Important areas to note: Breaking the Cycle started on 7th November, in the first few weeks after implementation, ambulance handover delays were reduced significantly. In November there was a 50% reduction in over 60-minute handovers and approx. 50% in 2-hour handovers. Additionally, a number of the winter schemes have commenced e.g., admission avoidance and using work from the clinical risk summit such as resetting the system to use the pathways that are currently available.
- Sir Jim Mackey, the national lead for elective care, has recently met with ULHT to discuss the '78 weeks' position. Members of the ICB also met recently with the Secretary of State for Health and Social Care where this focus was reinforced. It was evident from the meetings that there was significant pressure on systems to ensure achievement of the 78-week target.
- Cancer – significant work has been undertaken in relation to Cancer which was now starting to see good progress.

Current pressures

The current pressures on the system were discussed:

- Demand was extremely high especially in relation to Paediatrics and the anxieties of parents in relation to Strep A. There had not been a large number of confirmed Strep A cases within the county, but the system was seeing RSV.
- There are issues with the supply of antibiotics noted across all systems within the UK.

Integrated Community & Primary Care

An update on developing work was presented:

The programme framework is based on building the capacity and capability in the community. In order to ensure that system plans reflect the needs of the population, it has been agreed that PCN footprints are to be used as the building blocks. The development of services will be informed by activity data from current service provision, population health management intelligence and insights from key stakeholders including, but not limited to, clinicians and carers, other partners e.g., district councils, the third sector and people living in the community.

The approach will be to test new ways of working, develop agreed service models, adapt these to reflect the needs and context of the PCN area, and promote continuous improvement through application of quality improvement methodologists.

Services will be organised to provide the greatest impact and so be delivered at a GP practice level, at a PCN, across a cluster of PCNs (not just geographically adjacent but also grouped to reflect population need) and at a system level.

The foundation of the programme is the provision of GP and other services provided through PCNs. Given this, the performance and delivery reports presented use the data that is currently available. As the programme progresses, performance and service delivery reports will be developed further to bring together activity from across different services to provide an overview of the total service impact.

Lincolnshire Healthcare Collaborative
An overview of the Lincolnshire Health and Care Collaborative Assurance Report was provided covering detail on current structure, programmes of work and findings on resourcing and funding from a recent stock take review. Further consideration of this was recommended by the Committee.

Digital, Data and Technology
The Digital Data and Technology report was presented. There have been a number of challenges for the digital teams recently, namely:

- The uncertainty and challenge of significant changes in leadership (the Chief Digital and Information Officer left the role earlier in the year, followed by temporary external resource caretaking the role of CDIO and more recently a substantive CDIO has been appointed).
- Many of the programmes of work are supported by external temporary resource.
- A challenging political and therefore financial landscape too.

A review is currently underway to revisit plans of work to ensure that the strategy, plans, and financial assessments are reliable and accurate as the building blocks for future digital plans and enablement of the system.

Escalation points to highlight to the Board:

DDaT – Prioritisation and funding considerations.
Provider Collaborative – Further review recommended.

4.	**Management of Conflicts of Interest**

No conflicts of interest were declared at the meeting.

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	

NHS
Lincolnshire
Integrated Care Board

NHS LINCOLNSHIRE INTEGRATED CARE BOARD SERVICE DELIVERY AND PERFORMANCE TERMS OF REFERENCE

1. CONSTITUTION

The Service Delivery and Performance (the Committee) is established by the Integrated Care Board (the Board or ICB) and will be a joint Committee between the ICB and NHS providers in accordance with the ICB Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is an ICB Non-Executive Member Chaired Committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. AUTHORITY

The Service Delivery and Performance Committee is a formal Committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Service Delivery and Performance Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

The identified boards and groups currently reporting into the Committee (N.B not an exhaustive list and likely to change overtime):

- ASR Implementation Oversight Group
- UEC Partnership Board
- Cancer Board
- Planned Care and Diagnostics Board
- Mental Health Learning Disability and Autism Partnership Group (MHLDA)
- Lincolnshire System Infrastructure and Investment Group
- System Planning and Delivery Group
- Health Inequalities Programme Board
- Primary Care Delivery Group

3. PURPOSE OF THE COMMIITTEE

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

All group members will promote identified initiatives and issues within organisational governance structures.

