NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board

Public Board Meeting

Tuesday, 24th September 2024
at 9.30 am

The NHS Lincolnshire ICB Board meeting will be held at Bridge House, The Point, Unit 16, Lions Ways, Sleaford, NG34 8GG. Members of the public are welcome to come along and listen to the discussion, but they are not able to take part or ask questions during the formal meeting, which will also be held virtually as a Live Event via Microsoft Teams. Joining instructions will be available on the ICB's website: **www.lincolnshire.icb.nhs.uk**

Members of the public are encouraged to submit questions prior to the meeting using the **Questions Proforma**, which will be available on the ICB website. In addition there will be the opportunity to ask questions during the meeting using the on-line **Questions and Answers facility**.

NHS
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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 24th September 2024
Time: 9.30 am – 12.00 noon
Location: The Boardroom, Bridge House, Sleaford

Chair of the meeting: Dr Gerry McSorley, ICB Chair

AGENDA

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	TIME
1. Introductory Items					
i)	Welcome, introduction and apologies		-	Dr Gerry McSorley	9.30
ii)	Confirmation of quoracy		-	Dr Gerry McSorley	
iii)	Declarations of Interest	Information	-	Dr Gerry McSorley	
iv)	Minutes of the previous meeting held on the 30th July 2024	Approve	✓	Dr Gerry McSorley	
v)	Matters Arising, including Action Log	Note	✓	Dr Gerry McSorley	
2. Chair and Chief Executive Updates					
i)	Chair's Report	Note	-l	Dr Gerry McSorley	9.35
ii)	Chief Executive's Report	Note	-	Mr John Turner	9.45
3. Key Updates					
i)	Public Health	Note	-	Professor Derek Ward	10.00
ii)	Healthwatch	Note	✓	Mr Navaz Sutton	10.10
4. Population Health Planning					
i)	Annual Population Health Planning Cycle for 2024/25	Assurance	✓	Mr Feargus Mack	10.20
5. System Oversight and Assurance					
i)	Integrated Performance, Quality and Finance Report – July 2024	Assurance	✓	Mrs Clair Raybould/ Mr Martin Fahy/ Mrs Emma Rhodes	10.40
ii)	Process for Review of CQC section 48 (Calocane) Report	Assurance	✓	Mrs Sarah Connery	11.00
iii)	ICB Board Assurance Framework	Assurance	✓	Mr John Turner / Mrs Jules Ellis-Fenwick	11.15
iv)	ICB Risk Management Strategy	Approve	✓	Mr John Turner / Mrs Julie Ellis-Fenwick	11.25
6. Governance					

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	TIME
i)	Amendments to ICB Constitution	Approve	✓	Mrs Julie Ellis-Fenwick	11.30
ii)	ICB Annual Report and Accounts 2023/24	Receive	✓	Mr John Turner	11.35
7. Committee Highlight Reports					
i)	• System Quality and Patient Experience • Service Delivery and Performance • Audit and Risk Committee	Assurance	✓	Committee Chairs	11.40
8. Information/Closing items					
i)	Risks identified during the course of the meeting	Consider	-	Dr Gerry McSorley	11.50
9. Date, Time and Venue of the next meeting					
	Tuesday, 26th November 2024 at 9.30 am at Bridge House, Sleaford	Note	-	Dr Gerry McSorley	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, 30th JULY 2024 AT 9.30 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Dr Gerry McSorley	Acting ICB Chair and Chair of the Primary Care Commissioning and Delegated Functions Committee
	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mrs Sarah Connery	Executive Board Mental Health Member
	Ms Anita Day	Non-Executive Member
	Mrs Karen Dunderdale	Group Chief Executive, Partner Member, NHS and Foundation Trusts
	Mr Martin Fahy	Director of Nursing (Chief Nurse)
	Mr Matt Gaunt	Director of Finance
	Dr Sunil Hindocha	Medical Director
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Mrs Margaret Pratt	Non-Executive Member and Chair of the Audit and Risk Committee
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sharon Robson	Non-Executive Member
	Dr Kevin Thomas	Partner Member, Primary Medical Services
	Mr John Turner	Chief Executive
REGULAR PARTICIPANTS/ ATTENDEES	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Ms Charley Blyth	Director of Communications and Engagement
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mr Andy Fox	Consultant in Public Health (representing Professor Derek Ward)
	Mrs Kathy Fulloway	Chief Digital and Information Officer, Lincolnshire ICS
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Ms Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mr Navaz Sutton	Chief Executive Officer, HWLincs
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board
APOLOGIES:	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Professor Derek Ward	Public Health Representative

24/232 WELCOME AND INTRODUCTIONS

Dr McSorley welcomed all those present to the NHS Lincolnshire ICB Board and 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. 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.

The Board Members were asked to introduce themselves when presenting papers or asking questions/making comments both for the benefit of those in the room and also those people listening in.

Dr McSorley extended a warm welcome to Mrs Karen Dunderdale, who was attending her first ICB public meeting as the new Trust Partner Member since she took up Group CEO role on 1st July, commenting that it was great to have her on the Board.

242/233 CONFIRMATION OF QUORACY

Dr McSorley confirmed the meeting was quorate.

24/234 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

Dr McSorley reminded the Board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests. The Register is available either via the ICB Board Secretary or the ICB website.

Declaration of Interest from Committees:
No items declared.

Declarations of Interest from today's meeting:
Dr Hindocha and Dr Thomas both declared an interest in the item on GP Collective Action, as both individuals are practicing GPs. It was agreed that both individuals would not participate in the discussion on that item, or any decisions associated with it.

The Board agreed to:

- **Note the interest as declared.**

24/235 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 28th May 2024 and agreed to:

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

24/236 MATTERS ARISING

Dr McSorley advised there were no actions outstanding from previous meetings and nothing specific from the May meeting hence no Action Log has been included in the pack of papers.

24/237 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley advised that he had some specific points to highlight for information, but firstly wanted to acknowledge that since the Board last met there had been a General Election, and a new Labour government now formed with clear ambitions for the NHS, much of which was referenced in the recent King's Speech. The ICB will continue to engage and work constructively with national colleagues and local MPs as the new Government's NHS programme moves forward.

In respect of the local MPs, there have been some boundary changes and Lincolnshire has gone from seven to eight constituencies with Stamford moving into Rutland. The ICB intends to continue its approach of seeking to work openly and constructively with all of its MPs and this will continue with both the five Lincolnshire MPs who were re-elected and the three 'new' MPs. Dr McSorley and Mr Turner, along with the Trust Chairs and CEOs, have already written to offer to meet with them with the first one planned to take place the following day.

Dr McSorley advised that he had attended a number of local, regional and national meetings since the last Board meeting, including the Lincolnshire Leaders Group, Quarterly System Review Meeting (QSRM) and NHS Confederation. He had also attended a recent meeting of the Lincolnshire Health and Wellbeing Board and had the opportunity to spend some time with Melanie Wetherley from the Lincolnshire Care Association.

Other meetings he had attended included the East Midlands Joint Committee and one of the local ICB staff events and a whole day session on veterans that was hosted by colleagues at RAF Cranwell and had the opportunity and was grateful to the Lincolnshire Pharmacy Collective to visit a community pharmacy in Lincoln. In the light of the general election there had been a variety of meetings amongst ICB Chairs on working with the new Government moving forward.

On a final note, an interim report has been published on the state of the Care Quality Commission (CQC) which has deemed that organisation not fit for purpose. ICB Chairs have offered to work with the author of that report, which is Dr Penny Dash who is an Integrated Care Partnership Chair in terms of helping frame how the CQC works going forward. It clearly needs to be made fit for purpose in order to provide comfort and reassurance to members of the public that their health and care services are being properly regulated and monitored.

There were no questions received on Dr McSorley's update, who handed over to Mr Turner at this point to present his Chief Executive update.

Chief Executive update

Mr Turner commented that it had been a long time since the Board last met on the 28th May with a number of changes nationally since then. The core message for the Board at today's meeting is that the Lincolnshire system remained very focused on delivering its commitments as agreed through the 2024/25 planning arrangements including a number of key targets, such as cancer, urgent and emergency care, waiting times and also financial duties. It remained a very busy space and there were lots of variables as normal, many of which would be touched upon as the Board moved through the meeting.

The following points were highlighted for the Board:

- In terms of the new Government and recent announcements, the Secretary of State had indicated three strategic priority areas around prevention (|including health inequalities), out of hospital care (meaning community, primary and neighbourhood team working) and digital. Whilst further detail is awaited, those three areas are entirely consistent with the work that has been happening across the Lincolnshire ICS and also the ICP Strategy.
- Lord Darzi was undertaking an investigation of the state of the NHS. The outcome of that investigation was expected to report in the Autumn and Ms Sally Warren has been requested to lead on the development of the ten-year plan. It was really positive to see this will be a ten-year plan for health, not just the NHS.
- Mr Turner referred to the King's Speech, which included health specific details on reforming the Mental Health Act, tackling smoking by raising the age of the sale of tobacco products and restrictions on junk food and energy drink advertising to children.

- It was also important to note the Secretary of State's early engagement with the British Medical Association (BMA) and the announcement the previous day of the Pay Review Bodies. It was heartening to see in terms of supporting and developing people in the NHS and the county. The next steps were awaited but hopefully this will come to a successful resolution and prevent further industrial action.
- The BMA has also been undertaking a ballot of its GP Members on collective action, and more information would be provided later in the meeting.
- General practice; the ICB is one of seven ICBs involved in developing with some of the PCNs a new model and approach for primary care and was currently awaiting the formal outcome of the process in terms of how many PCNs and which ones will be accepted. Early feedback has been very encouraging in terms of Lincolnshire's profile. Mr Turner reflected on the ICB's understanding and general appreciation of the role of general practice and their teams day in, day out.
- The latest QSRM took place with NHSE a few weeks ago and involved many colleagues in the Board meeting. It was a very supportive and positive meeting. The formal letter issued after these meetings had not yet been received but NHSE indicated Lincolnshire is one of the most improved systems in the Midlands region and clearly seen as being focused on making improvements for the local population. NHSE also indicated their support for the ICS pressing forward to achieve National Outcomes Framework (NOF2) status.
- Mr Turner had recently attended a number of local conferences including the first ever Lincolnshire NHS and Armed Forces Symposium at the end of June. There had also been a great conference on Co-Production held in June which was attended by around 150 people with a lot of energy and dynamism in the room. LinCA also held their annual conference.
- Three staff events had taken place in late June/early July and were well attended, and Mr Turner found them very helpful. The actions from those events would be taken forward over the coming months.
- Last week Mr Turner had the pleasure of attending the ground breaking ceremony for the Community Diagnostic Centre (CDC) in Skegness. The building work is on track to have this up and running by the end of November. In the coming week there is a similar ceremony planned for the Lincoln building and also the extension of the CDC in Grantham.
- Lincolnshire Partnership NHS Foundation Trust (LPFT) Psychiatric Intensive Care Unit (PICU) had re-opened since the Board last met and was already having a significant impact.
- Ongoing liaison continued with the University of Lincoln and a couple of weeks ago there was first graduation of the Lincoln Medical School students. The Medical School and the University of Lincoln were both to be congratulated on this huge achievement.
- There are ongoing conversations with the University of Lincoln about a number of areas around research but also the Centre for Dental Development and a number of meetings were planned regarding this in the next week or so.
- The Lincolnshire Spring Vaccination Booster performance was above both the regional and national average, which was really noteworthy.
- Mr Turner had met recently with the CEOs at North West Anglia NHS Foundation Trust (NWAFT) and North Lincolnshire and Goole NHS Foundation Trust (NLAG), which was a regular occurrence every few months. Mr Turner and Mrs Dunderdale had a planned meeting with the Chief Executives of the Humber ICB and NLAG and Hull later that week.
- The recruitment process to appoint the ICB Director of Workforce Transformation had commenced with interviews due to take place at the end of August 2024.

On a final note, the ICB had opened up a really constructive and positive partnership with the Lincolnshire Co-op who have a significant presence and profile in the communities across Lincolnshire, much like the ICS. Their focus is on profits but with a purpose; the number one being to give back in terms of health and well-being to their communities.

The Board considered the update. Mrs Pratt asked whether the ICB would be submitting evidence as part of the Lord Darzi review. Dr McSorley advised that the ICB Chairs met the previous week and discussed the best way to engage with the Lord Darzi review, bearing in mind the report is due to be published at the end of September. The ICB Chairs with the support of the NHS Confederation are making steps to open up the dialogue and will know more once the offer is made. Mr Turner added that given the timescales involved there will be relatively little opportunity to submit the details of the positive work happening in Lincolnshire.

At this point Mr Turner referred to questions which had been received from members of the public. The questions were considered, and the topic areas noted with specific leads identified to respond.

Action: Mr Fahy and Mr Eccles

It was noted that the details of the questions and the associated responses would be attached separately to the minutes of the meeting.

The Board agreed to:

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

24/238 KEY UPDATES

Public Health

Mr Fox advised that there were a few items to highlight to the Board in terms of the national picture on health protection and then some information on policy at the end.

Firstly, the Board may be aware that there has been an E-coli outbreak that has been a national issue, with 288 cases seen to date. This is thought to be linked to the food chain and there have been a number of product recalls. Whilst there have been a significant number of hospitalisations, indications are that cases are now declining which is encouraging.

The next point related to the outbreak of measles with there now over 2000 confirmed cases since 1st January 2024. This is a vaccine preventable disease and there is no reason for anyone to catch measles. The highest proportion of the cases, which is about 41%, is from different regions in London. There has only been approximately 8.9% seen in the East with a handful of cases but associated with clusters elsewhere in the country. There are signs now looking at the data and the epidemiology that the number of cases has peaked over April, May and June and may now be declining as the message reaches people and individuals isolate. A specific piece of work has also been underway across the country to increase vaccination uptake of the MMR vaccines.

The other area to flag with the Board which is currently a very high profile concern for public health nationally and indeed internationally is Avian influenza, specifically the H5N1 strain. There has been a particular outbreak in America where transmission has been seen to cattle. This is clearly a concern in terms of that mammalian transmission. Mr Fox advised that he had conducted some research on this a few years back and there were some 860 cases of H5N1 globally, with just over half of those being fatal. However, the positive news is that of the 11 cases seen in the States, the symptoms have been relatively mild respiratory ones. The conclusion to date is that it appears to be difficult for humans to catch it and influenza is essentially only passed on to humans if they are in direct contact with the infected animals and is not going to become a pandemic. Secondly, the fatality rate of influenza is significantly lower in western countries.

The final point of note related to the national policy around health improvement, health protection and smoke regeneration. This was referenced in the Kings Speech as highlighted by Mr Turner and is expected that legislation will be brought forward. Early indications are that this will contain all of the elements that were in the previous government's proposal, but with some areas potentially being strengthened.

This will mean further restrictions on vaping, especially for children and young people, but particularly the age of sale will be raised by one year each year to prevent future generations from ever taking up smoking.

Dr McSorley thanked Mr Fox for his update. There were no questions raised so the Board moved to the next item.

Healthwatch

Mr Sutton presented the latest Healthwatch report and advised that the topics of the two public questions featured significantly in the report and would therefore not be covered in great detail. The following points were highlighted:

- In the last quarter (April – June) 473 people shared their views and experiences directly with Healthwatch on Health and Social Care in Lincolnshire, through their Information Signposting Team. As a result of that some outreach work had been undertaken which had demonstrated that a large proportion of the comments came from the East Coast specifically in relation to GP services. An additional 244 people shared their experience through the Respiratory Health Survey.
- One of the key themes was access to services and appointments, but also on the quality of services being provided, particularly in relation to the East Coast. This had also been articulated across the hospital feedback too and differed from previous reports. Healthwatch had delved into this, and the feedback had indicated time pressures about feeling rushed through the system or the appointment.
- In respect of dentistry, the comments had focused on long term of lack of appointments and also some particular issues in relation to the Mablethorpe practice and lack of communication on progress.
- The specifics which had come through related to the social care element with two key areas. The first was around home care and the second residential care for those with learning disabilities, and the quality of care. A piece of work was being undertaken by Healthwatch to look at that those areas.
- The report included information on some case studies, again which were reflective of the two topics detailed in the questions from the members of the public. The concerns highlighted around NRS (Wheelchair provider), and Neurodiverse pathways have been raised with the Healthwatch Lincolnshire Steering Group (HSG). As a result, a number of actions have been agreed. These included the issues being flagged with the ICB System Quality and Patient Experience Committee (SQPEC) and a meeting taking place with the Health Scrutiny and Health and Wellbeing Chairs.
- The report detailed the Yourvoice public engagement activities. The Community Primary Partnership (CPP) Co-Production Opportunity event was scheduled to take place on the 31st July 2024. Healthwatch was working directly with Public Health on this area. Feedback will be provided from that event.
- During 2024 Healthwatch have focused on several campaigns, which were detailed in the report, including menstrual health. This had now finished and the full report from that campaign and the workshop which took place as part of that was currently being finalised and would include the responses from providers. The respiratory health survey was coming to an end which sits alongside the ICB around the respiratory health services review. There is a supplementary survey taking place through the ICB Communications and Engagement Team and the intelligence and outcome of that will feed into the review.
- There was currently a live survey out ‘Have Your Say on Neurological Health Conditions’. The Board was encouraged to share the details as much as possible.
- Healthwatch had undertaken two deep dives – one into childhood vaccinations in areas of the population where there is low take up and the second on infant feeding and understanding the barriers to breast feeding by new mothers. The report on breast feeding was shortly due to be published.

The Board considered the update. Councillor Bowkett referred to the East Coast quality of service hospital feedback and doctors and sought clarification on where the data was from. In terms of the social care element, Lincolnshire County Council (LCC) was currently rated as one of the best in the East Midlands region and providing presentations across the region on good practice, so she would welcome further information on this. Mr Sutton advised that the contact/ data was from the last quarter, and he would be happy to discuss this and the social care element with Councillor Bowkett outside of the meeting.

Dr Hindocha advised that the ICB Clinical Directors have recently embarked on a full range respiratory review, and it would be really helpful to capture the patient voice for that as the team gather the evidence. Secondly, in terms of the vaccination piece, the importance of getting vaccinations cannot be stressed enough. These vaccines save lives and Dr Hindocha would be interested to understand the barriers. Mr Sutton advised that the challenges are around trying to interview people on vaccinations. An interim report is due mid-late August, and it would be good to share that and go through the details, including who Healthwatch are in contact with.

Councillor Woolley referred to the comments on the wheelchair provider and the case studies. and expressed concern about the style in which the report had been written, specifically in respect of the new wheelchair provider, NRS and LCC as the commissioner. NRS had only taken over as the wheelchair provider from the 1st April 2024 and some of the comments reflected in the report were made only three weeks later. It would have been helpful if the feedback was shared and discussed before being flagged in public. Mr Sutton apologised for the way in which the content had come across and advised that he would feed this back to the Healthwatch team.

Mrs Robson advised that she Chairs the local Maternity and Neonatal Group and was interested in the timescales of the infant feeding review as she would really like this to influence some of the development work of that group in October. Mr Sutton advised that he was scheduled to meet with Ms Sarah Ackerman, the ICB lead in the next few weeks, and the October timing would sit nicely with the finalisation of the report into that deep dive area.

Ms Blyth commended the number of responses to the infant feeding survey which compared to the quarterly responses covering all topics, was really positive. This shines a positive light on Ms Ackerman as the ICB dedicated lead around communications for better births and also Healthwatch.

The Board agreed to:

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

POPULATION HEALTH PLANNING

24/239 DRAFT INTEGRATED CARE SYSTEM RESEARCH AND INNOVATION STRATEGY

Dr Hindocha introduced the next item by first reflecting on some of the discussions that had taken place earlier in the meeting, from patients and Healthwatch, commenting that it was interesting to hear that although people are now getting into see their GP or in hospitals, they still do not feel the standard of care is as it should be. The purpose of having a Research and Innovation Strategy first and foremost is about increased academia and clinical excellence within the Lincolnshire system. This is the way to address all of the issues the system faces, whether that is clinical outcomes, great patient experience, financial issues and performance. There is also very good evidence that research and active systems have low mortality rates.

The draft five year Research and Innovation Strategy is a key milestone and reflects the ambition for research and innovation to drive excellence in rural and coastal health and wellbeing for the benefit of the Lincolnshire public and staff. The intention is to become a University Hospital county.

The strategy builds on the foundations of established relationships and partnerships allowing the Lincolnshire system to be ambitious so it can aim higher and move at pace to help transform health and care in the county. By 2029 the intention is to be a leading system in rural and coastal research and innovation.

This strategy recognises that Lincolnshire is a large rural and coastal county which has distinct characteristics, challenges and priorities that are best addressed locally. Lincolnshire, like many other systems, faces challenges that need to be acknowledged. Finances are stretched and there are difficulties recruiting and retaining staff, which means that across the system the care and wellbeing that should be delivered, is not delivered in the way it should be. Collaboration and partnerships are a way to maximise collective resources to provide the opportunities for improvement. It also allows creation of a supportive, learning environment where all partners can grow together, work through challenges and celebrate successes. This includes Public Health and Social Care.

The strategy sets out four principles that research and innovation in Lincolnshire will:

1. Reflect the needs of the ICS communities.
2. Be built on collaborative, co-ordinated and trusted partnerships.
3. Have research, innovation and evidence embedded in everything the ICS does.
4. Be delivered by a sustainable, capable and confident workforce.

These principles provide a collective focus and outline the way the system organisations, partners and the public will work together to drive research and innovation within the county, and become one of the leading forefronts, particularly in rural and coastal health care. The strategy will be followed by the development of an implementation plan which will be the blueprint of how the ICS achieves its goals.

Dr Hindocha added that the ICS Research and Innovation Hub, strategy and Hub webpage was launched at the University of Lincoln on the 17th April 2024. The event was attended by over 100 people, from leaders within our ICS and partners, to members of the Lincolnshire public. The event demonstrated the clear ambition and passion to collectively grow research and innovation within Lincolnshire.

The Board was asked to approve the draft Research and Innovation Strategy and support it within individual organisations and encourage staff to get engaged and involved in this work. The other ask is for organisations to support the establishment of innovation desks through a road trip whereby a desk will be set-up somewhere and anyone who is walking past and has an innovation idea, it will be supported.

The Board considered the document presented in detail. Mrs Connery thanked Dr Hindocha for his work on this strategy which was really interesting to see and confirmed her full support for it and the principles. In respect of mental health, learning disabilities and parity of esteem, if it was possible to make any changes to some of the stock images contained within the document, so they were reflective of local workforce and services, she would very much welcome that. Also, referring to principle one, she asked whether it was possible to include detail on parity of esteem. Both comments were supported by Dr Hindocha and would be picked up as part of the finalisation process.

Ms Day sought clarification on firstly, does the ICS have involvement of what is now Health Innovation East Midlands and how do we promote innovation. Dr Hindocha confirmed the Health Innovation Network is involved and Mr Paul Holmes is seconded from them to work in the Lincolnshire system. In terms of innovation, the intention is to look to the Trusts to do just that.

Mrs Dunderdale commended the strategy, which was really welcomed and very clear in terms of the outcomes and confirmed ULHT's commitment to this work and commented that she would look forward to seeing an innovation desk popping up in the near future.

Dr Thomas referred to parity of esteem and consideration being given to how the larger organisation and primary care were engaged in better way than currently. Dr Hindocha advised that over the next few weeks the intention is to create a plan to address just that.
Ms Blyth confirmed her support for the strategy and advised that she had worked quite closely with the team who had developed it and whilst this clearly focused on clinical research, it was really important to support the elements around how we can make this 'stick' and access a service that works for their lifestyles. There would be real value in connecting all of that.

Mrs Robson asked what the ambition is for commercial research partnerships and whether there is the opportunity within that for local partnerships as well as the national and international aspects. Dr Hindocha confirmed this is absolutely part of the ambition and as previously indicated there is significant commercial success. The presentation of the strategy at this stage is just about the launch; it is recognised there is much work to catch up on and there are ways to build capacity through national grants by way of an example.

Mrs Jolly asked how the innovation desk ideas can be shared across the wider sector of voluntary and social care where ideas of innovation can also manifest and feed into the system. Dr Hindocha advised that he works very closely with Paul Gutherson, LVET as part of the Research Leaders Group as this is not just about health and care, but also that sector which is vast, and he would be very happy to attend and present an innovation desk.

Dr McSorley summarised the comments, which clearly indicated great support for the strategy and expressed his appreciation to Dr Hindocha, the team and the wider community that has been behind the development work associated with this.

The Board agreed to:

- **Approve the draft Five Year Research and Innovation Strategy.**

24/240 HEALTH INEQUALITIES ANNUAL REPORT 2023/24

Mrs Williamson advised that the Board may recall that an update was provided in March 2024 which outlined the requirement of NHS organisations (ICBs and Provider Trusts) to report on a number of set mandated indicators for health inequalities. These are aligned to the Core20plus5 approach for Adults and Children and Young People (CYP). In terms of the information on CYP, it is relatively light in terms of the requirement, but there is a recognition of that nationally and there is an expectation that after the first two years of setting this statement, the indicators will develop and focus more on children, young people and communities.

The main purpose of collecting and analysing this information on health inequalities as the Board is to drive service improvement and the intention is to use this to inform strategy development, resource allocation, service design and embed this throughout the system planning process.

The report presented today is reflective of the first statement produced by the ICB reporting on the key indicators, outlining summary reflections on the inequalities revealed and key actions for 2024/25 on how the data will be used to improve and make progress on reducing health inequalities. The relevant programme boards have reviewed this information, and actions are embedded within operational plans for each of those, e.g. through the Mental Health Learning Disabilities Dementia Alliance and inequalities workstream.

The information helps to provide a baseline to monitor and track progress on the actions, and improvement initiatives identified. The intention is for this approach to be monitored by Trust Boards for provider specific information relating to these indicators and through the programme governance arrangements.

This information alongside qualitative feedback, listening to and engaging with individuals and the local communities through the inclusion lens will be used to better understand the needs of those to support and drive improvements in access, outcomes and experience of Lincolnshire health care services.

This report highlights the importance of recording and analysing the performance information - currently disaggregated by age, sex, ethnicity and deprivation. It is expected that other characteristics will be included through the Lincolnshire system work on Core20Plus5 population groups and will be part of the development piece in 2024/25. There are specific challenges around the recording of ethnicity data and improvement plans are in place within each of our Provider settings but whilst it might be small numbers of the population, it is really important that the information is coded correctly, to ensure accurate reporting to understand how the ICB is meeting the needs of that population.

The Board considered the report. Mrs Robson advised that the report was very detailed and a good starting point, but she felt required some further reflection and consideration by some of the Board Committees, particularly the System Quality and Patient Experience Committee (SQPEC). Whilst it included the mandated indicators it did not capture all the elements around inequalities captured in other areas. Mrs Williamson advised that she had asked each of the programme areas to look at what other additional indicators they would like to see included alongside this report, and that piece of work is on-going. The report presented is in short a position statement in time. A report on progress will be presented to SQPEC in September.

Mrs Raybould advised that the report was considered by the Service Delivery and Performance Committee and was well received, recognising there is a raft of other information, but this is a starter for ten. She wanted to place on record her appreciation to Mrs Williamson and her team for the support to the programme boards as whilst quite a lot of this work was potentially already being actioned, it probably was not being done so under the right umbrella. Mrs Raybould advised that she sits on a number of the system programme boards and this report contained information which was not necessarily known or was not evidenced. As a result of this work it has been possible to look at things quite differently. This piece of work is definitely the start of something, and she thanked the teams involved for their support.

Mrs Connery acknowledged this report represents a really positive start and shines a light on cutting data in a different way, particularly in terms of looking at performance and outcomes.

There was a lengthy discussion at this point about the report and a number of comments made. In short, it was recognised this is a snapshot in time and the indicators are mandatory. There needs to be further consideration and design of the way in which services are delivered in Lincolnshire and that piece of work has already commenced. Progress will be monitored on a quarterly basis through the programme boards and a six monthly update provided to the Service Delivery and Performance Committee. This will also influence the planning process.

As a final point of note, Mr Turner advised that the Board agenda has been restructured recently to reflect the agreed strategic objectives and it has also been agreed to have a strong health inequalities and social value focus as part of the population planning work at each meeting. This is the first report of this nature on health inequalities and the quality is reflective of the seriousness of how this is viewed by the ICB, and it will be published alongside the ICB Annual Report once it has been put into a public friendly format.

Dr McSorley echoed the comments and consideration may need to be given to have a deeper look at this in the Board or Committee frame going forward.

Dr McSorley thanked Mrs Williamson for all her efforts in producing the report and asked the Board to approve the document. The Board agreed to:

- **Approve the Health Inequalities Annual Report 2023/24.**

SYSTEM OVERSIGHT AND ASSURANCE

24/241 INTEGRATED QUALITY AND PERFORMANCE REPORT

Performance Section

Mrs Raybould presented the performance section of the Integrated Quality and Performance Report and advised that she would take the report as read but wished to highlight some key points.
Firstly, the reporting period contained the latest and what is currently anticipated to be the last of the junior doctor industrial action which took place recently over a five day period.

- From the end of June and beginning of July, it had been a very challenging period from an urgent and emergency care perspective and A&E four hour performance was below plan and that has continued to be the case to date. There had been a higher number of attendances versus the plan and that same picture had been seen regionally and in other parts of the country. There had also been an increase in the acuity of presentation of patients which is leading to more admissions, and this has impacted on patient flow of urgent and emergency care. Any trends demonstrated within that will be reviewed as part of the winter plan refresh which will be carried out in August.
- The Category Two mean continued to show improvement despite some challenges and often had been close to the 30 minute target or below which is primarily down to the strong relationships between EMAS, the ICB ambulance provider and ULHT the main acute provider, but also all of the provision that has been established in Lincolnshire that supports the urgent emergency care pathway in particular, and also mental health colleagues where that quite often is a challenge in other parts of the region with people spending far too long in emergencies with mental health presentations, which is not something usually experienced in Lincolnshire.
- From a cancer perspective, Mrs Raybould was delighted to share that the ICS did meet the Faster Diagnosis Standard (FDS) in May which as demonstrated in the report had continued to be met since. This was really positive news. The shift in focus had now moved to improving 62 day performance levels as the backlog continued to reduce. Performance at neighbouring Trusts was also improving.
- 78 week waits continued to be a priority and the numbers for July were expected to land at one or two and there is capacity to treat both patients but for various different reasons they have made a choice not to be treated by the end of the month. The 78 week target had in effect been met which was also very positive.
- The focus had now shifted to the 65 and 52 week challenge
- Talking therapies and people experiencing first episode of psychosis waiting for a start-up package with performance remaining stable and above the regional and national average and is on target, which was really positive to see.

The Board considered the performance update. Mrs Pratt asked whether there is a clinical audit going on to effect whether the acuity of presentation is real or perceived. Mrs Raybould advised that some clinical audit work has been undertaken which does provide information but there is a piece of work that has been discussed regionally about carrying out an impact assessment post COVID. This is as a result of seeing the presentation of people with more co-morbidity and effectively sicker than they would have been previously, so they are staying in hospital longer than previously as their discharge tends to be more complex and this impacts on patient flow.

Dr Hindocha added that there is a clinical audit programme, but this does not just look at one aspect, it looks at all elements, such as 12 hour waits, acuity at the door and discharge by way of examples. In short the pathway is broken down and includes actually listening to the dispatch calls. The purpose of that is to see what the patient said, what the response was and learning from that and embedding good practice. This is being undertaken at a system level.

Mrs Dunderdale added that there are quality audits undertaken on a regular basis across both ULHT and LCHS, but in particular for the UTCs and emergency department. There are very active and vibrant patient panels, and they are asked to undertake observational audits in the department and also to talk to patients and their families. The outputs of those helps the Trust to further enhance the action plans that are in place around care and comfort in the department.

Dr McSorley commented that understanding the acuity aspects of admission and the complexity of discharge would be really interesting to see, particularly in terms of the impact on residential, nursing home and domiciliary care and domiciliary particularly bearing in mind the recent announcement by the Chancellor about social care.

Mrs Raybould commented that the Urgent and Emergency Care Leaders Group includes representatives from LCC for the reasons highlighted by Dr McSorley. An intermediate care review was also being undertaken and the information being gleaned at the moment will feed into the winter planning process and may result in the winter plan being adjusted. One of the things there is in place in Lincolnshire are the Active Recovery beds and as a result of having those the ICS is seeing an intense input wrapped around an individual on discharge, even if it is complex and there is then an onward lower requirement for care packages.

Mrs Bowkett advised that when patients go into intermediate care beds, generally they do not require the on-going care, so the system is working really well.

Ms Mills advised that with regards to facilitating discharge, there is also the element abut how services can be developed whereby they are able to intervene sooner and building the capacity to step up, rather than step down and utilising some of the new services in place such as virtual wards.

Mrs Raybould handed over to Mr Fahy at this point.

Quality Section

Mr Fahy presented the Quality Section of the Integrated Quality and Performance Report and like Mrs Raybould he would take the report as being read but wished to highlight the following from the patient safety quality perspective.

- Urgent & Emergency Care: A System Patient Safety and Quality of Care for Pressurised Services meeting took place 28th June 2024. This was on the back of the Dispatches programme which was recently on Channel Four which highlighted some challenges in another system around UEC, particularly around managing people in shared spaces. The focus of the meeting was to provide assurance and consider further options in relation to alternatives to emergency department attendance and admission, especially for those frail older people; and maximisation of in-hospital flow. It was confirmed that areas of poor practice highlighted in the Dispatches programme are not happening in Lincolnshire. The Lincolnshire position was mapped against the 10 High Impact Interventions of the UEC recovery plan and there is a good level of confidence in that. Mrs Dunderdale had already alluded to the clinical audit process in place and there are also walk arounds in place by Non-Executive Directors and Executives in the large acute Trusts – ULHT, NWAFT and NLAG. Discussions had also taken place with Healthwatch about potentially joining up the quality and patient experience oversight heading into winter.
- ULHT Cancer Waiting List Management System: Regular Quality Review process has been initiated with the Trust to establish appropriateness of patients being listed and removed via the Somerset system administration process. 1,700 cases needed to be reviewed, with a small number requiring on-going support but this process was effectively closed.

- Lincolnshire Community Equipment Service provided by NRS - Wheelchair Services: New contract for Wheelchair Services started with NRS on 1st April 2024, who took over from AJM. At the point of handover NRS national systems went down and took several weeks to recover from this. This caused a delay in reviewing the inherited waiting lists from AJM. It has now been identified there is an outstanding works list of approximately 1,500 of which approximately half relates to people waiting for a wheelchair and half relates to outstanding schedule of PPMs (Pre-Planned Maintenance). Additional funding has been agreed with NRS to secure additional clinical capacity to triage the waiting list and timetable reviews in clinical priority order. A robust recovery plan is in place with assurance via LCC who manage this contract.
- Primary Care – no significant changes from the previous update to the Board.
- Serious incidents and Never Events - One new Never Event for NWAFT which related to an issue with temperature probe cover retained during ENT /Max Fax surgery. There was no significant harm to the patient.
- Quality Improvement: CHC: Process has commenced for procurement of care and nursing home provision. Draft care tiers and service specification have been drafted and the first round of engagement is underway, having completed three engagement days with providers focusing on the care tiers and the specification. The process is progressing well.
- Health Protection: Lincolnshire has been identified as an example of good public health practice in the Faculty of Public Health publication – link to the document was in the report. The example referenced was in relation to active case finding for Tuberculosis (TB) of factory workers after three cases of TB were linked by epidemiological analysis to a small-town factory setting.
- Local Maternity Neonatal Services (LMNS) - Maternity Heat Map which began with ULHT in amber which was now green and one of the best performing on the Heat Map metrics.
- Children and Young People (CYP) Speech and Language Therapy (LCHS) - Demand is overwhelming capacity of the service with a 188% increase in referrals into the service since 2019. Whilst there has been a temporary change in the referral pathway to focus on complex cases this has only had an initial positive effect which has not been sustained. A review is currently underway which will include a costed options appraisal.
- Neurodiversity Services for CYP (ULHT; LCHS; LPFT): There has been a significant increase in demand and the impact is insufficient capacity to meet need; increasing waiting times; and potential gaps in support for CYP with diagnosis of ADHD 37% and autism 41%. The MHDLDA Transformation Team are working with system partners and experts by experience to develop an improved, effective pathway.
- Family Support Workers in A&E (ULHT) – Lincolnshire has been successful in its bid through NHSE to become a pilot site working with Barnardo's. Positive progress is being made against the delivery plan, which includes consideration of evaluation requirements
- The Spring vaccination programme ended on the 30th June 2024. This was delivered in partnership by PCNs, the Mass vaccination centres and Community pharmacies, as has been the case in previous phases of the vaccination programme.

The Board considered the update. Ms Day advised that she had two questions, the first of which related to the reference in the report about safeguarding children service and asked for information on the mitigations being put in place to address this and secondly, the report is very comprehensive but there was nothing specifically about Pharmacy, Optometry and Dentistry (PODs). Mr Fahy referred to the safeguarding children front door issue and advised that the change is about the front door strategy meetings which involve health, the local authority and the police. Up until around two months ago, these meetings included the health visitor teams but they have only ever been able to represent pre-school children. 94% of all referrals were for children school aged or beyond.

An interim rota arrangement has been put in place until the end of the August which means the ICB is meeting its statutory requirements. A business case has also been produced and was currently being assessed and once approved would allow for a more permanent arrangement to be put in place. By way of assurance, if the interim arrangements need to be extended beyond August then they will be.

In terms of the PODs, Mr Fahy advised that consideration could be given to this but currently the information in the report is only by exception with the detail being presented through the System Quality and Patient Experience Committee (SQPEC).

This was discussed and it was noted that the Board has received previous updates on PODs, and it was important to bear in mind the detailed information is presented and considered through the Committees as part of the internal operational assurance process; bringing the same information to the Board potentially runs the risk of duplication.

The ICB Board agreed to:

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

24/242 SYSTEM FINANCIAL REPORT (MONTH THREE)

Mr Gaunt advised that the report presented set out the year-to-date and outturn position of both the ICB and the ICS for the financial year 1st April 2024 to 31st March 2025 at the 30th June 2024. This was the first reporting cycle since the final version of the Operating and Financial Plan 2024/25 was submitted in June 2024.

The Board was advised that the report only included the highlights, with the more detailed document having been presented to and considered by the Finance and Resource Committee which was discussed at some length at its recent meeting the previous week.

The first point to note is that the report presented indicated that the ICS' plan was to deliver a £14.0m deficit at month three and the ICS reported a deficit of £16.2m equating to a £2.2m adverse variance to the plan. The ICB has reported a year-to-date deficit of £4.1m, this is in line with the plan. The ICS' plan is to deliver a break-even position against in year allocations and income for the full financial year. The outturn position at month three is to achieve plan.

In summary, whilst the ICB position at month three is on plan, the system position is off plan, which is varied by £2m and there was two principle drivers for that; the first being the costs of industrial action and the second is a cost run rate issue within the ICB cost base. This was expanded on in the risk position. The report noted a £21.2m risk within the plan, which is unmitigated. This net risk includes a planning round gap of £16.0m relating to system investments and cost pressures. The Lincolnshire Chief Executives had requested that Mr Gaunt along with a range of Executive Director colleagues put intensive efforts in through a system wide 'four corners' approach to bridge the gap. This piece of work has taken place over a six week period across the system working closely on a series of task and finish groups.

The work to bridge the gap to date has found c.£5.1m of mitigations and a further phase of the rapidly bridging the gap programme has been agreed by the CEOs to close the remaining gap and a final update to the Chief Executives by Mr Gaunt was planned the following day. The report to the CEOs would identify that there is a still a gap and the next steps would need to be agreed. The next Board report in September would provide a further update, having been through the Finance and Resource Committee the week prior.

The second point to note is an update on the Cost Improvement Programme (CIP) position. The Board was advised that as part of the planning cycle every NHS organisation agreed to a 5% cost improvement target. This contributes in total to an £84m cash out target over the course of the year. This was consistent with the approach taken and delivered in the previous financial year. As such there should be a confidence this can be delivered in 2024/25 but there is an unidentified element with the largest single element being within the ICB's position.

The ICB has some work to do to close that out and as a matter of note that will be taken through the Finance and Resource Committee. The second concern is that given the ICB position is to co-ordinate and convene the system, this may distract attention away from the system to resolve the first issue. Mr Gaunt would be looking to lead on and redress this in the next quarter.

Moving on, at the 30th of June, the ICS is expecting to achieve its Mental Health Investment Standard (MHIS) target for 2024/25. The target spend for the year is £163.8m and the ICS is committed to meeting this target. This is inclusive of £2.8m expenditure relating to prior year under-delivery, as agreed with NHSE.

In respect of capital, the report indicates a total allocation of £37m. There is actually a capital allocation of £113m. £37m is referred to as business as usual which was not amended in the report before it was circulated, for which Mr Gaunt apologised. That said, against the full allocation the position remained on track to utilise that resource in full at year end, and which included a £9m capital bonus that was allocated to the ICS by virtue of having submitted a balanced financial plan. Those systems that did so were rewarded with additional capital monies as it was recognised that the ICS did not receive its fair share of revenue resources as that was provided to systems which did not submit break even plans. Mr Gaunt advised that he had recently tasked his finance team with looking at what is the likely impact on future revenue allocation should that position right itself.

Mr Gaunt concluded the update at that point and advised he was happy to take any questions. Dr McSorley asked whether Mrs Pomeroy had anything to add as the Chair of the Finance and Resource Committee, who advised that Mr Gaunt had summarised the position very well and the Finance and Resource Committee remained very focused on the CIP and the financial gap and some deep dives into key areas will be undertaken in the coming weeks.

The ICB Board agreed to:

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

24/243 GP COLLECTIVE ACTION

Mrs Mills provided a verbal update on the GP collective action and advised that following the recent BMA referendum where 99% of GP members did not accept the 2024/25 contract, the General Practice Committee England (GPCE) undertook a non-statutory ballot of members on collective action that they planned to take. The ballot ran from 17th June through to the 29th July 2024, so closed as of the previous day to the meeting. The results were awaited, but once they were published the proposed action could commence quite rapidly.

The Board was advised that there are 10 actions being proposed by the GPCE, originally having been 12. These included:

- Limit patient contacts per clinician per day to 25 – divert patients to urgent care once this limit is reached.
- Stop engaging with e-referral Advice and Guidance.
- Serve notice on any voluntary services which plug local commissioning gaps.
- Switch off medicines optimisation software where for financial benefit rather than clinical.
- Stop rationing referrals and investigations – refer where appropriate.
- Defer signing off digital telephony and online consultations – don't share telephony data, don't commit to keeping online triage open once maximum capacity is reached
- Switch off GP Connect functionality to permit entry of coding into GP clinical systems by third party providers
- Withdraw data sharing permission where used for secondary purposes (not direct care)
- Freeze sign up to new data sharing

Mrs Mills advised that there will be varying impacts on different parts of the Lincolnshire system, and it is a challenge to plan for this because each GP practice could choose no action, one or two or a multiple of all of those identified. However, in preparation a system arrangement which is not dis-similar to that put in place to manage industrial action has been stood up, which includes a strategic team with colleagues from all elements across the system. The management team will be looking at the different elements and then supporting the various work streams that can consider the impact and the mitigations that will need to be taken to manage the impact.

Mrs Mills added that this is a rapidly moving scenario. The publication of the DDRB report the previous day recommended a 6% increase for general practice contractors but there was no indication at this time whether that would be accepted.

There was little further information to advise the Board of at this time other than to assure the Board of the system arrangements that had been put in place and the situation would be monitored very closely.

The Board considered the verbal update. Mr Gaunt advised that he had considered the potential consequences of this action and was struck by the aspects of the areas that form a lot of the ICB intelligence work, such as data sharing and coding of activity. Reflecting on the papers already presented as part of today's meeting, without that information this would grind to a halt.

Mrs Pratt sought clarification on whether GP collective action and the emerging risk was included on the Corporate Risk Register. Ms Mills confirmed it was included and was added at the point the ballot opened.

Mrs Raybould referred to Mrs Mills comments about a similar approach to this being taken as per the industrial action in respect of data sharing where it relates to direct patient care general practice cannot choose not to continue with that as they have to keep patients safe. It was important to clarify that and provide assurance to the Board.

Ms Day sought clarification on what measures the acute providers were putting in place as there was the potential for people to drift towards A&E and Urgent Treatment Centres (UTCs) in response to the one action about limiting patient contacts to 25 per day. Mrs Dunderdale confirmed that she was working closely with Dr Hindocha, Mrs Mills and Mrs Raybould and all partners in terms of the wider implications of this as it could potentially have a significant impact on urgent emergency care services and the workforce that supports all of that and the experience of individuals that access those services.

Mrs Mills provided further reassurance to the Board, adding that there could be an increase in demand for 111 and that is being considered at a regional level. One of the areas which is harder to mitigate is the potential impact on pharmacies. Significant awareness of pharmacy first has been made as a route for people and having spoken to pharmacy colleagues they are very mindful of constraint capacity and is an area which the ICB will need to closely monitor. As part of the delivery group the pharmacy team are connected into that and supported to ensure visibility.