4. MEMBERSHIP AND ATTENDANCE – NEEDS TO CHANGE TO 75%

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution. Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Committee Members are:

- ICB Non-Executive Member (Chair)
- Non-Executive Directors from each Lincolnshire NHS Organisation (with 1 as the Deputy Chair)
- ICB Director of System Delivery
- ICB Director of Strategic Planning, Integration and Partnerships
- Nominated Director responsible for Strategy and Planning from an NHS Provider
- Nominated Director responsible for Operations from an NHS Provider

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

Attendees are:

- Senior Quality Lead
- Senior Finance Lead
- Associate Director – Planning & Transformation
- Head of PMO
- Deputy Director of System Delivery
- System SROs for programmes as required
- System Programme Leads as required

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.

Committee members will appoint a Vice Chair of the Committee who will be one of the Non-Executive Members of a provider Board.

The Chair will be responsible for agreeing the agenda and ensuring that matters discussed meet the objectives as set out in the Terms of Reference.

5. MEETING QUORACY AND DECISIONS

The Service Delivery and Performance Committee shall usually meet on a monthly basis (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

75% attendees from the membership outlined above – including at least Two NEDs and at least the one Executive Director.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

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

Decision making and voting

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Service Delivery and Performance Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Provide assurance of system operational planning processes and robust outputs(A)
- Review the integrated care system's service delivery and performance against its annual plan, and monitor any necessary corrective planning and action, escalating significant system issues that cannot be resolved (A).
- Identify key risks effecting the delivery of agreed plans to rectify issues and maintain a Committee risk register, with significant risks being escalated (D, A).
- Assurance of system operational planning process and outputs (A).
- Provide timely information and make recommendations to the ICB Board and NHS Provider Boards (and Provider Collaborative) on service delivery and performance issues where these impact at a system level, in the context of (A):
- National priority 'transactional' measures e.g. LD health checks, MH single sex wards, Community Diagnostic Centres
- Agreed system operational plan activity and performance metrics, and initiatives to be delivered e.g. elective recovery, cancer waits, health inequalities, ambulance handovers
- Agreed outcomes, KPIs and care standards for population segments and services that are the agreed system priorities for provider collaborative service redesign and transformation.
- Monitor the effectiveness of the integrated care system's service delivery and performance reporting systems, ensuring the ICB and NHS Provider Boards (and Provider Collaborative) are assured of its continued compliance (A).
- Provide overview and scrutiny of service delivery and performance of the NHS in Lincolnshire including benchmarked performance (A).

- Where non-NHS partner organisations are having a direct adverse impact on delivery, the Committee will escalate the matter to the ICB (A).
- Ensure 'lessons learned' reports and evaluation reports on benefit realisation following the delivery of transformational programmes are developed and utilised (A).
- Ensure the 'behaviours' agreed by system partners are in fact being adopted and adhered to. The Committee will 'call out' any system partner who is not doing so (A)

7. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

All committees and sub-committees are listed in the Scheme of Reservation and Delegation (SoRD). Each Committee and Sub-Committee established by the ICB operates under terms of reference and membership agreed by the Board or the relevant Committee who the Board has delegated the power to make further delegations to Sub-Committees. All terms of reference are published in the ICB Governance Handbook.

The Service Delivery and Performance Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded.

As a Committee that fulfils delegated functions of the ICB, the Service Delivery and Performance Committee will be required to:

a) Provide a written report to the Board following each meeting outlining the key matters discussed, any points for escalation, assurance and/or decision and/or any new areas of risk. The Chair of the Committee shall attend the Board (public meeting) to present the report.

b) A Committee Chair may also request an Executive lead to attend the Audit Committee to discuss significant risks or matters or issue arising from internal audit reports in greater detail.

8. BEHAVIOURS AND CONDUCT

ICB values

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

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make on the citizens of Lincolnshire.

9. DECLARATIONS OF INTEREST

Where a member of the Committee is aware of an interest, conflict or potential interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflicts of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting.

Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.

Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing conflicts of interest, and may result in suspension from the Committee.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Membership will be considered as part of TOR review processes.
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 14th September 2022

Date of review: September 2023

Item 8 (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	8 (ii)
Title of Report:	Update from Finance and Resource Committee – 13.12.22 and 24.01.23
Purpose:	For information
Appendices:	Committee Terms of Reference

1.	**Key Points for Discussion:**

The purpose of this paper is to provide the Board with a summary of the ICB Finance and Resource Committee meetings held on 13 December 2022 and 24 January 2023.

2.	**Recommendations**

The Board is asked to note and consider this report.

3.	**Executive Summary**

The ICB Finance and Resource Committee was held on held on **13 December 2022**. The Committee focused on the following key areas:

- **System Financial Position Report**
  - Delay to reporting actual forecast outturn of one month was agreed. To still be shown through risk adjusted position.
  - Committee to receive a plan to the next meeting which fully explains the actions and the gaps to deliver the protocol.
- **Medium Term Financial Plan**
  - Further update to be received at the next meeting following interpretation of the planning guidance and implications.
- **System Improvement Plan**
  - In early stages of development with further work required with significant resourcing required in order to deliver.
  - Further update to be received at the next meeting.

The ICB Finance and Resource Committee was held on **24 January 2023**. The Committee focused on the following key areas:

- **Finance Position and Risk Adjusted Outturn**
  - The committee received an update on the system financial position at reported at Month 9.
  - Improvement to risk adjusted forecast to £27.2m (£35.4m at Month 8).
- **Evidence for NHSE Protocol for Changes to Financial Forecast**
  - Committee agreed for the evidence to be reviewed by Richard Winter from NHSE.

- Committee agreed to aim for achievable target of £25/26m.

- **Financial Recovery Plan**
  - Governance arrangements to expedite progress was noted by the committee.
  - The need to have detail of KPIs and trajectories was noted.

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

Item 8 (iii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	8 (iii)
Title of Report:	System QPEC (Quality and Patient Experience) Committee Update
Author:	Professor Sir Van-Tam, Chair Martin Fahy, Director of Nursing Sarah Bates, Deputy Board Secretary
Appendices:	N/A

1.	**Key Points for Discussion:**

This paper provides an update on the discussions that took place at the System Quality and Patient Experience Committee meeting held on 22nd December 2022.

2.	**Recommendations**

The Board is asked to note the update.

3.	**Executive Summary**

The System Quality and Patient Experience Committee focused on the following agenda items:-

- **System Quality Group Update:** an update was provided on the discussions that took place at the last System Quality Group meeting in November 2022. The main issues to note include GP access, mitigations to address these, workforce challenges and waiting lists.

  Asylum seeker issues were addressed in terms of rapid mobilisation work to accommodate the additional requests and pressures. Issues from HealthWatch included GP and dental access concerns, communication issues and ambulance delays.

  Discussions took place regarding the urgent and emergency care pressures and ambulance delays and that ULHT are in the process of implementing the Breaking the Cycle initiative which will encourage patient flow.

  Mental health services including workforce challenges were discussed. It was noted that a risk assessment had taken place and a decision made to close the Psychiatric Intensive Care Unit to address this and re-deploy the workforce.

  Discussions ensued regarding the outcomes from the SMI health checks and LD health checks and it was requested that this is part of the thematic discussions going forward.

  An update was provided on the PSIRF process, and that work is being progressed with providers and good progress being made.

- **Patient Engagement Group Update:** the Continuous Listening Model was presented which sets out the proposed arrangements for ensuring that there is a holistic approach to receiving feedback from patients and the public through a variety of engagement activities. Members were asked to consider how the information gathered through the processes is used to inform assurances regarding the quality of care and patient experience and a proposed reporting arrangement was included. It was noted that some elements of the listening model were based around co-production, in particular, communities/groups with regards to changes which may be taking place and the re-development of services.

- **Complaints Annual Report and Quarter One Update:** it was noted that the report sets out information from the complaints received by the former NHS Lincolnshire Clinical Commissioning Group (CCG) for the period 1 April 2021 - 31 March 2022 and includes Quarter 1 2022/23 complaints information. It was highlighted that 116 complaints had been received for the period April 2021 – March 2022. An update on the category of complaints and the learning shared was presented. For the period April 2022 to June 2022 19 complaints had been received.