Mrs Jolly sought clarification on the list of actions and reference to voluntary sector and asked that once there is a better understanding of the situation how the details will be fed across the system to include the voluntary and independent sector and whether they are part of the system arrangements. Mrs Mills advised that in respect of the voluntary sector, it is services which general practice undertake outside of the GP contract, such as enhanced services so in reality it is voluntary services, not sector. In respect of keeping colleagues briefed a communication team has been established and that the mechanism for ensuring colleagues across the third and social care sectors will be through that. LVET are not currently included in the group, but the local authority is.

If there was felt to be an impact on the voluntary sector this could be picked up as part of the planning work.

The Board agreed to:

- **Note the verbal update.**

Mrs Kathy Fulloway joined the meeting to present the next item and was welcomed by Dr McSorley.

24/244 UPDATE ON CYBER ASSURANCE

Mrs Fulloway presented a paper which provided an update on Cyber Security and had been produced to provide the Board with assurance that the ICB and its NHS partners are working in line with national requirements. Mrs Fulloway advised that she would take the report as read, but wished to highlight the following points:

- In a modern healthcare system cyber incidents threaten electronic systems which increasingly underpin and are business critical to everything an organisation does. Globally there has been an increased threat of cyber-attacks which occur because criminal gangs, individuals, or nation states attack NHS systems, or those of its suppliers or partner organisations.
- The ICB and its NHS partners, must give due consideration to ensuring it has appropriate controls in place for the associated risks.
- Cyber attackers seek to breach systems, with the most common root cause being phishing attacks and the impact on organisations in losing or having systems disrupted, losing or suffering corrupted data, or being the victim of a scam was highlighted.
- All Boards for Operators of Essential Services have a responsibility under the Network and Information Systems (NIS) Regulations 2018 to ensure that systems are secure and protected. NHS Providers recommended in a recent publication that every Board member and senior leader has a role in keeping their system safer. There also needs to be time invested in understanding an organisation's supply chain, sharing of skills and expertise system-wide and also assets.
- Each NHS organisation in Lincolnshire assures its own Board through their own governance arrangements, on cyber security risks and compliance with Data Security Protection Toolkit. There is support and resources available to Boards such as training and the National Cyber Security Centre provide a Cyber Security Toolkit for Boards.
- Cyber-attacks will be attempted and are highly unlikely to be completely preventable. However, it is possible to move from safe to safer and the report presented highlighted four key areas to consider in terms of response and preparedness.
- There is a national team at NHSE that provide monitoring and early threat warnings, and it is important to access this resource.
- As infrastructure and software gets older, suppliers choose a point in time to stop providing security updates. This means vulnerabilities cannot be addressed and mitigation of risk of breached systems undertaken.
- There are various technical controls which can be implemented to help reduce risk of attack, but the most effective is Multi Factor Authentication (MFA). All Lincolnshire organisations have implemented MFA wherever possible.
- Regardless of technical controls, staff are the most important defence and need the right skills and confidence through training, and the right culture of learning and psychological safety to be able to talk about issues, so as to protect systems.
- Business Continuity Plans outline how the ICB, and its partners respond to incidents. These need to be in place for all services and organisations, and that are also tested.
- An ICS cyber strategy and plan needs to be developed and there are opportunities for greater collaborative working at a system level which is not yet in place. The Lincolnshire system needs to agree how it uses its resource together for greatest overall impact and a desktop exercise undertaken to test plans.
- The supply chain needs to be better understood in its fullest sense.

- Cyber Security is a high priority for the NHS in England. The importance of this has been further emphasised recently in light of the Cyber Attack in laboratory services in London, and also the recent Crowdstrike incident and global IT impact including aspects of NHS services.

Mrs Fulloway advised that the NHS in Lincolnshire is working closely in line with NHSE and CSOC guidance. IT teams across the system organisations are continuously striving to keep the infrastructure safe and protected from cyber-attacks in line with the national guidance.
This requires continuous vigilance and updating not just from the IT teams, but also by the NHS workforce across the county. Given the key importance and profile of cyber security, it is recommended that the Board has more detailed discussion and gives further consideration to cyber security going forward, potentially for example in a Board Development Session.

Dr McSorley thanked Mrs Fulloway for the update and asked whether there were any questions. Mrs Dunderdale advised that at last week's Group Board Development Session (ULHT and LCHS) they had a cyber piece on the agenda which gave a real understanding and visibility of the exposure the acute and community Trusts face around cyber security, particularly around information and contract assets. It also emphasised the need, which Mrs Fulloway had already touched on, for the Board to have its own assurance processes around cyber security. Mrs Dunderdale was happy to share the detail, which was welcomed.

Action: Mrs Dunderdale

Mrs Robson referred to the establishment of an ICS cyber strategy and sought clarification on the timescale for establishing that and whether there was support from all the organisations involved in its development. Mrs Fulloway advised that she met with the system Chief Executives early in 2024 and received overwhelming support. The timescales as outlined by NHSE was for the Lincolnshire system to have a draft ICS Cyber Strategy by September this year with an approved version in place by April 2025. There was some temporary funding associated with this which had been delayed, but the intention remained to establish a draft strategy by early 2025.

Mrs Raybould advised that cyber forms part of the Emergency, Preparedness and Resilience Response (EPRR) core standard assurance and she was fully supportive of cyber security being the focus of a future Board Development Session.

Ms Day referred to system working and the supply chain and expressed the need to scope out those two areas and the work that could be undertaken now. Mrs Fulloway advised that this approach is being taken with the recruitment process to appoint some support having already commenced. Referring to Ms Day's comments, existing teams can carry out work on the two areas specified.

Dr Thomas referred to the comment in the update about business continuity planning and bearing in mind how dependent primary care is on IT and electronic systems compared to the time of the previous cyber-attack, asking 81 practices to plan for being potentially affected for weeks rather than days would be a real challenge. It would be really helpful to have some support from the ICB to the practices in this regard, which was noted by Mrs Fulloway.

Mr Gaunt referred to the detail in the report on shadow IT which is potentially where the real risk sits and asked what it would take to eliminate that. Mrs Fulloway responded and advised that a piece of work is being undertaken, predominantly at ULHT in the first instance, on network access control which addresses some of the points referred to. Shadow IT relates more to equipment offered by a supplier (such as a data base by way of an example), which is really challenging to address, and in reality is difficult to fully eliminate.

Dr McSorley drew the discussion to a close and thanked Mrs Fulloway for her attendance, who left the meeting at this point.

The Board agreed to:

- **Note the report.**

24/245 LINCOLNSHIRE HEALTH, CARE EDUCATION PARTNERSHIP

Mr Turner advised that as the Board was aware over the past number of years, a series of meetings have taken place between leaders across Lincolnshire's Health & Care and Further and Higher Education sectors to develop a really strong and dynamic relationship. As a result of these meetings, the respective organisations have committed to working in partnership together to develop and implement a comprehensive and integrated approach to meeting the future health and care workforce requirements with education provision.

The Partnership Agreement along with the Ambition Statement was included at Appendix One for endorsement. This is essentially a commitment to work together and identified what the organisations involved want to achieve.

Mr Turner advised that the document is in the process of being presented to the Boards of all organisations in the Partnership for endorsement. On that basis, the ICB Board was asked to endorse the ambition and associated papers.

The Board agreed to:

- **Endorse the Partnership Commitment and Ambition Statement of the Lincolnshire Health, Care and Education Partnership**

GOVERNANCE

24/246 DRAFT BOARD FORWARD PLAN 2024/25

Dr McSorley advised that good governance practice dictates that Boards and Committees should be supported by a Forward Plan of business that sets out a coherent overall programme for meetings. The ICB Board Forward Plan for the formal public meetings was presented having been prepared based on the Board meeting dates agreed for 2024/25 and reflected good practice. A Forward Plan was also included of topics for the Board Development Sessions in 2024/25.

Dr McSorley advised that in previous years the Annual Report and Accounts would have been presented as part of the Annual Public Meeting, but NHSE had advised there is no requirement for ICBs and Trusts to hold APMs this year; the Annual Report and Accounts can be presented at a public Board meeting. It was therefore proposed that the Annual Report and Accounts be considered by the Board at its next meeting on the 24th September. This approach was supported by the Board.

The Board was asked to consider the paper presented and identify any gaps. Apart from some slight typographical changes, nothing material was identified.

The Board agreed to:

- **Approve the Board Forward Plan for 2024/25 subject to the minor amendments noted.**
- **Support the move to present the Annual Report and Accounts to the September public Board meeting, rather than holding a separate Annual Public Meeting.**

24/247 COMMITTEE HIGHLIGHT REPORTS

The Board received and considered the Committee highlights reports from the following Committees:

- Service Delivery and Performance
- System Quality and Patient Experience

- East Midlands Joint Committee

It was noted that the key items flagged in the reports had been discussed during the main part of the meeting and the Chairs of the Committees present advised they had nothing further to add.

The Board agreed to:

- **Note the reports.**

24/248 ANY RISKS IDENTIFIED

It was agreed that no new risks has been identified during the meeting.

24/249 DATE AND TIME OF THE NEXT MEETING

The next formal ICB Public Board meeting will take place on Tuesday, 24th September 2024 at 9.30 am at Bridge House, Sleaford.

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Chair Signature **Date**

Questions from the Board meeting held on 30th July 2024

Question One

My questions concern the Healthwatch Report and, in particular, the wheelchair services formerly provided by AJM and now provided by NRS. They are as follows:

My questions concern the Healthwatch Report and, in particular, the wheelchair services formerly provided by AJM and now provided by NRS. They are as follows:

(1) How is the performance of NRS measured, including:

(a) What key performance indicators are now used to assess and report on the quality, timeliness and efficiency of NRS wheelchair services delivery?

The contract in place with NRS includes a number of key performance indicators which are summarised as follows and are used as part of routine oversight to help understand performance of the contracted service. This includes measures of:

- Referrals screened within 2 working days
- Incomplete referrals returned to referrer for completion
- Urgent and standard assessments undertaken within contracted timescales
- Deliveries of stock; specialist or non-stock; fast track service; and made to measure wheelchairs within contracted timescales following assessment
- Emergency and non-emergency repairs and modifications within contracted timescales
- Collection of wheelchairs following notification within contracted timescales
- First outpatient appointments rearranged due to cancellation by provider

In addition the contract has a number of metrics which the provider is required to report to the ICB on a monthly basis including:

- Referrals (broken down by first; re-referrals; and rejected)
- Completed appointments
- Home visits
- Planned preventative maintenance
- Modified; reconditioned; repaired; stripped; and scrapped items
- Equipment issued; delivered and collected
- Personal wheelchair budgets

The provider is also required to complete and report patient/customer satisfaction surveys.

It is recognised that NRS inherited a backlog of cases when then took over the service. Work to resolve the backlog was also compounded by IT difficulties experienced by NRS that affected their ability to be able to promptly address delayed orders. Work is continuing to ascertain the full extent of the delayed orders and an action plan has been put in place with the provider to address these delays. Additional OT resource is being funded to support this process.

(b) Who comes together to review what aspects of NRS's performance, when (how frequently), why (and do they feel they have the appropriate decision-making responsibilities) and how?

Due to the inherited backlog weekly meetings are taking place with the provider to monitor progress. These meetings are being led by Lincolnshire County Council (LCC) with input from Lincolnshire ICB (LICB).

In addition there are monthly meetings in place to review quality indicators, highlight any risks to patient safety and quality of care and ensure appropriate mitigation is in place.

(2) Who is ultimately accountable for the performance of NRS wheelchair services, and who is responsible for delivering planned improvements in performance?

LICB are the responsible commissioner for the wheelchair service however the wheelchair service forms part of the larger community services contract which is held and managed by LCC who are accountable for the performance of the service under the contract with NRS. A section 75 Partnership Agreement provides the framework for this and LICB is working closely with LCC to ensure appropriate monitoring and oversight is in place.

(3) How will the Board judge if the performance of NRS wheelchair services has improved (or not) by the time of the next LICB Board Meeting on 24 Sep 24, notably in terms of:

a) Clearance of the backlog of outstanding wheelchair users' issues and other problems inherited from AJM?

b) Additional OT resource is in place to undertake the triage work required to assess the needs and complexity of those people on the waiting list. Performance will be monitored in terms of resolution of concerns and complaints and assurance that all cases on the current backlog have been triaged by NRS, so that there is an up-to-date assessment of people's needs, so that the right equipment can be ordered / replaced to ensure patient safety.

c) Confidence that everyone across the LICB system is clear about who is accountable, responsible and needs to be consulted and/or informed about the performance of NRS wheelchair services in future?

d) There is a section 75 Partnership Agreement in place between the ICB and LCC which details the objectives and obligations of each party and associated governance arrangements.

e) Will the wheelchair services provided by NRS by covered inspections by the CQC (or their equivalent) in future?

This is not a regulated service under CQC so will not receive CQC inspections. LICB is working with LCC to ensure appropriate metrics and quality monitoring processes are in place. The LICB, working with LCC will undertake quality visits where there are areas of concern highlighted.

Question Two

Chronic insomnia is one of the various ADHD comorbidities:

- 83% of ADHDers experience sleep disturbances.
- ADHD is associated with increased rates of sleep-disordered breathing, restless leg syndrome, circadian rhythm sleep disorders, insomnia and narcolepsy.
- Sleep deprivation causes additional struggles for ADHDers, such as increased sensory sensitivities and executive functioning struggles.

Sleep disorders are a serious health matter, but they are overlooked. The cumulative effects of chronic sleep disorders are associated with a deterioration of health, including a higher risk of hypertension, diabetes, obesity, depression, heart attack, and stroke.

Despite that, there is no healthcare plan in place to help adult ADHDers manage it. The NHS website about melatonin states, "adults under the age of 55 and children with longer-term sleep problems can take melatonin if a specialist recommends it."
It's important to note here that it doesn't specify anything else. It only informs that the patient must get a specialist to recommend the melatonin.

I have a formal ADHD diagnosis. Due to the massive waiting times, I had to go to a private clinic through the NHS Right To Choose. The psychiatrist there cannot do anything about the insomnia because this condition is not included in the terms of the Shared Care Agreement, despite it being a condition treated by psychiatry and it's a comorbidity.

Then, I found a private psychiatrist who specializes in ADHD and sleep disorders. They prescribed melatonin and sent a letter to my GP, and part of their care plan is to do follow-up consultations to check how am I doing with the melatonin. Unfortunately, my GP refuses to help. They told me the only way is to have an autism diagnosis made by an NHS psychiatrist. The GP suggested referring me to an NHS autism diagnosis, which has a prohibitive waiting list time.

Both NHS and private psychiatrists hold the same certifications and standards. One is not more certified than the other. I don't understand why I waste NHS resources by putting me on the waiting list and having me continue suffering from insomnia for an undetermined amount of time. A qualified sleep disorders specialist already assessed me and wrote a care plan.

The GP was also about to reject my ADHD care plan because they thought I went to PUK as a private patient. I was there as an NHS Right To Choose referral, which saved me.

It is baffling how easily GPs refuse to help when it's about mental health, which doesn't happen when it's a care plan from a private doctor about my physical health.
There is a lack of adult ADHD services in Lincolnshire, and when we turn to private providers, the GP reject us. The same goes for sleep disorders. You are leaving us abandoned and with no access to healthcare.

My questions are:

1. **What are you going to do to address sleep disorders as a comorbidity for adult ADHD** and give us proper healthcare?

Response: Demand for ADHD diagnosis has significantly increased locally and nationally since 2019.
Working with colleagues at the Lincolnshire Academy of Clinical Excellence (LACE).
The current pathway and ADHD services were reviewed by an expert reference group (ERG) including Clinicians, Experts by Experience and ICB Commissioners.
The ERG also identified that the pathway for young people (16–17 year olds) with ADHD transitioning from community paediatrics to adult services needed to be more robust. The aim was to fully understand the needs and current provisions of services for adults with ADHD in Lincolnshire and make recommendations for future service developments.

The outcomes of this work were to:

- Gain a detailed picture of the need in relation to ADHD services for adults in Lincolnshire.
- Create a view of best practice evidence and gap analysis in relation to current provision.
- Have an agreement upon national and local recommendations.
- To develop a strategy and clear commissioning intentions in response to the issues identified.

- Have a blueprint for future service provision and clear care pathway for adults and young people transitioning from Children's to adult services.

LACE working with the ERG produced a series of recommendations which Lincolnshire ICB is in the process of implementing. As part of this Lincolnshire ICB is currently developing a new specification for ADHD providers delivering assessment and treatment services for Lincolnshire citizens, the pathway will ensure a holistic approach to supporting adults with ADHD including those with sleep disorder.

2. What will you do to provide much more comprehensive, fully commissioned services for adult ADHDers?

Response: see answer to question 1.

3. What will you do to offer comprehensive services to diagnose and treat sleep disorders in adults?

Response: United Lincolnshire Hospital Trust (ULHT) are currently running a consultation regarding sleep disorder services in the east of the county. The consultation is open until the 4th of October 2024 and can be found at Sharing your views - United Lincolnshire Hospitals (ulh.nhs.uk)

4. What are your plans to provide training for your GPs so they treat mental health as equally important as physical health?

Response: We have educational sessions both online and in person where we promote clinical pathways in mental health.

5. What is the big difference between an NHS psychiatrist and a private one?

To work as a psychiatrist, the doctor needs to be registered with the GMC and work to guidelines issued by NICE and the Royal colleges. Some doctors choose to work in private practice, whereas the large majority work in our NHS services. If a doctor chooses to work outside of the NHS family of commissioned services, they would be required to adhere their own governance and oversight and prescribing protocols as they are working in an independent capacity.

6. Why do GPs reject assessments from private psychiatrists?

GP's work under shared care agreements where the clinical responsibility is clearly articulated. If that is not in place, which would be the case with a non-NHS psychiatrist as they operate outside of the NHS agreed governance and oversight processes, this means the GPs would be operating outside of their agreed parameters of their operating license, hence they not able to accept a prescription from an independent prescriber as they don't have the speciality knowledge required to oversee that prescription. There may not be shared cared arrangements for independent private prescribers between the NHS and independent doctors.

Question Three

Please could you advise what action is being taken to ease the appointment situation at the Deeping Practice?

Response: The ICB continues to work with GP practices and Primary Care Networks to optimise access, all Primary Care Networks (local groups of GP practices) have developed and are delivering Access Improvement Plans. Overall, GP practices, including the Deepings, are delivering more appointments than in previous years.

The General Practice Improvement Programme is available to all practices to review and improve how they work to deliver the best possible care and to be as efficient as possible.

Same day appointments are, according to their website, only available for those over 80, under 2 and those receiving end of life care with others waiting 3 weeks on a waiting list. Even if a GP asks to see you again within a given time period, that appointment cannot be booked, the patient goes back on the waiting list.

Response: The Deepings Practice has confirmed a number of priority slots are available for all ages and have updated their website accordingly – appointments with an Advanced Nurse Practitioner are available daily.

Online repeat prescriptions take on average 12 days to be available for collection from the onsite pharmacy.

Response: The practice had a dispensing backlog due to sickness, but this has been reduced with dispensing within one week from request.

This is extremely stressful for patients, and I suspect is just as stressful for staff working within this criteria.

Response: The practice recognises waits for appointments or medication can be stressful for patients but aim to make appointments available with the practice team as soon as possible and has confirmed that same day appointments are available for those with the most urgent need.

It seems all departments are overstretched with more patients than they can cope with.

What is planned to alleviate this situation for both staff and patients?

Response: As noted above, the ICB is supporting GP practices and Primary Care Networks to optimise access – the ICB is working with healthcare Trusts alongside GP practices to recruit and retain GP practice and primary care network staff. The ICB is working with GPs to support the sharing of best practice across the County e.g. using online consultation tools to improve access and manage demand, alongside ensuring people who do not wish to use online access are able to contact their practice using other routes.

Not Delivered
In Progress
On Track to Deliver
Complete

NHS
Lincolnshire
Integrated Care Board

ACTION LOG - PUBLIC

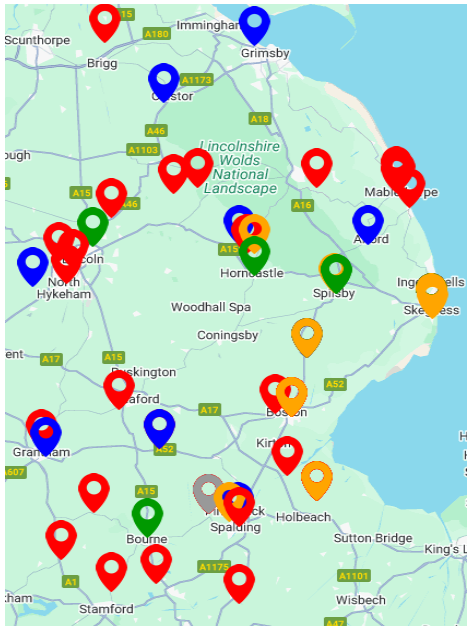
Date of Meeting:	**Tuesday, 24th September 2024**
Agenda Item:	**1 (iv)**
Reporting Officer:	**Dr Gerry McSorley, Acting ICB Chair**

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
30/07/24	24/237	Chief Executive Update	To respond to the questions submitted from two individual members of the public.	Mr Fahy and Mr Eccles	August 2024	Both individuals have received full and detailed responses to the questions submitted.	Complete.
30/07/24	24/244	Cyber Security Update	To circulate the presentation slides of the Lincolnshire Group update on cyber security.	Mrs Dunderdale	August 2024	Slides circulated as requested.	Complete.

ICB Board September 2024 Healthwatch Updates

healthwatch Lincolnshire

People sharing their views and experiences with us on Health and Social Care in Lincolnshire.



Location of comments:
Location data is mapped using postcodes of services. The map points are coloured according to the sentiment of the comment:
Positive - green
Negative - red
Mixed - orange
Neutral - blue
Unclear - grey

August 2024

In August **104** people shared their experiences of health and social care with us. An additional **286** people shared their experiences through our Neurological Health Survey, and **157** people through our Pharmacy Survey.

Out of the 104 experiences shared to our Information Signposting Team, 58% were negative and 6% were positive. The remaining were neutral, mixed or unclear.

The service areas commented* on the most this month were:

- GP Services (38%)
- All Hospital Services (36%) - (6% of all comments were about A&E)
- Dentistry (8%)

*Some comments relate to multiple service areas.

People sharing their views and experiences with us on Health and Social Care in Lincolnshire.

healthwatch Lincolnshire

Wheelchair Service
Recent concerns regarding wheelchair services highlighted significant issues with delays, miscommunications, and the overall quality of service.

Impact
In the last month we have met with new provider NRS and LCC colleagues we have shared the patients concerns and now pleased to say that they are now responding to us and patients and the majority if not all the patients we have shared with them have now had a call from NRS and are moving forward.

Wheelchair Service LCC contract Manager response:

The wheelchair service was transferred to NRS in April after the service was recommissioned.