  Discussions ensued and it was felt that there is some confusion of where patients complain to, and it was agreed to raise this with the Communications Team. It was suggested that the report is re-modelled content wise and the frequency of the presentation to be agreed. It was agreed that this would be discussed at the Development session.

- **Local Maternity System Update:** an update was provided on the following key points:

  - Ockendon update– All the immediate and essential actions, 15 in total alongside and a series of thematic reviews from the findings from the East Kent recommendations are progressing. East Kent was another enquiry following failure to deliver and poor quality in terms of services. Colleagues at ULHT have benchmarked themselves against both the Ockendon and East Kent recommendations and Mr Fahy is pleased to say that they have made significant progress. Since the last meeting, ULHT have formally exited the NHS E maternity support programme, which is testament to the work undertaken at ULHT especially at the Pilgrim site.
  - The LMNS facilitated a quality and equity development day in Skegness– the session was set up to provide an alternative approach to engagement of pregnant mothers and young families by providing targeted support to the East Coast. This was the second event of this nature , with a further session planned for February 2023, all these sessions are aimed at supporting communities / areas of high deprivation with bespoke support.
  - Military Project – Lincolnshire has one of the highest populations of military personnel, approximately 9,000. Lincolnshire has been chosen as the first national funded programme for a dedicated support team to support military families.
  - The NHS E Benchmark insight visit – the regional team spent time at ULHT, and the visit went exceptionally well.

  Mr Fahy informed the members that he had now taken over as the SRO for LMNS, which was previously Mrs Pilcher. Sue Liburd has been appointed as the Independent Chair.

- **Integrated Performance Report:** a revised version was shared with members noting that the report had been divided into two areas: constitutional standards and quality outcomes. It was noted that the SEND team have won a national award and have put together a video guide which is a co-produced piece of work. It was suggested that an outcomes achieved column is added to the report. It was agreed to maintain the report in its current format however this may change following the discussions at the Development session.

- **System Quality Risk Register:** a report was shared detailing 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.

  It was discussed that it would be beneficial to have one single repository of what has been identified as quality issues and that the format of this would be discussed at the forthcoming System QPEC Development session. It was noted that there are Senior Responsible Officers for each ICB programme of work (e.g., Cancer, LDA/TCP & UEC) and that there would be an opportunity to invite these if a deep dive was required.

- **Committee Terms of Reference:** the Terms of Reference had been reviewed on a number of occasions and these may change again following the future System QPEC Development session.

- **Clinical Policies Subgroup and Terms of Reference:** a proposal was shared to consider delegation of authority to ratify policies through the Clinical Policies Sub-Group and a draft revised Terms of Reference. Members agreed to ratify the following policies: Safeguarding Policy, Managing Supporting Employee Experiencing Domestic Abuse, and the ReSPECT Policy. In terms of the Supporting Employees Experiencing Domestic Abuse this is an ICB specific policy and provider organisations will have their own.

  The Committee supported the delegation and ratification of all future ICB clinical policies to this subgroup, the ToR will be altered to reflect this decision.

- **Suggested Cycle of Business:** the proposed Cycle of Business was presented. Discussions took place that this would be an item for a detailed discussion at the future System QPEC Development session.

- **Future System QPEC Meeting Dates:** proposed meeting dates for 2023 were shared with members. It was noted that these would take place on a hybrid basis of face to face and via MS Teams. It was agreed that a System QPEC Development session would take place in February 2023.

Items for escalation to the ICB Board:-

- PICU Update
- Clear information about association complaints returns/delay in treatment
- Support on PSIRF – Need to ensure Board understanding and awareness
- NWaFT continued journey towards the understanding of their mortality figures

4.	**Management of Conflicts of Interest**
The management of conflicts of interest are dealt with in accordance with the agenda and items.	

5.	**Risk and Assurance**
A System Risk Register and ICB Risk Register is in place. Going forward it has been agreed that the System Quality Risk Register will be streamlined, and a single source presented.	

5.	**Financial/Resource Implications**
Nil to note.	

6.	**Legal, Policy and Regulatory Requirements**
Nil to note.	

7.	**Health Inequalities implications**
Health inequalities considered in all aspects of the work programme.	