The expected backlog at the point of transfer was 750 open activities, this the equivalent of a freeze frame of the functioning service including people booked into clinic but yet to be seen, deliveries, repairs and collections booked in but not completed yet and is what we would expect.

In April it became clear that NRS had instead inherited 3000 open activities which is several months of work.

These 3000 activities represent work that is separate to the newly commissioned service that began in April and as such will be managed differently. In these 3000 activities there are activities dating back over a year. The delays people are experiencing is leading to a significant number of complaints which in turn is consuming a lot of NRSs time.

People sharing their views and experiences with us on Health and Social Care in Lincolnshire.

healthwatch Lincolnshire

Inequalities - ***Sensory Loss***

At the Lincolnshire Sensory Services Open Day in Boston, individuals with sensory loss shared challenges in accessing healthcare, particularly around communication.

A lack of understanding among NHS dentists was a key issue, with one patient being discouraged from bringing their assistance dog, causing anxiety. There is also a need for interpreters during dental appointments, yet some dentists rely on language line services instead of face-to-face interpretation.

Case Study 1

"A few people mentioned how difficult it was to access NHS Dental treatment with dentist who had an awareness or understanding of sensory loss. Very few supported them whilst at an appointment. One patient mentioned that their dentist does not want the patients assistance dog in the consulting room as it was a clinical area. On the first occasion this happened, the patient was on their own and felt pressurised into not taking the dog in, this made them feel very anxious about treatment.
The second visit to the same dentist a few weeks ago, the patient took their dog and a friend with them, where the friend argued with the dentist that they needed the dog. Dentist was very reluctant to proceed, but eventually did examine the patient. Patient was made to feel very uncomfortable and now is hesitant about going back. Patient understands how difficult it is to get an NHS Dentist and has tried to find another one."

Case Study 2

"Patient expressed how difficult it was to get an interpreter. If a hospital appointment is cancelled it can take months to get an interpreter booked and the hospital do not always rebook the interpreter for the patient. There have been a few occasions that the patients appointment has been cancelled and not the interpreter and vice versa, this causes lots of extra stress when trying to keep appointments at the hospitals."

People sharing their views and experiences with us on Health and Social Care in Lincolnshire.

healthwatch Lincolnshire

Inequalities - ***Sensory Loss (continued)***

Communication barriers make accessing care difficult for patients with hearing and sight loss, who struggle with phone communication and online services. Scheduling is also tough due to reliance on community car schemes.

One individual shared difficulties booking interpreters for hospital appointments, especially when cancellations happen at short notice, adding to their stress.

Case Study 3

"Patient with sight / hearing loss and access to dental services. Uses currently a dental practice in Boston but would like to have an interpreter at the appointments. Dentist is using language line but refuses to bring in someone face to face. The patient finds it difficult to see what's on the screen."

Case Study 4

"As a patient with sensory loss (sight and hearing) and no internet access, living on my own with no transport, it can be extremely difficult to get an appointment at the practice. When I finally do get through on the phone, their usual response is, 'use the online service'. I have explained to them about the fact that I do not have internet/smart phone etc, I cannot see the texts on the phone and find it hard to use the phone.

If I do manage to get an appointment, they want me to come in on that day, which I cannot always do due to transport issues. I use the community car scheme and need to book in advance, at least a couple of days notice. They don't seem to want to support their patients. Due to sight loss, a bit worried about changing surgeries because I know my way about this one, once I get there."

Our Campaigns

Respiratory Health

We hosted a workshop to share findings from our respiratory health project, which included input from 230 participants (223 service users and 7 healthcare professionals). Attendees shared feedback, experiences, and updates on initiatives to improve respiratory health services in Lincolnshire.

The presentation of the findings from the webinar can be viewed on our YouTube Channel 'HWLincs':
Respiratory Health: Respiratory Health Survey Findings Healthwatch Lincolnshire 2024

Watch our previous webinars here:
Menstrual Health: Menstrual Health Survey Findings Healthwatch Lincolnshire 2024

Our Campaigns

healthwatch Lincolnshire

Pharmacy Survey

To support the pharmaceutical needs assessment (PNA) and ensure that people's experiences are included in discussions about pharmaceutical services in the county we launched a survey. The survey explores the accessibility and quality of pharmacy services, including the Pharmacy First scheme. 160 people have shared their views.

Neurological Survey

We have so far heard from 330 people about their experiences of health and care across a variety of neurological conditions. This survey closes at the end of September.

Patient Survey

Professional Survey

Our Campaigns

Through 2024 Healthwatch Lincolnshire has focused and will be focusing on the following:

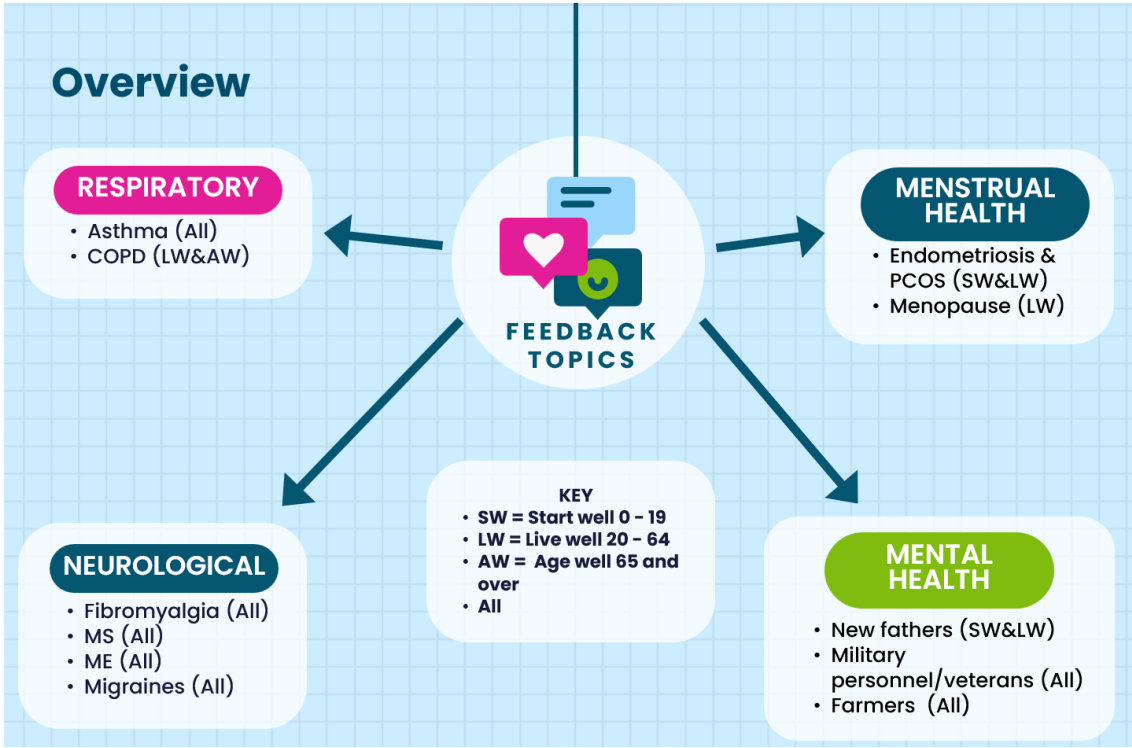
Jan – Mar	Menstrual Health
Apr – Jun	Respiratory Health
Jul – Sep	Neurological health
Oct – Dec	Mental Health

Mental Health

For the final quarter of 2024, we turn our attention to mental health. We are particularly keen to hear from:

- New fathers
- Serving military personnel and veterans
- Those working in farming, agriculture and or horticulture

The survey will be live shortly, more information to follow.



YourVoice@Healthwatch

Join us for our next YourVoice@Healthwatch event

Healthwatch Lincolnshire is excited to invite you to our next YourVoice@Healthwatch event, which will focus on our previous impact and offer you the opportunity to shape our future priorities.

Event details:

Date: Wednesday, October 23rd, 2024
Time: 10am - 1pm
Location: Boston United Football Club, Jakeman's Community Stadium, PE21 7NE

Current HWLincs Focus

HWLincs The Engagement to Insight People

healthwatch Lincolnshire

Childhood Vaccinations

HWLincs aims to help Public Health understand the behaviors, values, and beliefs of the 7-10% of families who do not fully immunize their children at key stages (8 weeks, 1 year, 5 years) according to the Quality and Outcomes Framework (QOF) VI001-VI003. This includes families who choose some but not all recommended vaccines.

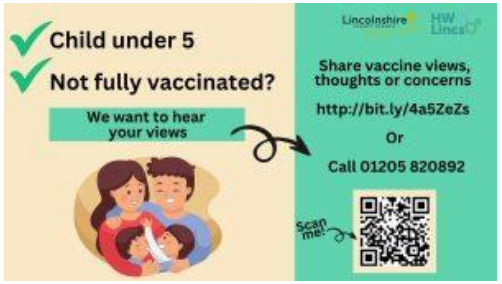
Agreed Areas of Focus:

Boston: Children with no vaccines
East Coast: Children with some but not all vaccines
Stamford: Anti-vaccine cohort
Inner Lincoln

Infant Feeding

To work with new mothers to understand barriers to breastfeed and to seek the views of other involved parties, i.e. Partners and family. 2-part project, firstly digital survey, secondly field work.

To date, we have had 848 responses to the survey (KPI: 300-500) and have carried out 12 in-person interviews (KPI: 2).



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healthwatch Lincolnshire

Item 4 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	4 (i)
Meeting Date:	17/09/24
Title of Report:	NHS Population Health Strategy & Planning
Report Author:	Feargus Mack (Associate Director – Planning & Transformation LICB)
Presenter:	Feargus Mack (Associate Director – Planning & Transformation LICB)
Appendices:	Annual population health planning cycle for 2024-25 (v.12-09-24)

To approve ☐	For assurance ☐	To receive and note ☒	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The committee is asked to:

- note the population health planning approach for 2024/25 that has been agreed by the Lincolnshire Leaders Group
- flag any areas requiring further clarification that would support the committee's role

Summary

The aim and scope of this approach

To set out our approach and associated process for our population health planning work in 2024/25, including:

- How we are working together: Mindset and behaviours; Principles; Key shifts; Language
- Our strategic framework: Strategy map; Strategic priorities and success measures; Assumptions; Our improvement planning and delivery cycle
- Deliverables and project plan: What's being done, when by whom
- Key building blocks and deliverables: Intelligence; Efficiency; Demand & capacity modelling
- Governance and oversight arrangements: key groups; decision making

How this proposal has been developed

- Understanding the key drivers at both a system level (planning review) and national level (the new government's emerging plans, summarised on P6 of the appendix). A survey was carried out after conclusion of 2024/25 operational planning in June to capture reflections regarding our planning work over the last 12 months, including the positives, the issues/shortcomings and proposals to improve future work
- Three workshops have been held over July and August – involving executives from the ICB, the Lincolnshire Community and Hospitals NHS Group and Lincolnshire Partnership NHS Foundation Trust – to identify the key lessons and develop the approach set out in this paper
- It has been acknowledged that both the ICB and the Group are considering their operating models – it is essential that our respective system partner roles evolve in step with each other. With this in mind, the draft ICB TOM has been shared with system partners.

All relevant teams have been given the opportunity to suggest how they can add value to this work.

Summary of the overall approach

The aim of this approach is to strike the balance of supporting the delivery of our long-term population health improvement goals as well as care delivery: helping meet today's challenges, while shaping the landscape of tomorrow.

With that in mind, there is an evolution and continued refinement of existing elements:

- *Expert-led*: including all the different system voices who understand the issue – tapping into the best available expertise e.g. People with lived experience; clinical (multi-professional), operational and corporate support subject matter experts
- *Intelligence-driven*: analysis of all relevant sources of intelligence viewed through the lens of our population's health to get the best possible understanding of the Lincolnshire population's evolving needs, current care delivery and the opportunities for improvement; more systematic evaluation to inform future planning
- *Integrated process*: Multi-disciplinary; Triangulation and alignment of quality & performance, activity, workforce and finance; Joined-up conversations re. resource allocation/re-allocation,
- *Year-round process*: Proactive and measured – ensuring the requisite time is dedicated to analysis, idea generation, strategy setting, prioritisation, detailed planning and modelling; Agile and responsive – PDSA-style approach to refining/stopping/scaling up work
- *Multi-year scope*, extending our planning horizon beyond next March

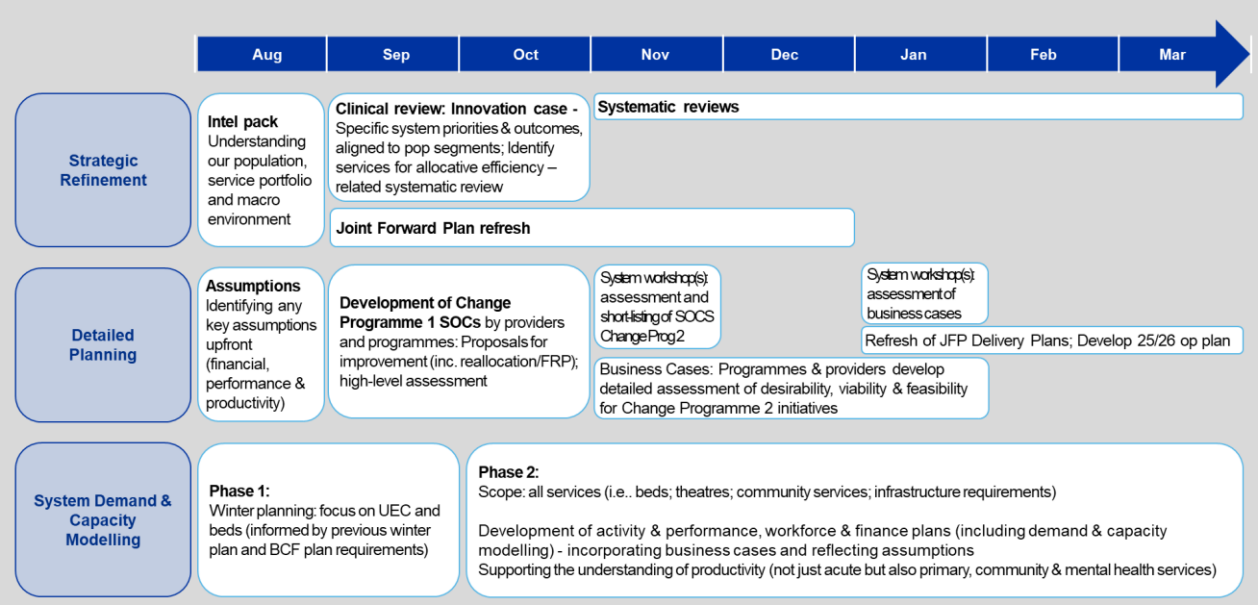
…with two key shifts:

- *Longer term, strategy-driven approach*
  - In line with the role of ICS partners to set priorities for improvement that give greatest benefit to population health, shifting the planning lens from short-term performance targets to longer term population health goals
  - Understanding how different groups of people interact with our services is fundamental to making informed decisions about allocation of resources: we will use the population segmentation model as the frame to understand the sustainability gap between population need and system resource – and how this gap can be closed through more targeted objective/priority setting, plus innovation and risk management

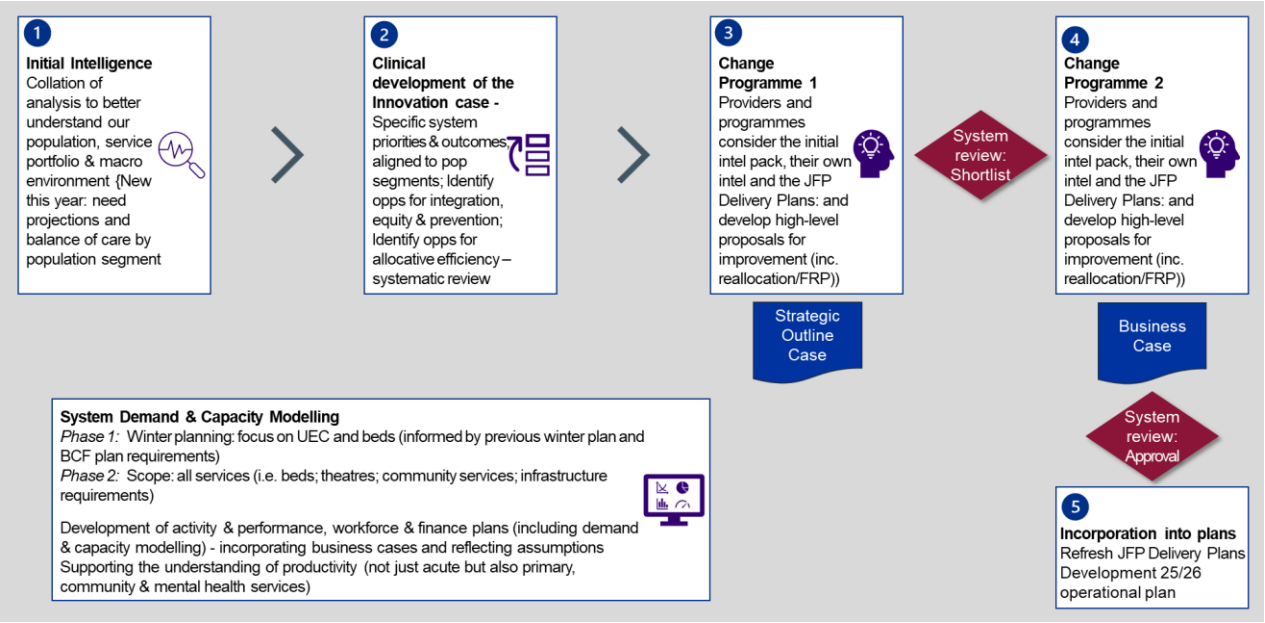
- *Taking a more sophisticated approach to resource allocation*
  - Proportionate universalism: resourcing and delivering universal services and interventions at a scale and intensity proportionate to the degree of need of the population segments (including Core20PLUS5)
  - Not only looking at technical efficiency (doing things right – including the productivity agenda), but also allocative efficiency (doing the right things): this means understanding the current value of pathways and services and analysing how resources should be shifted around the system to maximise the health gain for the Lincolnshire population

Summary of the overall approach

Planning deliverables and timescales



Resource allocation sequence



Governance and oversight arrangements

- Development and delivery of the planning approach
  - The Executive Strategy & Planning Group will manage the development of the planning process: ensuring alignment between system work; troubleshooting at executive level
  - Technical Strategy & Planning Group will manage the progression of the planning process: acting as key conduits for facilitating planning comms in and out of the organisation and linking the relevant colleagues into programmes; delivering the planning products
- Prioritisation decision-making
  - The Clinical & Care Directorate will lead the development of the Innovation Case: identifying specific system priorities & outcomes, aligned to population segments; in terms of allocative efficiency, identify services/pathways for systematic reviews
  - A multi-professional system leadership group (incorporating strategy, clinical, operational, workforce and finance) will carry out a collective and holistic assessment of high-level proposals and business cases. There will be consideration of how initiatives need to be linked and any gaps in addressing key opportunities. Priorities developed taking into account resource constraints, urgency for change and national mandates (including tackling health inequalities, with a focus on our Core20PLUS5 approach)
- Board assurance
  - Monthly updates will provided to the ICB Service Delivery & Performance Committee and Finance & Resource Committee. These committees will meet jointly to review plans
  - LCHG and LPFT strategy executives will ensure the requisite involvement of their boards
  - LLG will act as the main approval body for NHS strategies, plans and final submissions to NHS England. CEOs will be the approval body for any draft submissions

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	
Aim 2: Tackle inequalities in outcomes, experience and access.	
Aim 3: Enhance productivity and value for money.	
Aim 4: Help the NHS support broader social and economic development.	
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Include details of risk and assurance implications, and in particular any risks aligned to the Board Assurance Framework and Corporate Risk Register.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report highlight any quality and patient safety implications?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report highlight any health inequalities implications/	If yes, include the details otherwise state 'No or Not Applicable'

Does the report demonstrate patient and public involvement?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	If yes, include the details otherwise state 'No or Not Applicable'

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☐
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☐
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☐

Report previously presented at:

ICB Executives; ICB Service Delivery & Performance Committee; Lincolnshire Leaders Group

Is the report confidential or not?

Yes ☐ No ☒

NHS Population Health Strategy & Planning

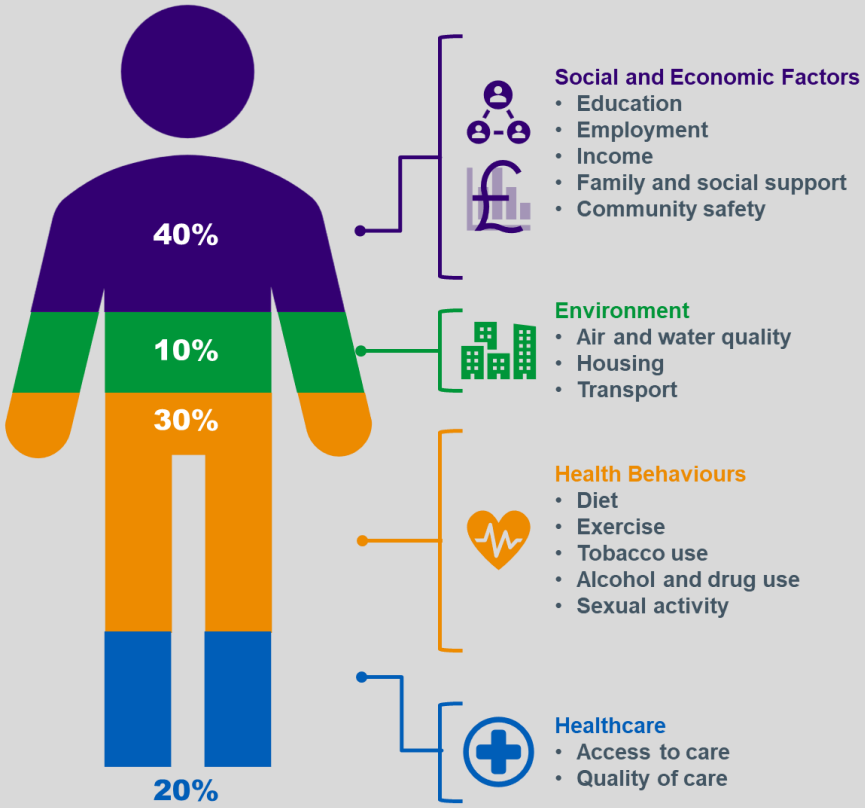
Overview of our integrated approach for developing the key planning deliverables in 2024/25

Summary for the ICB Board on 24/09/24

The aim and scope of our population health planning work

- The aim and scope of our population health planning work is meeting the evolving needs of the Lincolnshire population, while making the most of our collective resources
- Our health is shaped by a range of factors. The Better Lives Lincolnshire Integrated Care System partners are increasingly working together to consider all determinants of health, focussing on integration, equity and prevention. As our partnership matures, our joint approach to population health planning will evolve to support this.
- The approach detailed in this document majors on how we can refine our planning as the Lincolnshire NHS in 2024/25, while also identifying the system partnerships, infrastructure and joint-resource planning we need to implement to maximise the health and wellbeing gain for the Lincolnshire population. It strives to balance supporting the delivery of our long-term population health improvement goals as well as care delivery: helping meet today's challenges, while shaping the landscape of tomorrow.