8.	**Equality and Diversity implications**
Equality and diversity implications considered in all aspects of the work programme.	

9.	**Patient and Public Involvement (including Communications and Engagement)**
Patient and public involvement and engagement is embedded within the System QPEC.	

11.	**Report previously presented at**
N/A	

12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Martin Fahy – Director of Nursing – m.fahy@nhs.net ☎ 07880157221	

Item 8 (iv)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

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

1.	**Key Points for Discussion:**
This paper provides an update on the discussions that took place at the Public Primary Care Commissioning Committee meeting that was held on 21st December 2022.	

2.	**Recommendations**
The Board is asked to note the update.	

3.	**Executive Summary**

The December 2022 Public Primary Care Commissioning Committee focused on the following agenda items:-

- **Sidings Procurement Update:** it was noted that the mobilisation issues have now been resolved and that the contract has moved into business as usual. There will be regular meetings with Omnes the provider between now and March 2023 of which will transition into the usual quarterly contract monitoring processes.

- **Spalding Update including Expression of Interest Process:** an update was provided regarding the managed list dispersal process that is being undertaken and that there has been a change to the initial process with the patient list now being transferred to three providers instead of one.

  It was highlighted that there had been some challenges with the processes of which the ICB apologised for and that patient communications will be issued in the New Year. The three Practices involved in the dispersal process are:- Gosberton, Munroe of which will re-open the Branch Practice in Pinchbeck in January and Beechfield of which is also due to open a Branch Practice in February. Members of the public were reminded to continue to utilise the Practice as normal to access services until such further notification has been issued.

- **Primary Care Network Development:** it was noted that meetings have taken place with the PCN's to understand their current position and priorities and how the ICB can provide support. A recent Time Out session took place with the PCN Managers. Work is ongoing in terms of population health management.

An update was provided on the work being undertaken to support the Additional Roles Scheme and how these are being utilised to support winter planning initiatives particularly admission avoidance and 2023/24 workforce planning.

It was noted that work continues with the PCN Alliance and that a recruitment process is currently underway for two Deputy Chairs. In addition, work is ongoing within the Alliance on becoming a legal entity by the end of March 2023 and the Additional Roles Scheme workforce planning.

- **GP Appointment Data Publication:** an update was provided that the data had been published in November 2022 of which highlights that there continues to be an ongoing increase in demand for GP access appointments of which has risen by 30% since 2019. In terms of the provision of same day GP access provision in Lincolnshire this has increased by 46.4% since 2019.

  Discussions took place regarding the variation of GP access across the County of which predominantly relates to workforce constraints. It was noted that there are a number of alternative services available including guidance on self-care, NHS App, community pharmacies, 111 and on-line resources.

- **Winter Planning:** it was noted that the System Plan has now been signed off by the Urgent and Emergency Care Partnership which focusses on capacity, demand management and patient flow. In terms of the operational requirements and demand there has been an increase in the acuity of patient admissions, paediatrics with respiratory conditions, Strep A and associated antibiotic shortages. Work is taking place across primary and community care with risk stratification of patients with a particular focus on those patients that are high intensity users.

  An update was provided on the additional funding that has been received which has supported additional sessions for enhanced access of which 294 sessions have been made available across the PCN's. Furthermore, medical cover for transitional care rehab and recovery beds and the provision of an additional 60 beds in the community. In addition to this there has been an opportunity to apply for further funding and the following PCN initiatives have been supported:-

  - K2 Federation and the work taking place with Paramedics and the Urgent Care Team.
  - South Lincoln Healthcare and care co-ordination and personalised care planning.
  - Deepings and enhanced access to support the over 75's, under 5's and respiratory patient cohorts.

  It was discussed that the Winter Planning is an iterative process and that there are a number of reporting mechanisms in place.

- **System Planning:** it was noted that a yearly stock take takes place on the progress made including a focus on the priorities for the forthcoming years. It was highlighted that for primary care there is a focus on GP access, PCN development and the development of services across the Pharmacy, Optometry and Dental services which will be delegated to the ICB in April 2023. It was noted that the main change for 2023/24 will be the way that services are delivered and bringing care closer to home.

- **Lakeside Medical Practice:** it was noted that the Practice had initially been inspected by the CQC in June 2021 and rated as Inadequate with a further inspection in March 2022 rated as Requires Improvement and the Practice placed in Special Measures.