Determinants of health



Better Lives Lincolnshire Integrated Care System partner functions

How we are working together | Principles

- **Expert-led:**
  - including all the different system voices who understand the issue – tapping into the best available expertise e.g. People with lived experience; clinical (multi-professional), operational and corporate support subject matter experts

- **Intelligence-driven:**
  - Analysis of all relevant sources of intelligence viewed through the lens of our population's health (e.g. patient & citizen engagement; public health needs analysis; joined dataset; performance & benchmarking data; fragile services assessment) to get the best possible understanding of the Lincolnshire population's evolving needs, current care delivery and the opportunities for improvement
  - More systematic evaluation to inform future planning

- **Integrated process:**
  - Multi-disciplinary
  - Triangulation and alignment of quality & performance, activity, workforce and finance
  - Joined-up conversations re. resource allocation/re-allocation, not separate investment & FRP work
  - Agreeing/reviewing key planning assumptions & fixed points (i.e. finance including CIP targets; activity & performance targets; workforce) as a system; one reporting suite

- **Year-round process:**
  - *Proactive and measured* – ensuring the requisite time is dedicated to analysis, idea generation, strategy setting, prioritisation, detailed planning and modelling
  - *Agile and responsive* – PDSA-style approach to refining/stopping/scaling up work

- **Multi-year scope,** extending our planning horizon beyond next March
  - *Tactical* (Immediate transactional improvements e.g. reducing non-pay/discretionary spend; Year 0 and Year 1; Within individual organisations)
  - *Operational* (Continuous improvement: questioning how we can deliver the same service better e.g. increasing productivity; Years 1 & 2; Both individual organisations and system)
  - *Strategic* (Transformational change: re-thinking the whole system and pathway; questioning why and how we do everything; Years 2 – 5; System)

[N.B. Year-round and multi-year does not mean trying to do everything all of the time. It's having a logical cycle that allows us to move forward together. It does not preclude work throughout the year .e.g. idea generation can happen at any time – just that there is a specific focus in Q1 and Q2 when there is more headroom and enables a holistic and collective approach to resource allocation decision-making]

How we are working together | Key shifts

1. **Longer term, strategy-driven approach**
   - In line with the role of ICS partners to set priorities for improvement that give greatest benefit to population health, shifting the planning lens from short-term performance targets to longer term population health goals
   - Understanding how different groups of people interact with our services is fundamental to making informed decisions about allocation of resources: we will use the population segmentation model as the frame to understand the sustainability gap between population need and system resource – and how this gap can be closed through more targeted objective/priority setting, plus innovation and risk management

2. **Taking a more sophisticated approach to resource allocation**
   - Not only looking at technical efficiency (doing things right – including the productivity agenda), but also allocative efficiency (doing the right things): this means understanding the current value of pathways and services and analysing how resources should be shifted around the system to maximise the health gain for the Lincolnshire population
   - Proportionate universalism: resourcing and delivering universal services and interventions at a scale and intensity proportionate to the degree of need of the population segments (including Core20PLUS5)

We have invested in a wide range of PHM infrastructure and intelligence tools (e.g. Lincolnshire Joined Intelligence Dataset and the PHM Projections tool which leverages this resource): we can now understand how population need will grow in future years, how this will affect activity and resources, the greatest areas of opportunity and model the impact of any initiatives we introduce to “bend the curve”.

The emphasis is now on using these in earnest to:

- Systematically support data-driven planning and care delivery to optimise health outcomes
- Accelerate the shifts described above to enable a more proactive, preventative and collaborative system that is focusing on interventions to prevent illness, reduce the risk of hospitalisation and address inequalities

Lincolnshire population segmentation model and Core20PLUS5 segments

Generally Healthy

At Risk
Alcohol/Substance abuse; Care Plan; Current Smoker; Electronic Frailty Index (eFI) - Not Fit; Heavy Drinker; High Blood Pressure; High Cholesterol; High QRISK score; Memory & Cognitive problems; Low Mood; Not Fit For Work; Obesity; Opioids Prescription; Social Vulnerability

Children & Maternity
Age 0-16

Low Risk
Doesn't fit into any other criteria

Acute Episodic

Major
1 or more Emergency Admissions in year

HIUs
6 or more A&E attendances in year

Long Term Conditions

Moderate Frailty
Moderate Frailty (eFI)

Big Six
Cancer; Chronic Kidney Disease; Chronic Respiratory Disease; Diabetes; Heart Failure; Stroke

Disability
Activity Limitation; Learning Disability; Requirement for care

Mental Health
Anxiety; Autism Spectrum Disorder; Depression; Serious Mental Illness (e.g. bipolar & schizophrenia)

MSK
Trauma & orthopaedics, rheumatology or physiotherapy (primary care, admission, OP or waiting list)

Living with Illness
Living With Illness

High Need

Severe Frailty
Severe Frailty (eFI)

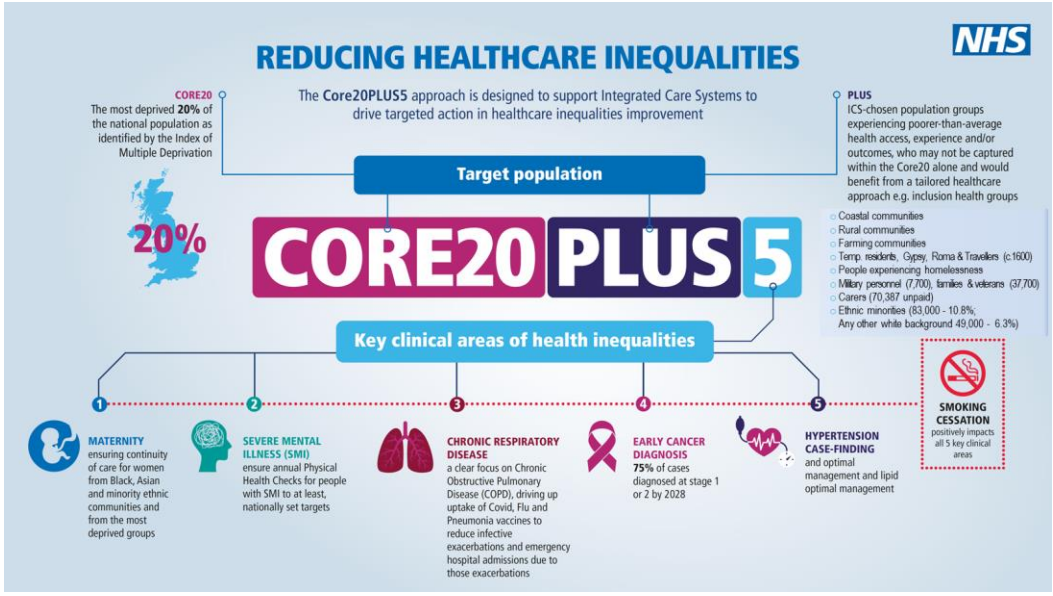
High Complexity
High Complexity

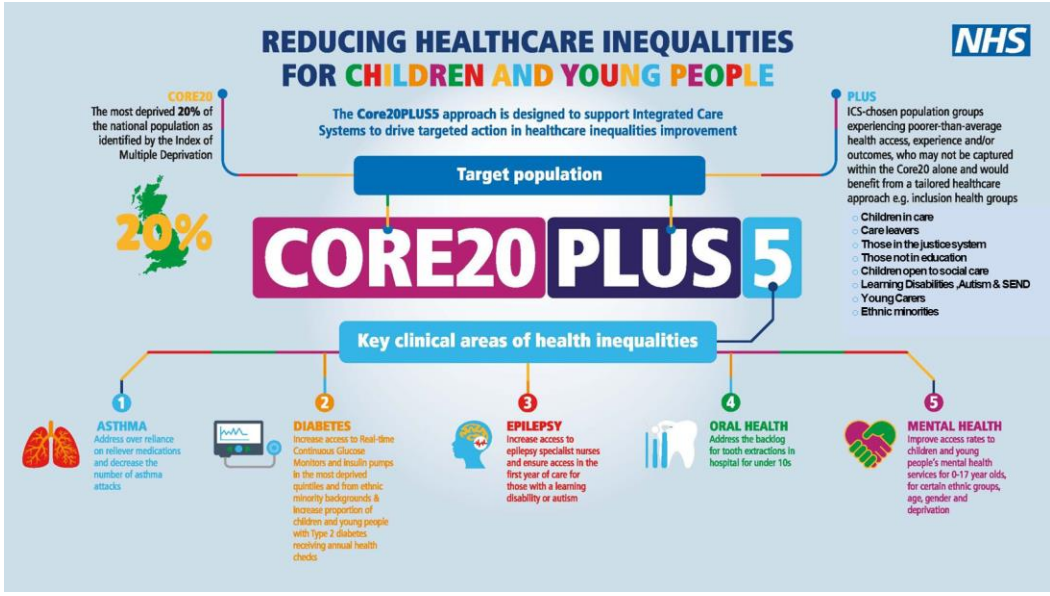
Dementia
Alzheimer's Disease; Dementia

Palliative & End of Life

Cancer
Metastatic Cancer

Non-Cancer
Hospice Palliative





Resource allocation sequence

1

Initial Intelligence
Collation of analysis to better understand our population, service portfolio & macro environment {New this year: need projections and balance of care by population segment

2

Clinical development of the Innovation case -
Specific system priorities & outcomes, aligned to pop segments; Identify opps for integration, equity & prevention; Identify opps for allocative efficiency – systematic review

3

Change Programme 1
Providers and programmes consider the initial intel pack, their own intel and the JFP Delivery Plans: and develop high-level proposals for improvement (inc. reallocation/FRP)

Strategic Outline Case

System review: Shortlist

4

Change Programme 2
Providers and programmes consider the initial intel pack, their own intel and the JFP Delivery Plans: and develop high-level proposals for improvement (inc. reallocation/FRP))

Business Case

System review: Approval

5

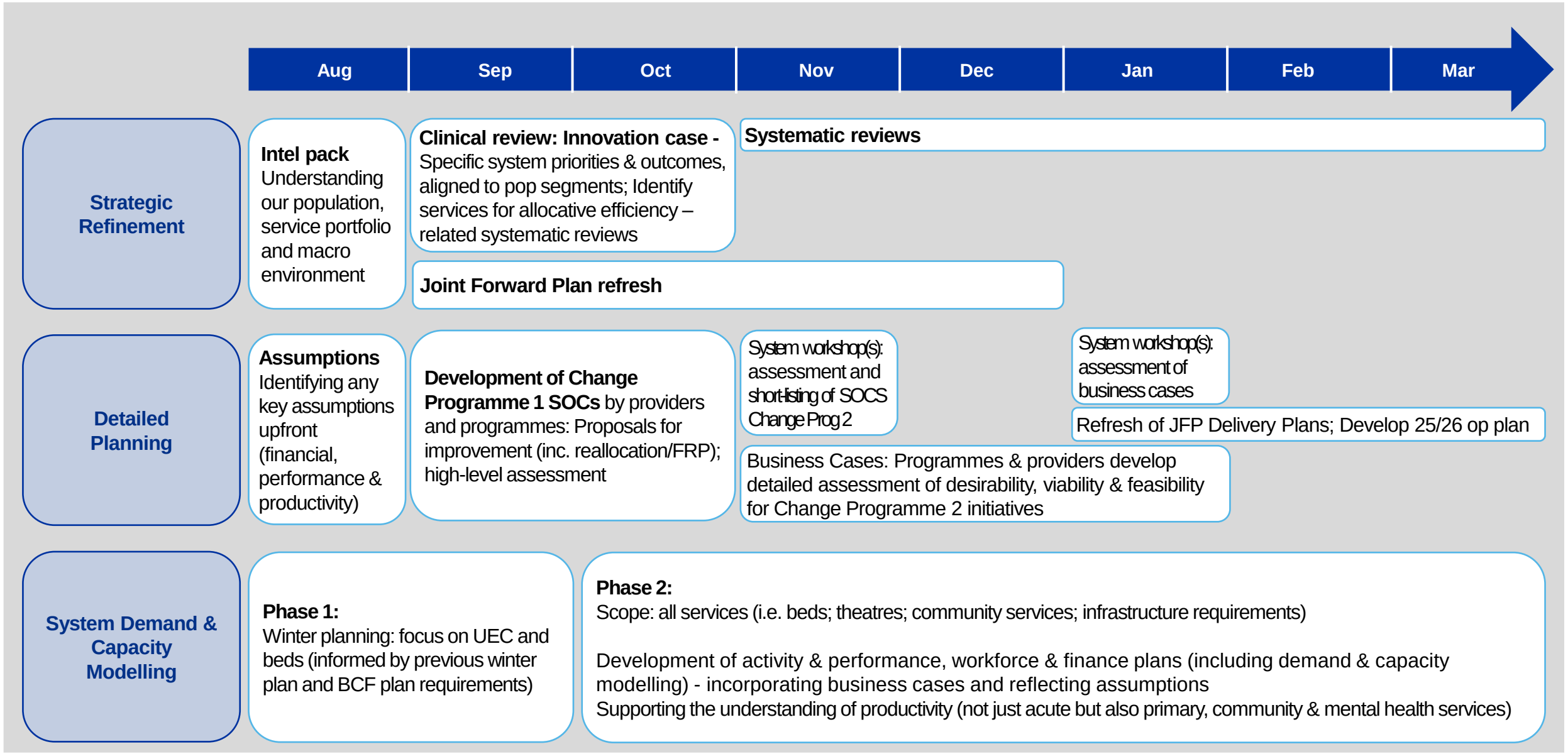
Incorporation into plans
Refresh JFP Delivery Plans
Development 25/26 operational plan

N.B. Ideally, Step 1 is completed in Q1 and Steps 2 and 3 would be sequential. However, timescales for 2024/25 have been concertinaed by national and system circumstance, which means that Step 2 and 3 will be concurrent. The expectation is that 2025/26 will be more proactive, with the process spread more evenly across the year

System Demand & Capacity Modelling
Phase 1: Winter planning: focus on UEC and beds (informed by previous winter plan and BCF plan requirements)
Phase 2: Scope: all services (i.e. beds; theatres; community services; infrastructure requirements)

Development of activity & performance, workforce & finance plans (including demand & capacity modelling) - incorporating business cases and reflecting assumptions
Supporting the understanding of productivity (not just acute but also primary, community & mental health services)

Overview of planning deliverables and timescales



Making it happen | planning development, oversight & governance overview

Development and delivery of the planning approach

- The Executive Strategy & Planning Group will manage the development of the planning process: ensuring alignment between system work; troubleshooting at executive level
- Technical Strategy & Planning Group will manage the progression of the planning process: acting as key conduits for facilitating planning comms in and out of the organisation and linking the relevant colleagues into programmes; delivering the planning products

Prioritisation decision-making

- The Clinical & Care Directorate will lead the development of the Innovation Case: identifying specific system priorities & outcomes, aligned to population segments; in terms of allocative efficiency, identify services/pathways for systematic reviews
- A multi-professional system leadership group (incorporating strategy, clinical, operational, workforce and finance) will carry out a collective and holistic assessment of high-level proposals and business cases. There will be consideration of how initiatives need to be linked and any gaps in addressing key opportunities. Priorities developed taking into account resource constraints, urgency for change and national mandates (including tackling health inequalities, with a focus on our Core20PLUS5 approach)

Board assurance

- Monthly updates will provided to the ICB Service Delivery & Performance Committee and Finance & Resource Committee. These committees will meet jointly to review plans
- LCHG and LPFT strategy executives will ensure the requisite involvement of their boards
- LLG will act as the main approval body for NHS strategies, plans and final submissions to NHS England. CEOs will be the approval body for any draft submissions

Item 5(i)

NHS
Lincolnshire
Integrated Care Board

NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5(i)
Meeting Date:	August 2024
Title of Report:	Integrated Performance, Quality & Finance Report – August 2024
Report Author:	James Singleton, Performance Manager
Presenter:	Clair Raybould- Director for System Delivery Martin Fahy- Director of Nursing Emma Rhodes – Deputy Director of Finance
Appendices:	Performance, Quality and Finance Report

To approve ☐	For assurance ☒	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

1. To note the key issues set out in the paper and the actions in place to support improvement.
2. To discuss any areas the board would like committees to seek further assurance on
3. To note ongoing the ongoing impact of Industrial actions

Summary

• This report is underpinned by the reporting that is received at the Board Committee for Quality and the monthly Service Delivery and Performance Committee.
• This report shows the latest analysis of key system operational performance and quality indicators covering normal variation, trends and shifts in performance over time for key metrics and measures across a number of areas of ICB delivery
• The report is designed to provide assurance to the Board that there full understanding of the drivers for performance and the high level actions in place to address off track performance and quality in areas that are likely to have the most significant impact for patients.

Urgent & Emergency Care

- All Types 4-hour performance for Lincolnshire ICB for August 2024 was 73.7% below the planned local position of 75.7% (95% constitutional target).
- Category 1 mean response times for EMAS Trust was 08:46 minutes

against a standard of 07:00 minutes during August 2024.

- The Category 2 mean response time for EMAS trust was 30:53 minutes against an expectation of 30 mins (18:00 constitutional target).

Cancer

- 185 patients were waiting over 62 days at the end of August, this is higher than July where we finished with 172 in the backlog
- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral decreased to 64.1% in July from 69.2% in June
- The faster diagnosis standard was achieved in July, overall performance was 78.7% against the 75% standard

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals remains relatively static, although improvements are being made to reduce the longer waits
- The number of patients waiting more than 78 weeks across all Providers was 11 at the end of July and all were either due to patient choice or complexity of the clinical pathway.
- All providers are aiming to eliminate over 65 week waits by September 2024, although this will be extremely challenging. The number of patients waiting over 65 weeks was 733 at the end of July.

Mental Health, Learning Disabilities & Autism

- The NHS Talking Therapies (previously IAPT) waiting times standards were both achieved in July. 95.4% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 99.4% received their first treatment appointment within 18 weeks, against the 95% standard.
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 85% in July (rolling 12 months) which is above the 60% standard.
- LDA adult inpatients remain above trajectory but is expected to recover during quarter 2 as delays to LTS17(3) project have been resolved.

Primary Care

- GP Collective Action - GP members of the British Medical Association (BMA) voted in favour of 'collective action' which commenced 1st August 2024 and has no end date currently. ICS governance arrangements have been established, which includes multi-disciplinary representation from across the whole system, to monitor impact of this and respond accordingly.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	✔
Aim 2: Tackle inequalities in outcomes, experience and access.	
Aim 3: Enhance productivity and value for	

money.	
Aim 4: Help the NHS support broader social and economic development.	
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Risks to the achievement of performance standards are outlined in the body of this report and where required are incorporated into the Risk Register at programme and ICB level.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	Quality and patient safety implications directly associated with the issues outlined in this report are set out in the body of the report.
Does the report highlight any health inequalities implications/	Health inequalities implications directly associated with the issues outlined in this report are set out in the body of the report.
Does the report demonstrate patient and public involvement?	Not applicable- although through normal operations there has been engagement and communications directly particularly in relation to winter pressures
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an equality impact assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Not applicable

Is the report confidential or not?
Yes ☐ No ☒

Integrated Performance & Quality Report

NHS
Lincolnshire
Integrated Care Board

September 2024

20/09/2024

Contents

Executive Summary

NHS Lincolnshire Integrated Care Board

Overview

The September 2024 ICB OQAG quality & performance report incorporates constitutional standards, quality and safety measures and elective recovery activity, and presents system performance updated to August where available.