  The Practice was re-inspected in November 2022 and the ICB is awaiting the publication of the report. The initial feedback has highlighted that the Practice has made significant improvements and it is hoped that the position will be improved. The ICB and LMC (Local Medical Committee) continue to support the Practice.

  Hawthorn Medical Practice CQC Inspection: it was noted that the CQC had re-visited the Practice on 14th December as an interim visit and that progress had been noted in terms of infection, prevention and control standards and dispensary.

It was discussed that there are a number of actions in progress and work is taking place to address these and that the ICB and LMC continue to support the Practice.

- **Risk Register:** an update was provided and that the risk in relation to staffing and the changes from Federations to PCN's had been reviewed as mitigations have been put in place between now and March 2023 and subsequently reduced.

  It was noted that two new risks had been identified relating to Group A Streptococcus concerns and antibiotic supply and energy supply outages for health providers. It was noted that there are controls in place for all the risks identified on the Risk Register.

- **Terms of Reference:** it was discussed that the initial Terms of Reference had been presented at the first Committee meeting in July 2022 where it was agreed that these would be reviewed after a six-month period. Discussions took place regarding the Terms of Reference and it was agreed to approve these noting that a further review will need to take place in the Spring following the delegation of the Pharmacy, Optometry and Dental services.

Items for escalation to the ICB Board:

- Hawthorn Medical Practice.

4.	**Management of Conflicts of Interest**

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

5.	**Risk and Assurance**

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

5.	**Financial/Resource Implications**

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

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

Legal considerations include:-

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

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

7.	**Health Inequalities implications**

Include details of health inequalities implications.

8.	**Equality and Diversity implications**

Include details of any equality and diversity implications.

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

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

11.	**Report previously presented at**

Regular monthly progress reports have been provided at PCCC meetings.

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

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8 (v)

NHS
Lincolnshire
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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 31st January 2023
Location: Boardroom, Bridge House, Sleaford

Agenda Number:	8 (v)
Title of Report:	Audit & Risk Committee Update
Purpose:	Mrs Margaret Pratt – Interim Chair of the Audit and Risk Committee (Non-Executive Director)
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 Wednesday, 25 January 2023.

2.	**Recommendations**

The Board is asked to note the update and progress.

3.	**Executive Summary**

The Audit & Risk Committee meeting held on 25 January 2023 focused on a number of areas including the following:

- External Audit Update
- Internal Audit Progress Report
- Audit Action Update
- Counter Fraud Progress Report
- Risk Management & Board Assurance Framework Update
- Write Offs
- Financial Governance Review and Action Plan

Key points for noting were as follows:

External Audit Update
CCG Q1 closedown audit: A near full audit is required with very few requirements scaled down. A near final draft audit closure report to be shared at the March meeting.

ICB Q2-Q4 audit: The EY audit plan will be presented at the March meeting

Internal Audit Progress Report
DSPT terms of reference have now been approved. Of the 10 days left, five have now been allocated to provide an advisory piece of work related to the action plan for the Financial Governance review and wider consideration of the system design for financial governance and reporting arrangements.

Audit Action Update
There are 14 open actions in total, with 10 not due and four that are open and overdue. Colleagues provided update presentations on the overdue actions around risk management, BCF and contract register. The Audit Committee will receive a further update from the Director of Finance in March following discussions with the Lincolnshire County Council Director for Adult Care regarding governance and assurance process.

Counter Fraud Progress Report
Activity has mainly focused on the delivery of the internal audit work around Personal Health Budgets. Confirmed that there will be no requirement to sign off the three months for the CCG on the nine months for the ICB.

Risk Management & Board Assurance Framework Update
Work undertaken by Kevin Street has now finalised. There remains work to be undertaken to ensure aligns to the ICB. The documents will be reviewed over the next week and shared with the Risk Management Group for feedback and the suite of documents will then be shared at the next Audit & Risk Committee in March.

Write Offs (Losses)
The committee agreed to the write off the CHC salary overpayment of £311.28.

Financial Governance Review and Action Plan
Actions would be different across the system, however, these are being reviewed through the System Finance Group.

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	