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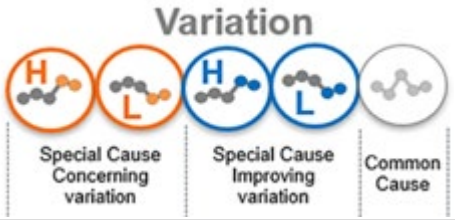
Key to Run Charts

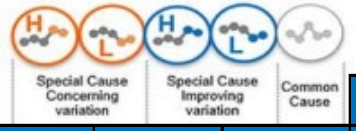
NHS Lincolnshire Integrated Care Board



	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly.** It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance.
H	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
L	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
H	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
L	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	

Lincolnshire ICB Performance Dashboard

NHS Lincolnshire Integrated Care Board

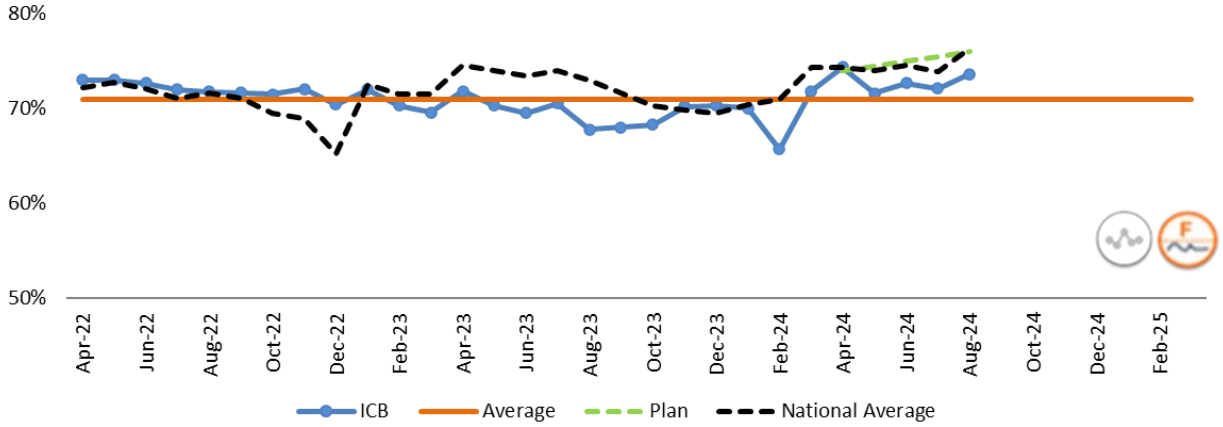


Programme	Indicator	Standard	Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Variation	Assurance
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	95%	76.0%	Aug-24	73.7%	74.8%	76.3%			
	Ambulance response times - Mean response time- Category 1 (EMAS)	00:07:00	-	Aug-24	00:08:46	00:08:18	00:08:03			
	Ambulance response times - Mean response time- Category 2 (EMAS)	00:18:00	00:30:00	Aug-24	00:30:53	00:24:35	00:27:25			
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	96%	-	Jul-24	89.6%	90.5%	91.9%			
	Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade	85%	-	Jul-24	64.1%	63.2%	67.7%			
	% of patients told cancer diagnosis outcome within 28 days (ICB)	75%	-	Jul-24	78.7%	77.7%	76.2%			
Elective Care	RTT: % of incomplete pathways within 18 weeks	92%	-	Jul-24	54.2%	57.1%	58.8%			
	Patients waiting over 65 weeks for treatment (ICB) (% of total ICB waiting list size)	-	-	Jul-24	0.63%	0.51%	0.67%			-
	Patients waiting over 78 weeks for treatment (ICB) (% of total ICB waiting list size)	-	-	Jul-24	0.01%	0.01%	0.04%			-
	Percentage waiting six weeks or less for a diagnostic test	99%	-	Jul-24	69.7%	75.1%	77.6%			
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	0.8%	-	Q1 2024/25	26.4%	24.9%	23.5%			
Mental Health	NHS Talking Therapies access - first treatment appointment within 6 weeks (ICB)	75%	-	Jul-24	95.4%	N/A	90.7%			
	NHS Talking Therapies access - first treatment appointment within 18 weeks (ICB)	95%	-	Jul-24	99.4%	N/A	98.2%			
	People experiencing first episode psychosis waiting to start a package of care (ICB)	60%	-	Jul-24	85.0%	78.7%	71.5%			
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	95%	-	Mar-24	66%	74%	73%			
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	95%	-	Mar-24	70%	76%	79%			

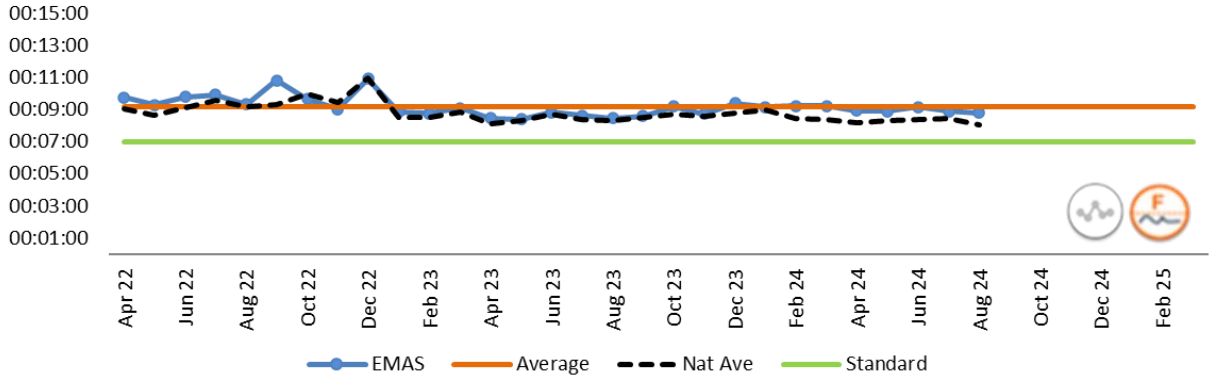
Urgent Care

NHS Lincolnshire Integrated Care Board

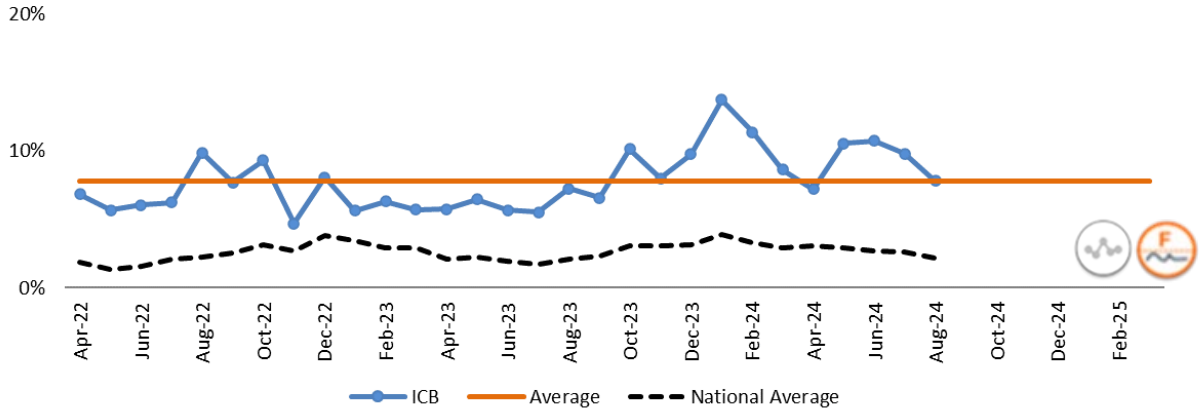
A&E admission, transfer, discharge within 4 hours (ICB)



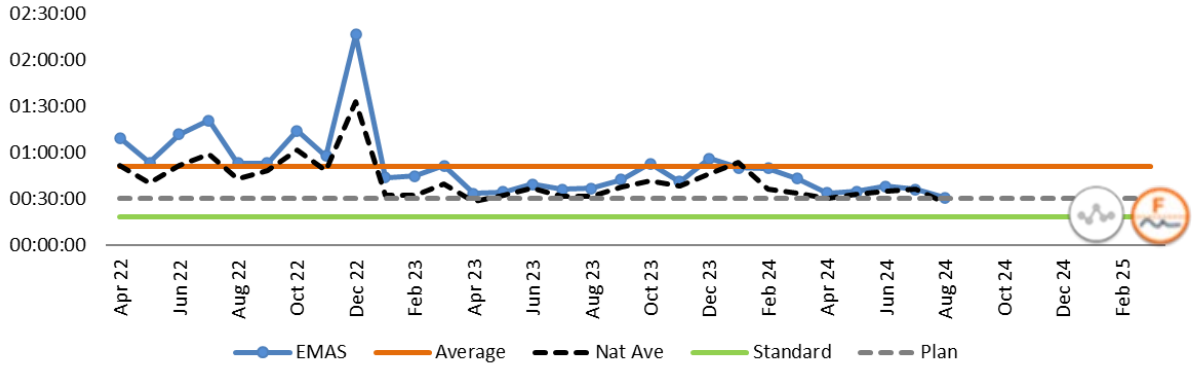
Ambulance response times - Mean response time- Category 1 (EMAS)



12+ hour delays from decision to admit (ICB)



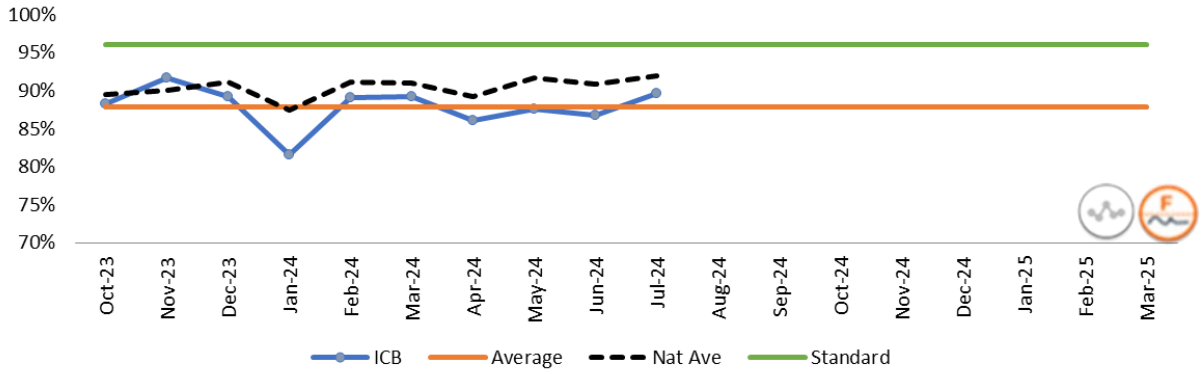
Ambulance response times - Mean response time- Category 2 (EMAS)



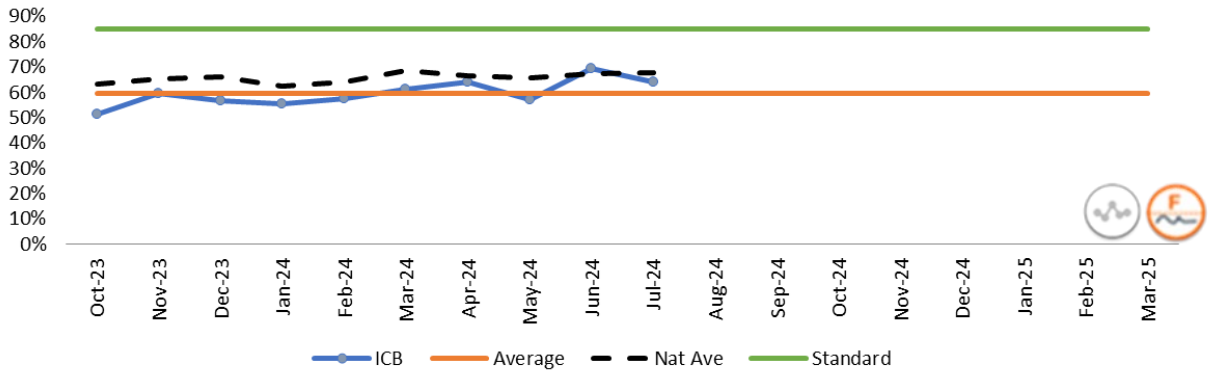
Cancer

NHS Lincolnshire Integrated Care Board

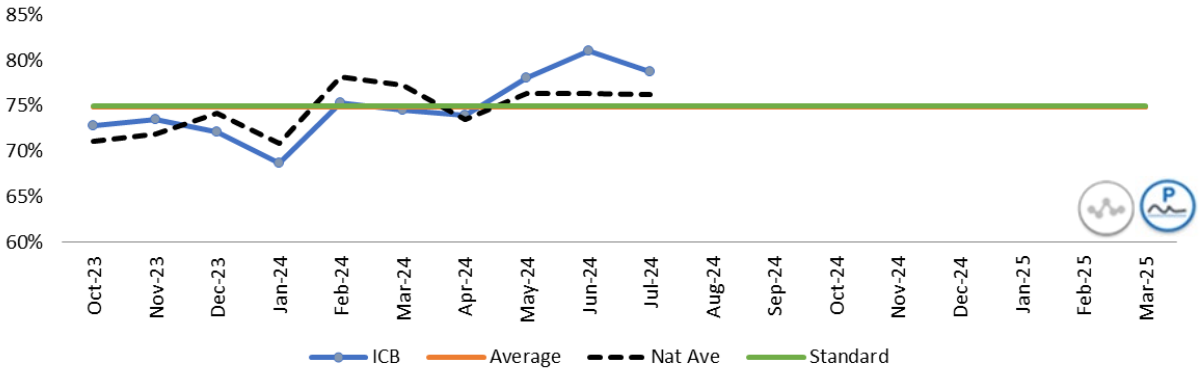
Patients receiving treatment for cancer within 31 days of decision to treat (LICB)



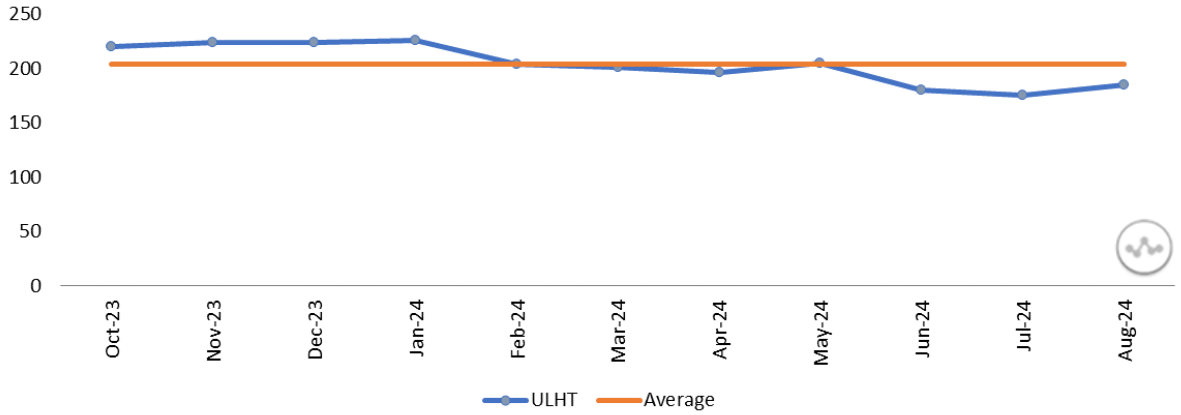
Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade (LICB)



Faster Diagnosis Standard- % of patients told cancer diagnosis outcome within 28 days (LICB)



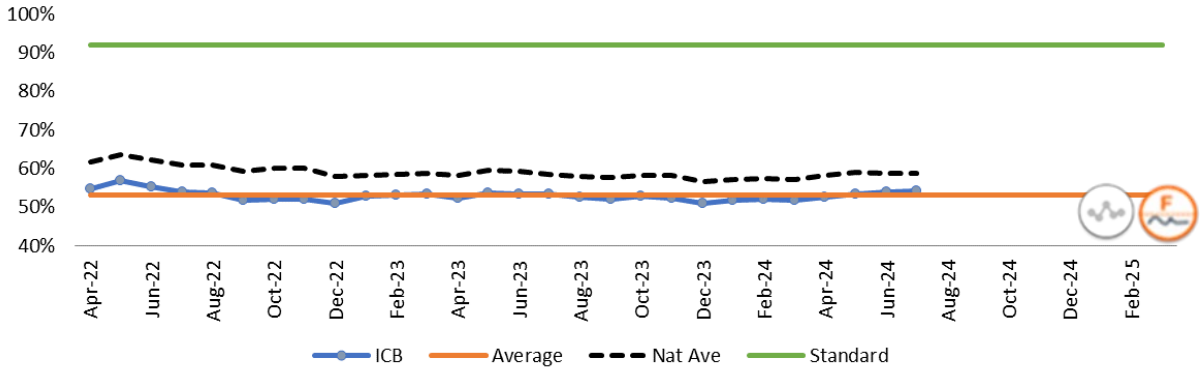
Total 62 Day Backlog (ULHT)



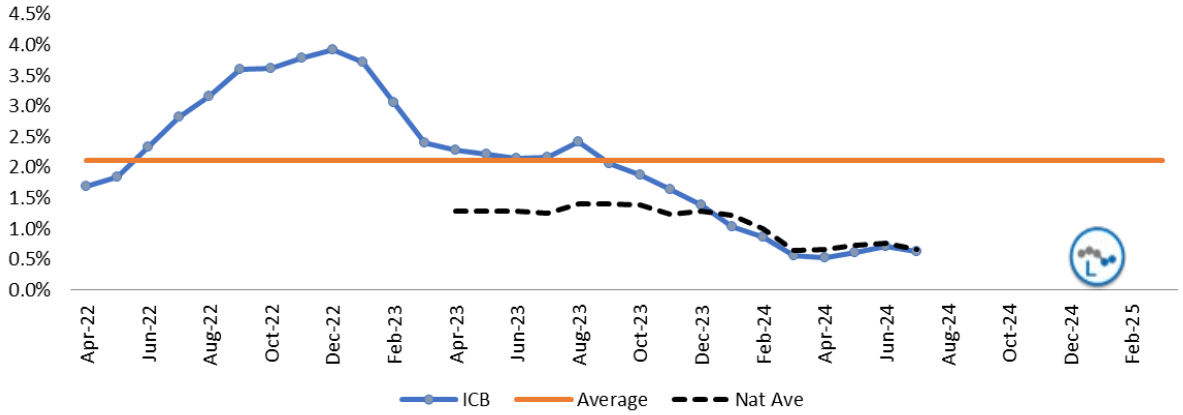
Elective Care

NHS Lincolnshire Integrated Care Board

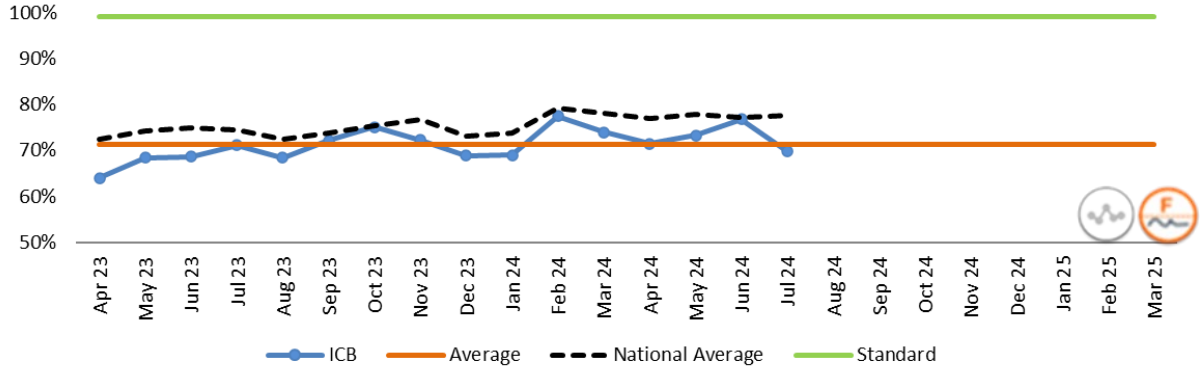
RTT- Patients waiting 18 weeks or less from referral to hospital treatment (LICB)



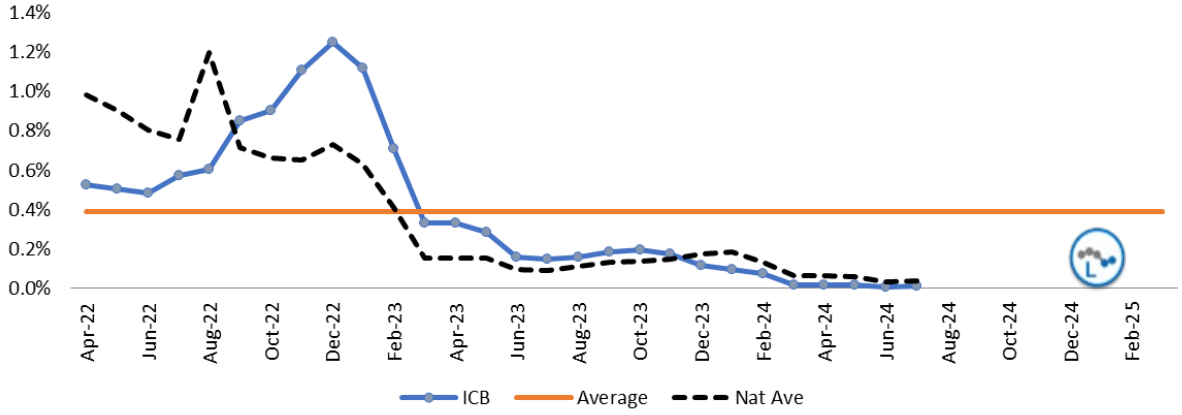
RTT- Patients waiting over 65 weeks for treatment (LICB)



Percentage waiting six weeks or less for a diagnostic test (ICB)



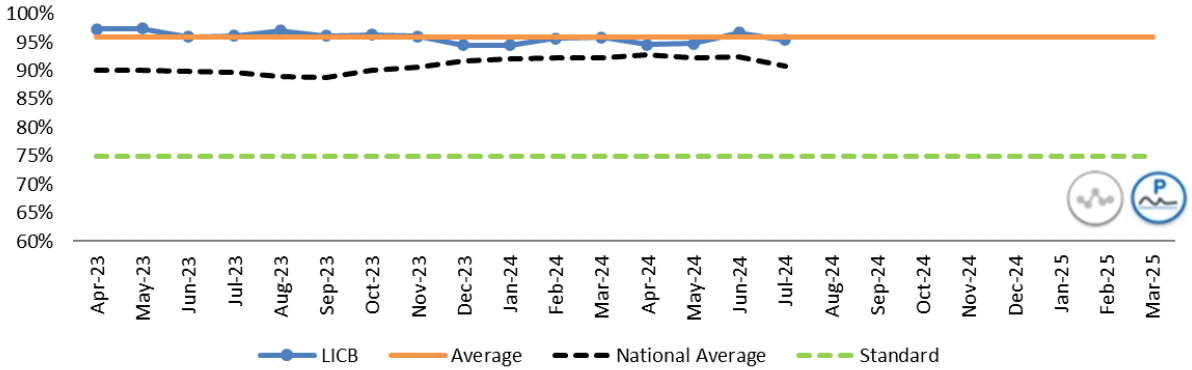
RTT- Patients waiting over 78 weeks for treatment (LICB)



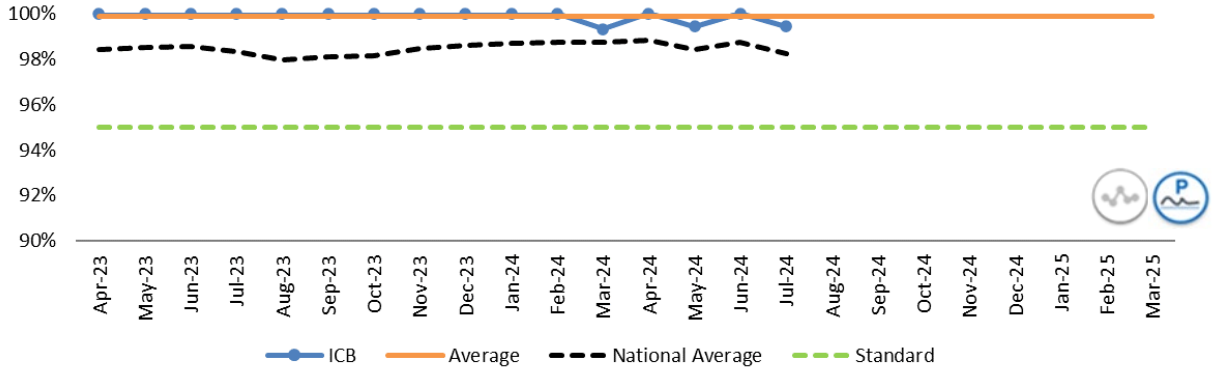
Mental Health

NHS Lincolnshire Integrated Care Board

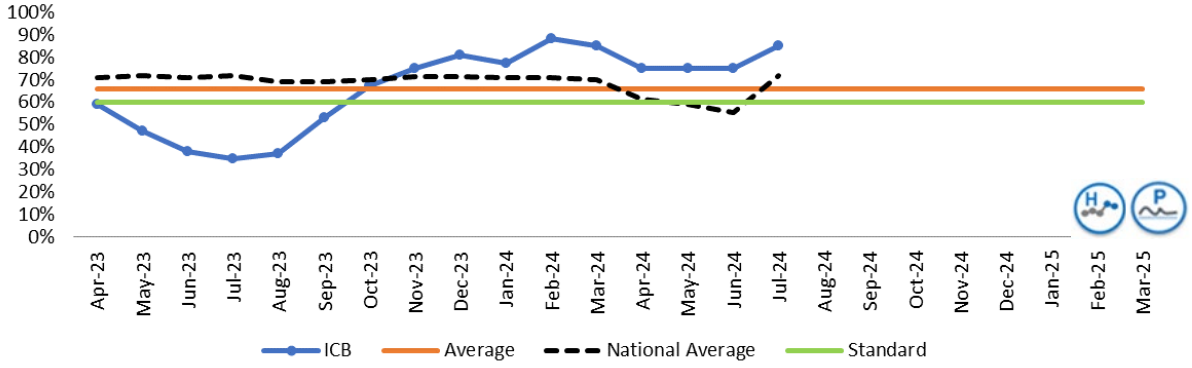
Talking Therapies: First treatment appointment within 6 weeks of referral (ICB)



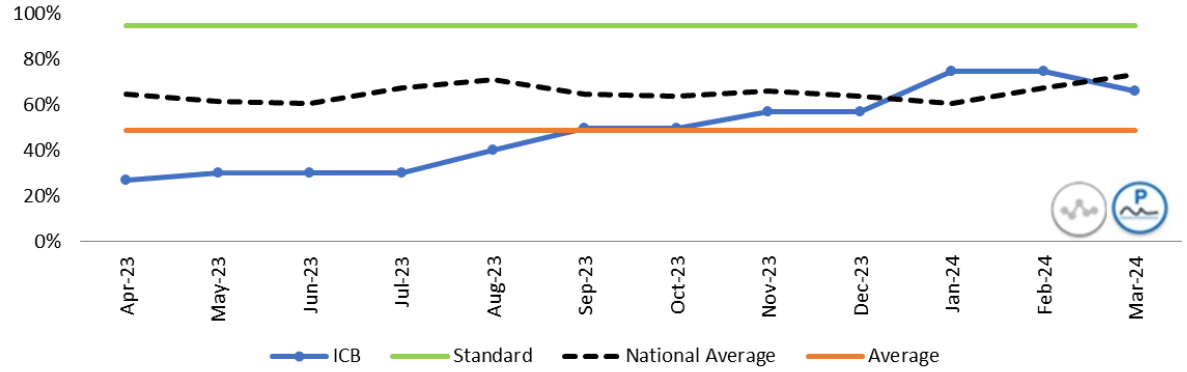
Talking Therapies: First treatment appointment within 18 weeks of referral (ICB)



People experiencing first episode psychosis waiting to start a package of care (ICB)

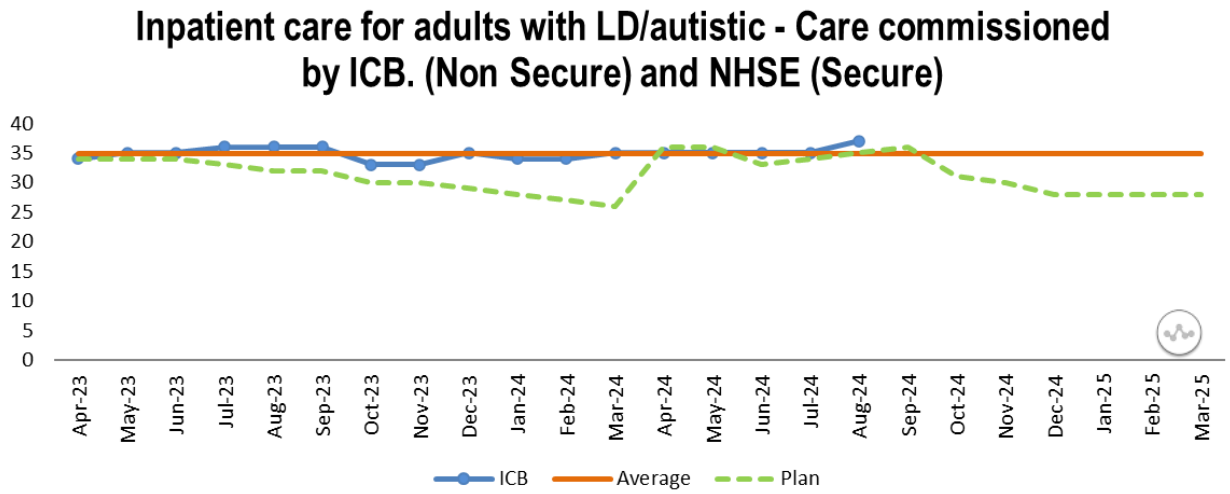


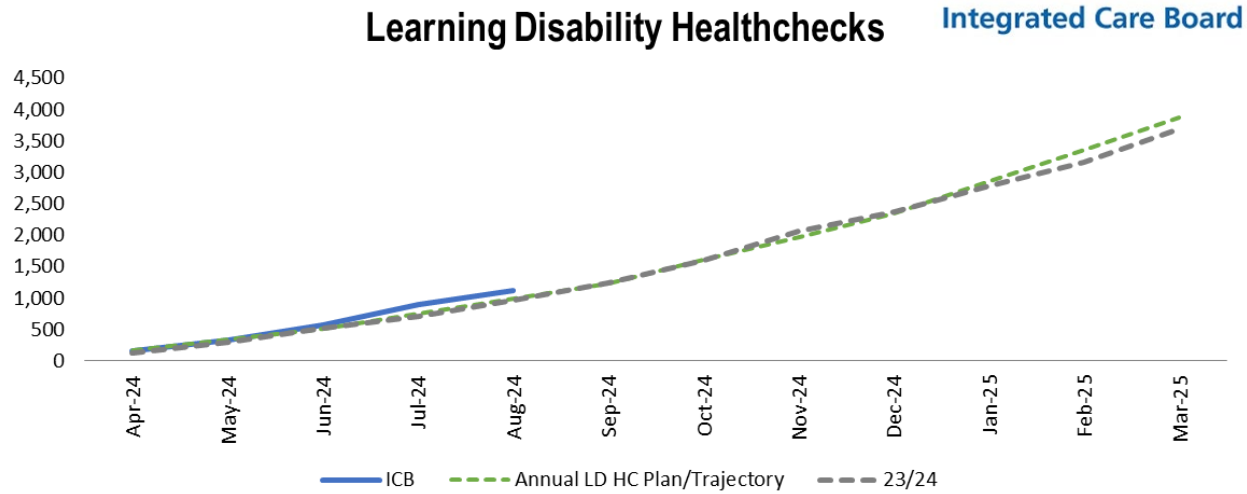
CYP with an eating disorder (urgent) that start treatment < 1 week of referral (rolling 12 months)



Learning Disability & Autism

NHS Lincolnshire Integrated Care Board





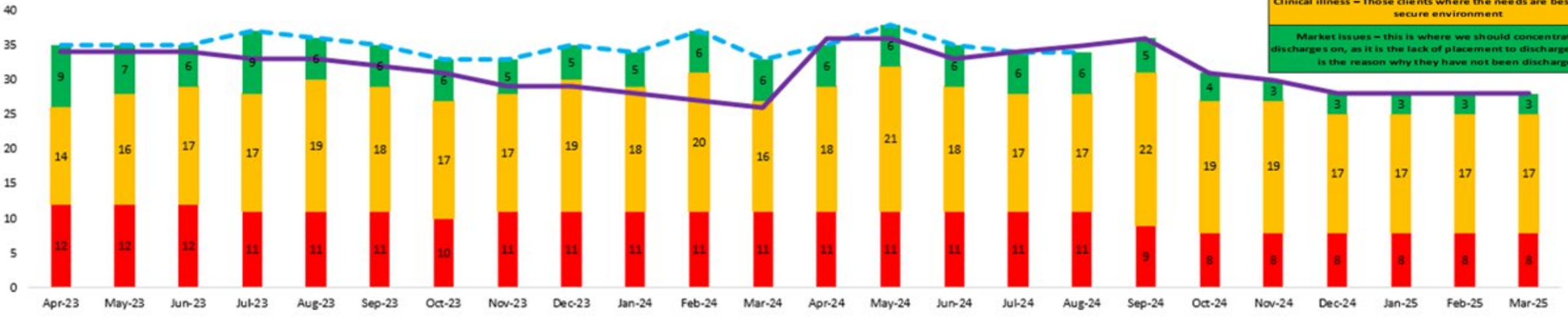
Legal Framework / MM Judgement	Actual Trajectory
Clinical illness - Appropriately placed	Submitted Trajectory
Market issues - Discharge plan in place	

RAG RATING Key

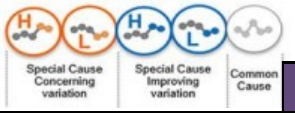
Legal framework – This is the barrier to the discharge and may prevent the discharge from happening for several years etc.
a.Those on extended S17 Leave granted under the MH Act
b.Those on MM judgements which will state when the ruling applies to. Looking into capacity issues as well

Clinical illness – Those clients where the needs are best met in a secure environment

Market issues – this is where we should concentrate the discharges on, as it is the lack of placement to discharge to, which is the reason why they have not been discharged



Lincolnshire ICB Quality Dashboard



Programme	Indicator	Standard /Plan	Period	Performance	Midlands	England	Trend		
							Sparkline	Variation	Assurance
Incidents	Never events - YTD (ULHT)	0	Jul-24	2	N/A	N/A	-		
	Never events - YTD (NLAG)	0	Jul-24	0	N/A	N/A	-		
	Never events - YTD (NWAFT)	0	Jul-24	2	N/A	N/A	-		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)	-	May23 to Apr24	1.0597	1.0409	1.0034			
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	-	May23 to Apr24	0.9810	1.0409	1.0034			
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	-	May23 to Apr24	0.9986	1.0409	1.0034			
Infection, Prevention, Control	MRSA Cases (ULHT 12 month rate per 100,000)	-	Jul-24	0.59	1.03	1.01			
	C-Diff Cases (ULHT 12 month rate per 100,000)	-	Jul-24	29.68	30.79	28.81			
	E-Coli Cases (ULHT 12 month rate per 100,000)	-	Jul-24	33.21	38.40	38.95			
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICB)	35	Aug-24	37	N/A	N/A			
	Cumulative Learning Disability Healthchecks (ICB)	990	Aug-24	1125	N/A	N/A			
Patient Experience	Patient experience of GP services (ICB)	-	2024	73.0%	N/A	74.0%			-
	Friends & Family Test: A&E Recommended (ULHT)	-	Apr-24	73.6%	N/A	79.0%			-
	Friends & Family Test: Inpatient Recommended (ULHT)	-	Apr-24	90.0%	N/A	94.0%			-
	Friends & Family Test: Maternity Recommended (Birth) (ULHT)	-	Apr-24	96.0%	N/A	93.0%			-
	Friends & Family Test: Community Recommended (LCHS)	-	Apr-24	90.0%	N/A	94.0%			-
	Friends & Family Test: Mental Health Recommended (LPFT)	-	Apr-24	91.0%	N/A	85.0%			-
Primary Care	Primary Care CQC- percentage of practices rated as 'Inadequate' by CQC	0	Aug-24	2.5%	N/A	0.9%			
	Primary Care CQC- percentage of practices rated as 'Requires Improvement' by CQC	-	Aug-24	7.4%	N/A	7.4%			-
	GP Appointments- Total appointments in GP practice	511,455	Jul-24	555,626	N/A	N/A			
	GP Appointments- time from booking to appointment same day	-	Jul-24	48.2%	N/A	43.9%			-
	GP Appointments- time from booking to appointment < 2 Weeks	85%	Jul-24	87.9%	N/A	82.7%			
	Enhanced access minutes provided (ICB) (YTD)	1,099,696	Aug-24	1,107,834	N/A	N/A			
	The percentage of available GP enhanced access appointments utilised (ICB) (YTD)	80%	Aug-24	85.5%	N/A	N/A			

Insight and Signals – Quality and Patient Experience

Mpox virus – The Lincolnshire ICS Health Protection and Infection Prevention and Control leads are working together to ensure there is a system approach to published UK Health Security Agency (UKHSA) guidance on Mpox and ensure processes are in place to review and respond readily to any changes in published guidance with local health and care implication.

Care and Comfort in Emergency Departments - United Lincolnshire Hospitals Trust is currently implementing a quality improvement project called 'Care and Comfort' which is working to improve the overall quality and safety of patient care and experience within the Emergency Departments and Urgent Care Centres. This will complement work around winter planning for 24/25 and will consist of different workstreams which aim to support a reduction in pressure ulcers and falls, improved nutrition and hydration, improved clinical documentation and reduced complaints.

Discharge - A review and improvement project is also underway to provide assurance that the services provided from the discharge lounges at LCH and PHB are appropriate, this follows a small number of extended lengths of stay for some patients with complex needs and pathways. The work is ensuring the right overnight provision and care pathway enhancements.

Healthwatch continue to observe that the most common issue currently highlighted by the public is **Dental Access.** However the issue is being raised less frequently and concerns now are more likely to be in connection to routine dental care access as opposed to emergency access. A Dental advice line is available through DHU 111 for Lincolnshire. Urgent dental care hubs are provided from sites across the county & weekend working has been increased. Also the Dental Team are working on several initiatives to recruit to vacant posts. System partners have worked together to define Lincolnshire's new Dental Strategy which details the ongoing work and approach to continue to improve dental access moving forward.

Lincolnshire Partnership NHS Foundation Trust are leading the system partnership work to ensure the recommendations of the **CQC Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust (published Mar 24)** are considered for Lincolnshire Mental Health Services, with improvement actions facilitated where necessary in response.

There were 2 **never events** reported by United Lincolnshire Hospital NHS Trust, these related to an incorrect site nerve block and a retained swab. Both never events are being investigated through the Patient Safety Incident Investigation process. There have also been two never events reported this year by North West Anglia NHS Foundation Trust, one reported in May 2024 which was a wrong side block, and the never event reported in July 2024 was a retained temperature probe from a Le Fort osteotomy in April 2024 that did not cause any symptoms and was discovered through a routine follow up. It was removed by endoscopy.

Insight and Signals – Primary Care

GP Collective Action - GP members of the British Medical Association (BMA) voted in favour of 'collective action' which commenced 1st August 2024 and has no end date currently. ICS governance arrangements have been established, which include medical and nursing representation, to monitor impact of this and respond accordingly.

Type of Provision	Practice	CQC Rating	Information to note
GP	Sutterton Surgery	Good (2015; reviewed July 2023)	ICB led revised Quality Review meeting took place on the 20th August 2024 to look at the progress with patient reviews that are being undertaken following identification of concerns relating to QOF. The revised plan aims to have all reviews completed by the end of September 2024.
GP	Glebe Park Surgery	Good (March 2016)	This surgery has seen a significant list size increase in the run up to their new practice site being operational in April 2025, this is being monitored for quality and safety.
GP	The Deepings Practice	Good (April 2022)	The ICB Quality Team and Primary Care Team are working with the practice to understand recent change in patient feedback and any underlying factors associated with this.

Quality and Patient Experience Thematic Update- LMNS

Maternity and Neonates

Overall, the Maternity and Neonatal Services are on track with delivery of the National requirements

The 3 Year delivery plan is showing progress in all 4 themes and improvements are now implemented in reference to the Pelvic Health Service. Funding has been agreed, the service has now been commissioned and a Midwife lead has been recruited.

Saving Babies Lives (SBL) now in version 3, awaiting the next publication of SBLV3.2. Compliance has been consistent in previous quarters. The last 'Touch Point' has shown a moderate decrease in compliance in Element 4. This is due in part to an altered process by which to audit evidence in relation to Fresh Eyes on CTG interpretation. In addition a Divergence has also been completed and submitted to region for transparency against an altered standard regarding Fetal Monitoring across the 2 sites within ULHT. Action Plan is secured and assurance queries have been met therefore no current risks to patient safety.

Clinical Negligence Scheme for Trusts (CNST) Year 5 completed compliance on all 10 Safety Actions. Work is underway now for CNST Year 6 submission in early 2025

Midlands Heatmap Data which enables monthly oversight of triangulated data and is for the direct purpose of consolidating and sharing information within the regional footprint to identify and support improvements in the safety and quality of maternity and neonatal care has been progressive. ULHT have gone from Amber to Green within 6 months. The August 2024 heatmap highlights Lincolnshire is best preforming within region

Members of the LMNS will join in collaboration with our local provider for the yearly Insights Visits which are planned for 24th and 25th of September. Due to continued progress regional input is not required on this round.

Digital update: will hopefully see improvements; Digital Matron has been appointed and a new MIS will start to be implemented over the next few months.

The Equity and Equality Strategy has been completed and shared with LMNS members for comments, final report will be published mid Sept 2024

Vaccination Programmes – Seasonal & New

NHS Lincolnshire Integrated Care Board

Seasonal Programmes

Flu

- The 2024 flu campaign begins on 1st September for pregnant women and children, and 3rd October for all other cohorts
- The start of the flu campaign for adults is later than previous years. This is due to evidence that the flu vaccine's effectiveness can wane over time in adults and flu virus circulation typically peaks in December or January
- The flu vaccine will be delivered by General Practice, Community Pharmacies and maternity services in Lincolnshire with support from LCHS Vaccination & Rapid Response Team (VRRT) for Health Inequalities groups
- The following groups are eligible for flu vaccination
  - Aged 2 and 3 years on 31 August 2024
  - Eligible school aged children
  - Persons aged 6m – 64y in a clinical risk group
  - Pregnant women
  - All adults aged 65 years and over
  - Residents in long-stay residential care homes
  - Carers
  - Household contacts of immunocompromised individuals
  - Frontline health and social care staff

Covid-19

- The Autumn 2024 Covid-19 vaccination campaign begins on 3rd October for all cohorts
- The campaign will be delivered by PCNs, Community Pharmacies and VRRT where there are access gaps and to Health Inequalities groups
- VRRT will also be delivering Covid-19 vaccines within ante-natal clinics, and for Lincolnshire County Council care home and domiciliary care staff
- Lincolnshire now has 34 Community Pharmacies providing Covid-19 vaccination, this is an increase of 14 from Spring
- The following groups are eligible for an Autumn Covid-19 vaccination
  - Residents in a care home for older adults
  - All adults aged 65 years and over
  - Persons aged 6 months to 64 years in a clinical risk group
  - Pregnant women
  - Frontline health and social care workers

New Programme

Respiratory Syncytial Virus (RSV)

- The RSV vaccination programme began on 1st September 2024
- There are two eligible cohorts – all pregnant women from 28 weeks gestation, and older adults at age 75 with a catch-up campaign for those already age 75-79 years running until 31st August 2025

Maternity

- The maternity programme is to mainly be delivered via maternity providers
- There are several options for ladies in Lincolnshire – ULHT led clinics based at Lincoln County and Pilgrim sites, or community-based clinics run by LCHS in family hubs in Skegness, Gainsborough and Spalding

Older Adult

- The older adult programme is contracted to be delivered in General Practice
- Over 14,000 vaccines ordered in to date
- Anecdotal feedback from a number of practices has been positive and reporting good uptake
- Formal uptake data for RSV will be available from January 2025

Finance: Summary Financial Position (1)

NHS Lincolnshire Integrated Care Board

Year To Date Financial Position: The ICS' plan was to deliver a £15.2m deficit at month 5 and the ICS reported a deficit of £18.8m equating to a £3.6m adverse variance to the plan (£2.1m adverse variance to plan at month 4).

The ICB has reported a year-to-date deficit of £2.1m. Against a planned deficit of £3.7m at month 5 this equates to a £1.6m favorable variance to plan (£2.5m favorable variance to plan at month 4).

Outturn Financial Position: The ICS' plan is to deliver a break-even position against in year allocations and income for the full financial year. The outturn position at month 5 is to achieve this plan.

The ICB expects to deliver a £4.7m surplus for the full year. This is in line with the agreed plan.

Risk Position: The ICS overall plan reflected a level of net risk of £21.1m. A net risk of £11.1m has been reported at month 5, an improvement of £10.0m from month 4.

Of the £21.1m net risks reported at month 4, £16.0m related to system investments and cost pressures identified in the plan. At the time of reporting £10.0m mitigations have been confirmed. Mitigations for the remaining £6.0m continue to be sought through the system wide 'four corners' rapid bridging the gap exercise.

Finance: Summary Financial Position (2)

NHS Lincolnshire Integrated Care Board

Cost Improvement Plan: At Month 5 the ICS has reported £22.5m cost improvements against a plan of £20.9m equating to a £1.6m favorable variance to plan.

The ICS has a full year cost improvement plan of £84.8m and expects to break-even against this plan by the financial year-end.

Capital: The ICS has a £41.0m capital allocation for the full year and is expected to utilize this in full by the financial year-end.

The ICS has a full year Capital Departmental Expenditure (CDEL) Limit of £116.3m. The ICS is expecting to utilize £111.6m against this. This equates to a £4.6m underutilization against CDEL. At the 31st of August the plan against this was £29.8m and the reported spend is £21.7m. This equates to a year-to-date under-spend of £8.1m.

Item 5 (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (ii)
Meeting Date:	Tuesday, 24th September 2024
Title of Report:	Process for Review of CQC section 48 (Calocane) Report
Report Author:	Nick Harwood, LPFT Director of Community Services and Sharon Harvey LPFT Chief Nursing Officer
Presenter:	Mrs Sarah Connery, Chief Executive, LPFT and Executive Mental Health Member
Appendices:	N/A- but link to CQC report embedded

To approve ☐	For assurance ☒	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g., approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Board is asked to:
Receive this paper and be assured there is a robust approach in place to review our services in the context of the Care Quality Commission's (CQC) section 48 review of Nottinghamshire Healthcare NHS Foundation Trust's care and treatment of Valdo Calocane.

Summary

Background

The CQC completed a section 48 review of Nottinghamshire Healthcare NHS Foundation Trust's care and treatment of Valdo Calocane following the tragic deaths of three people. The CQC found a number of failings in Mr Calocane's care and treatment which has led to recommendations to review a number of elements of service delivery to minimise the risk of this occurring again. Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 - Care Quality Commission (cqc.org.uk).

This paper outlines the NHS Lincolnshire Integrated Care Board (ICB) and the Lincolnshire Partnership NHS Foundation Trust's (LPFT) response to this review. The ICB and LPFT are taking the findings of this case extremely seriously and are jointly reviewing our local services in line with a maturity index that has been issued by NHS England to support a local assessment of services in light of the learning and recommendations of the S48 review. This matrix will be completed and returned by the deadline of the 30th September 2024 and will inform a national assurance document as well as drive our local action planning in Lincolnshire.

Mr Calocane is classified as having a severe mental illness with a diagnosis of paranoid schizophrenia, had poor engagement with services and treatment and was sectioned under the

Mental Health Act four times in two years. The reports from the CQC outline a number of missed opportunities and make recommendations to the Trust and to NHSE which are all relevant and applicable to our services and will be reviewed accordingly and an action plan developed.

It is important to be clear about the cohort of patients this review relates to, NHSE guidance states this is individuals who:

1. Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
2. May not respond to, want to or may struggle to access and use 'routine' monitoring, support and treatment that could minimise harm
3. Are vulnerable to relapse and/or deterioration with serious related harms associated (esp but not limited to violence and aggressions)
4. Have multiple social needs (housing, finance, self-neglect, isolation etc)
5. Likely present with co-occurring problems (eg drug and alcohol use/dependence)
6. May have had negative (eg harmful and/or traumatic) experiences of mental health services or other functions of the state (eg the criminal justice systems)
7. Concerns may have been raised about by family/carers

These are individuals who have severe mental illness and are often experiencing command hallucinations telling them to harm others which they feel unable to ignore or resist, or are experiencing high levels or threat due to paranoid beliefs.

It is important to note, homicide by people experiencing psychosis is rare.

Assessment
We are committed to engaging in this national review fully and openly to ensure we are providing services in the best way we can.

It is important to note that whilst LPFT does provide care and treatment to those experiencing psychosis within both community and inpatient pathways LPFT does not have a dedicated service for the care of patients in this cohort. Until 2013 LPFT did provide an Assertive Outreach Team (AOT) whose function in part was to provide specialist and intensive care and treatment for these particular individuals. This was disestablished and the function was absorbed into our Community Mental Health Teams.

The LPFT service Standard Operating Procedure makes clear statements that disengagement by this cohort should not lead to discharge from care. However, the recent guidance emerging from NHSE indicates this is not adequate and the county should at least have staff dedicated to this cohort if not a service. The joint review by LPFT and the ICB will determine what changes are required in line with the guidance.

There are a number of short-term actions underway or planned to begin shortly (listed below). We have set up a task and finish group to develop and implement actions that will report into both the LPFT and ICB Quality Committees and to the LPFT and ICB Board as appropriate.

1. Stephen Skinner (LPFT, Service Development Lead) and Sara Brine (ICB, Head of Mental Health Transformation) are jointly completing the NHSE Maturity Index and NHSE Assurance template, they are holding a series of stakeholder events to support this completion, including lived experience representation. This will support the creation of a clear understanding of the current position for our system and formulation of an action plan.
2. Communication to people using our services, their families/ carers and our staff members who are supporting patients with psychosis, as they may be worried by the recent coverage of this, as well as ensuring we hear the patient/carer voice in our review.
3. Creating space/additional supervision for our staff who have any concerns about practice or therapeutic risk taking and encourage Multi-Disciplinary Team discussions and joint decision making for complex individuals.

4. To review Standard Operating Policies to ensure the guidance for this cohort of patients is clear and that lack of attendance at appointments is never used as a reason to discharge someone with this level of need, with random sampling/audit.
5. To identify clearly within our teams those patients that meet the definition for this group of individuals and audit the care being delivered against best practice, including family/carer engagement, care planning, risk assessment/management and discharges.
6. Review of incidents (Patient Safety Incidents and Incident reports) over the past 5 years relating to this group of individuals across our services to establish any themes or useful intelligence.
7. Review patients that have had repeated detentions under the Mental Health Act, particularly repeated section 2, which are detentions for 28 days for assessment.
8. Support to Primary Care who may have concerns about patients they see who are not open to LPFT. LPFT will reach out to the Primary Care Network Alliance to ensure colleagues are assured they can bring these cases to our attention.
9. Developing agreed joint pathways and protocols with the Lincolnshire Recovery Partnership for this group of individuals to ensure support is joined up and mutually supportive.

Ultimately the completion of the Maturity Index and NHSE Tool is going to provide the detail in terms of our current position and support the development of an action plan. NHSE have set up an expert reference group and will be developing firm guidance over the next year, which we will engage constructively with.

It should be noted that LPFT and ICB Medical and Nursing Directors are actively engaged in the review process. There will be further engagement as appropriate with partners including East Midlands Ambulance Service Trust and Lincolnshire Police.

Timeline

Action	**Date**	**Lead**
ICB Board Briefing Paper	24/09/2024	Sarah Connery, LPFT CEO
Review and sign off of return to NHSE by LPFT Executive Team Meeting	25/09/2024	Nick Harwood (Director of Community Services)/Sharon Harvey (Chief Nursing Officer)
Review, sign off and submission of NHSE return by ICB	30/09/2024	Sara Brine
NHSE return to be presented to LPFT Quality Committee for assurance	08/10/2024	Sharon Harvey
Task and Finish group mobilised (& associated governance set up)	October, 2024	Nick Harwood
LPFT and ICB Quality Committees joint review	October & November 2024	Sharon Harvey Martin Fahy
Receipt and Consideration by LPFT and ICB Boards	November 2024	Sarah Connery

The recommendation is for the ICB Board to receive this paper and be assured there is a robust approach in place to review our services in the context of the CQC reports and emerging NHSE guidance and assurance process, starting with the NHSE templates to focus attention on our current service provision position and action plan that will be developed.

This matter will return to the ICB Board November meeting, following Quality Committee consideration as indicated above.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The assessment will support identification of service provision gaps for this highly stigmatized cohort
Aim 2: Tackle inequalities in outcomes, experience and access.	People with serious and enduring mental illness have barriers to accessing services and assertive outreach models help to facilitate engagement
Aim 3: Enhance productivity and value for money.	Keeping people safe and supported in their communities will deliver better VFM than inpatient models of care
Aim 4: Help the NHS support broader social and economic development.	Like suicide, the societal cost of homicide is substantial not only in financial terms for services but also the perpetual emotional impact for families, friends and staff
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
As identified within the paper.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	To be ascertained through the review
Does the report highlight any quality and patient safety implications?	Considerable implications if care pathways are not robust
Does the report highlight any health inequalities implications?	
Does the report demonstrate patient and public involvement?	Yes in use of lived experience voice within stakeholder events and going forward
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Assertive Outreach models are based around visits to peoples places of safety within their communities – which has implications for travel and carbon footprint.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☐ No ☒

Item 5 (iii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (iii)
Meeting Date:	Tuesday, 24th September 2024
Title of Report:	ICB Board Assurance Framework
Report Author:	Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Jules Ellis-Fenwick, ICB Board Secretary
Appendices:	Board Assurance Framework

To approve ☐	For assurance ☒	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g., approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Board is asked to:

- Consider the ICB Board Assurance Framework.

Summary

Background

The ICB Audit and Risk Committee has been regularly briefed on the progress on the development and establishment of robust risk management arrangements for the ICB, including the development of the ICB Board Assurance Framework (BAF) and Risk Appetite.

To support this on-going work the BAF and Risk Appetite has been a key part of the agendas for the Audit and Risk Committee and the Board Development Sessions.

TIAA, the ICB internal auditors, carried out a review of the adequacy and effectiveness of the ICB's risk management arrangements in 2023/24 including how it interfaces with the ICS wide risk management structures. The overall assessment was Reasonable Assurance but building on previous external audit reports, TIAA highlighted some improvements required to the ICB BAF and risk reporting which has meant that the ICB governance team has been working to revamp various BAF documentation, including the strategic risk reporting. This builds on the various Board workshops that have been run during 2024.

In relation to the BAF, the internal audit report set a timeline of completion of actions by the end of June. To close off the actions, the revised BAF was circulated to the ICB Executive Team and considered as part of its meeting held on Thursday, 25th July 2024. The revised format was very well received and the Executive Team was supportive of the approach to agree a risk appetite level for each of the strategic risks using the Good Governance Institute on Risk Appetite.

The revised format of the BAF was presented to the Audit and Risk Committee at its meeting held on the 31st July 2024.

The BAF was discussed by the Audit and Risk Committee on the 31st July who were very supportive of the revised format but agreed there are gaps in the strategic risks – such as transformation, digital and health inequalities (by way of examples).

The Executive Team were asked to take the four strategic risks as identified in the BAF through the relevant Committees in August/September to ensure they were reviewed and consideration was also given to the gaps. During August/September 2024 this has been actioned and the BAF has been presented to and reviewed by the respective Board Committees and also at two Executive Team meetings.

As a point of note, the BAF is a live document and is continuously reviewed and updated.

The latest version of the BAF is presented for the Board's consideration.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.

Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
No specific risks identified.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	No.
Does the report demonstrate patient and public involvement?	No.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Updates and progress reports on the development of the BAF and Risk Appetite have regularly been presented to the Audit and Risk Committee and Executive Team meetings.
Is the report confidential or not?
Yes ☐ No ☒

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Lincolnshire
Integrated Care Board

NHS LINCOLNSHIRE ICB
BOARD ASSURANCE FRAMEWORK

v1.0

SEPTEMBER 2024

The Board Assurance Framework (BAF) sets out the principal risks to the achievements of the Integrated Care Boards (ICBs) strategic objectives. The BAF is also a primary source of evidence in describing how the ICB is discharging its responsibility for internal control.

The BAF further sets out the controls in place to manage the risks and the assurances available to support judgements as to whether the controls are having the desired impact. The BAF additionally describes the actions to further reduce each risk.

RISK APPETITE MATRIX

RISK APPETITE LEVEL	0 NONE	1 MINIMAL	2 CAUTIOUS	3 OPEN	4 SEEK	5 SIGNIFICANT
RISK TYPES	Avoidance of risk is a key organisational objective.	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust
FINANCIAL ***How will we use our resources?***	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY ***How will we be perceived by our regulator?***	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements	We will avoid any decisions that may result in heightened challenge unless absolutely essential	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision	We are prepared to accept the possibility of som regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweight the risks	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders
QUALITY ***How will we deliver safe services?***	We have no appetite for decisions that may have an uncertain impact on quality	We will avoid anything that may impact on quality outcomes uness absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation	We will pursue innovation wherever appropriate. We are willing to take decisions on quaity where there may be higher inherent risks but the potential for significant longer-term gains	We seek to lead the way and will prioritise new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement
REPUTATIONAL ***How will we be perceived by the public and our partners?***	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no change of significant repercussions	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders	We are willing to take decisions that are likely to bring scrunity of the organisation. We outwardly promote new ideas and innovations where potential beneifts outweight the risks	We are comfortable to take decisions that may expose the organisation to singificant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders
PEOPLE ***How will we be perceived by the public and our partners?***	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long term gains	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

NHS Lincolnshire ICB Risk Appetite in Five Domains

DOMAIN	STRATEGIC LEAD	RISK APPETITE	THRESHOLD SCORE
Financial	Director of Finance	Cautious	12
Regulatory	Board Secretary	Cautious	12
Quality	Chief Nurse	Cautious	12
Reputational	Director of Strategic Planning, Integration and Partnerships	Cautious	12
People	Director of People & Organisational Development	Cautious	12

RISK APPETITE	DESCRIPTION
Minimal	Avoidance of any risk or uncertainty. Every decision will be with the aim of terminating the risk
Cautious	Preference for safe delivery options but is able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the level of risk
Open	Open to consider all options and take a greater degree of risk and tolerate higher uncertainly to achieve a bigger reward. Likely to choose an option that has a greater reward and accepts some loss
Seek	Eager to be innovative and take on risk to achieve strategic objectives. Will choose the option with greater reward and will accept any loss at the price for the reward
Significant	Confident is setting high levels of risk appeitive because controls, forward scanning and responsive systems are robust

NHS Lincolnshire ICB Strategic Objectives

Delivery of key 24/25 operational and financial objectives (as per 2024/25 Plan as agreed with NHSE)	Create a 'high performing' ICB and ICB Board	Maximise the opportunities to enhance our health and care system to the benefit of our population, patients, workforce and partners
→ UEC 78% and Cat2 30 mins → Planned Care 65 weeks → Cancer 62 days → Learning Disabilities and SMI Health Checks → System Financial Plan 24/25	→ Complete and implement the outputs of the Audit Yorkshire Board Development work → Undertake a shadow 'ICB CQC' assessment exercise and implement findings → Finalise the design of the new ICB Target Operating Model, and agree and mobilise implementation plan with partners → Support implementation of new ICP Partnership Board arrangements → Implement EDI Annual Plan and develop Strategic EDI Plan	→ Further develop and deepen integrated health and care system partnership working ('lock step' partnerships) → Implement a 'step change' in Prevention activities in line with shared commitment and resource plan with Lincolnshire County Council → Lead with partners implementation of 24/25 actions as per the Health Inequalities Strategy → Support the development of CPPs, including the development of 'pilot' CPPs → Develop a 'GP Strategy' for Lincolnshire and participate in NHSE supported ICB 'testing' of new GP delivery hypothesis → Complete and implement recommendations of System Digital Review → Implement the agreed recommendations of System Workforce Review → Establish joint Health & Care and Lincolnshire Colleges & Universities Partnership, Strategic Ambition and 24/25 Action Plan

BOARD ASSURANCE FRAMEWORK - DASHBOARD

ICS AIM	RISK DESCRIPTION	RISK OWNER	RESPONSIBLE COMMITTEE	RISK SCORE					TARGET	RISK APPETITE
				Apr-24	May-24	Jun-24	Jul-24	Aug-24		
To improve outcomes in population health and healthcare	**0002** - The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county.	Pete Burnett	System QPEC	**8**	**8**	**8**	**8**	**4**	**4**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery
To tackle inequalities in outcomes, experience and access	**0005** - There is a risk that we fail to create a culture which supports transformation of services and address health inequalities which leads to no improvement or a deterioration in outcomes for our population	Sandra Williamson								
To enhance productivity and value for money	**0001** - Maintain and improve the quality of commissioned care and improve patient outcomes, ensuring these are not adversely affected due to insufficient or delayed access to services	Martin Fahy	System QPEC	**9**	**9**	**9**	**9**	**9**	**6**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery
	0003 - The ICB is unable to create and implement a workforce strategy so serevices continue to operate unsustainably with significant fragility in day to day operation	Claire Low	Workforce Group	**12**	**12**	**12**	**12**	**12**	**6**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery
	0004 - ICB is unable to devise and implement a sustainable service improvement and financial recovery plan to remove unwarranted variation and consequently continues to operate without full autonomy.	Matt Gaunt	Finance & Resource Committee	**12**	**12**	**12**	**12**	**12**	**8**	**Open:** Open to consider all options and take a greater degree of risk and tolerate higher uncertainly to achieve a bigger reward.
To support broader social and economic development										

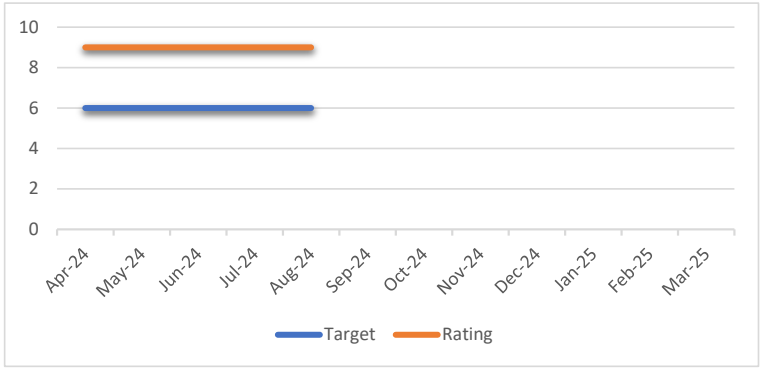
BAF Ref - 0001	**STRATEGIC OBJECTIVE** : Delivery of key 24/25 operational and financial objectives.	**PRINCIPAL RISK :** Maintain and improve the quality of commissioned care and improve patient outcomes, ensuring these are not adversely affected due to insufficient or delayed access to services.	**RISK DOMAIN :** Quality	**CURRENT SCORE 9** ⟺

Executive Risk Owner	Chief Nurse	Assurance Committee	System QPEC	Date added to BAF	01 April 2023

Risk Applies to ICB	Risk applies to ICS
	✓

CQC DOMAIN	RISK APPETITE
	2: Cautious

RISK RATING	Impact	Likelihood	Total
Initial	4	4	16
Current	3	3	9
Appetite	3	2	6



LAST REVIEW NARRATIVE:

Positve Assurance & Key Controls in Place	Gaps in Control and/or Assurance
Quality governance arrangements in place which meet the expectations set out in the National Quality Board (NQB) Shared Commitment to Quality; and National Guidance on Quality Risk Response and Escalation in Integrated Care Systems i.e. SQPEC and SQG plus PCCC for Primary Care LICB Framework for Primary Care General Practice Quality Support and LICB Framework for Quality Assurance and Improvement of Providers of NHS Services in place - oversight through PCQ&POG and OQAG ICB Quality Lead Officers aligned to contracted service providers and quality representation at Contract Oversight Group ICB quality leads assigned to key transformation programmes to ensure consideration of the quality implications of current and future state.	Limitations of nationally available data and information to support effective quality monitoring across all commissioned pathways of care. Visibility of all transformation programmes across the system. Sufficient capacity within ICB quality team to pick up extended remit for Primary Care (including Pharmacy, Optometry & Dental). Non contracted activity; or where LICB is not the lead commissioner are not always visible to the ICB quality team

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month
ICB Quality Strategy being refreshed to outline current key priorities as agreed through SQPEC	01 April 2024		
Further develop quality dashboard information locally as access to national data becomes available e.g. inclusion of data for neighbouring trusts; independent providers	Ongoing		
Recruitment to existing vacant posts within ICB Quality Team to ensure sufficient capacity	01 July 2024		
Embed Contract Oversight Group processes to ensure appropriate oversight of all potential quality contract risks	01 November 2024		

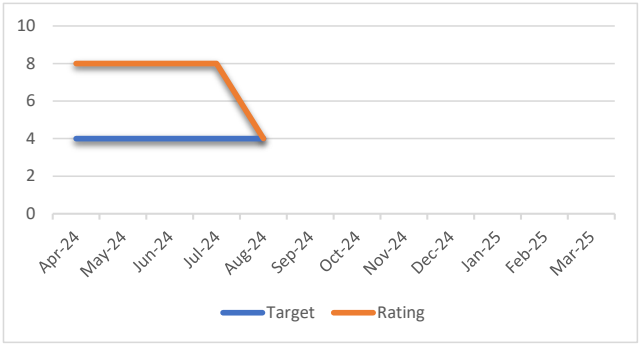
BAF Ref - 0002	**STRATEGIC OBJECTIVE** : Maximise the opportunities to enhance our health and care system to the benefit of our population, patients, workforce and partners.	**PRINCIPAL RISK :** The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county.	**RISK DOMAIN :** Quality	**CURRENT SCORE 4** ⇩

Executive Risk Owner	Director of Strategic Planning, Integration and Partnerships	Assurance Committee	System QPEC	Date added to BAF	01 April 2023

Risk Applies to ICB	Risk applies to ICS
✓	

CQC DOMAIN	RISK APPETITE
	2: Cautious

RISK RATING	Impact	Likelihood	Total
Initial	4	2	8
Current	4	1	4
Appetite	4	1	4



LAST REVIEW NARRATIVE:

Positve Assurance & Key Controls in Place	Gaps in Control and/or Assurance
Quarterly reporting of engagement activities and feedback to QPEC and quarterly / Bi-annual reporting to ICB Board to offer assurance and evidence of adhering to statutory duties to involve. People and Communities Strategy updated and 24/25 delivery plan developed and signed off at SQPEC in May 24 Involvement Annual Report 23/24 signed off at SQPEC in May 24 and on agenda for LICB Board in June 24 Engagement team aligned to key programmes of work to ensure involvement included in any changes to services Recruited to the Health Inequailityes engagment lead role and the succesful candidtate started in April 24. Engagement lead sits on some Programme Boards to steer involvement opportunities. Engagement lead a member of the Operational Quality Assurance Group and attendance at SQPEC Involvement reporting to LICB Board being scoped Public facing Involvement webpages being developed and improved to evidence outcomes of engagement Ongoing development of relationships with key stakeholders, partner organisations and community groups to facilitate engagement. Building of stakeholder database - currently 10,000 patient, public, stakeholders and groups we engage directly with. Embedded regular engagement channels - fortnightly engagement bulletin sent to 10,000 database and shared with Provider Trusts and partners to share; regular use of social media and Nextdoor app Sub working group established with LCVS, Local Authorities and key partners to develop a system wide approach to engagement (led by LICB) Scoping of stakeholder / CRM and Insight software to roll out across NHS organisations and collaborate system wide Exploring system wide approach to sharing involvement insight alongside Health Inequalities and PHM data to ensure robust baseline for future engagement Service Change protocal agreed by all organisations which should identfy the requirment for involning and engaging with the public.	Sufficient engagement capacity to provide a best practice service to all programmes. Requests to support Provider Trust engagement activity.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month

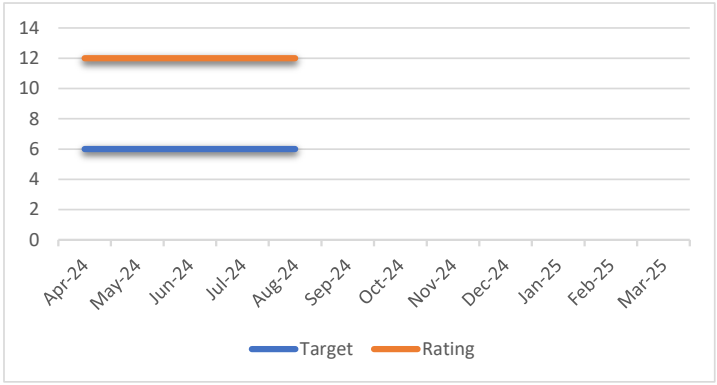
BAF Ref - 0003	**STRATEGIC OBJECTIVE** : Maximise the opportunities to enhance our health and care system to the benefit of our population, patients, workforce and partners.	**PRINCIPAL RISK :** The ICB is unable to create and implement a workforce strategy so serevices continue to operate unsustainably with significant fragility in day to day operation..	**RISK DOMAIN :** Quality	**CURRENT SCORE 12** ⟺

Executive Risk Owner	Group Chief People Officer	Assurance Committee	Workforce Group	Date added to BAF	01 April 2023

Risk Applies to ICB	Risk applies to ICS
	✓

CQC DOMAIN	RISK APPETITE
	2: Cautious

RISK RATING	Impact	Likelihood	Total
Initial	3	4	12
Current	3	4	12
Appetite	2	3	6



LAST REVIEW NARRATIVE:

Positve Assurance & Key Controls in Place	Gaps in Control and/or Assurance
A list of fragile services and workforce challenges has been collated based on individual organisational input including Acute, Community, Mental Health, primary and social care. A regular meeting with NHSE colleagues to discuss current processes and challenges are now in place and will also be reported for the main NHS providers through the Workforce Group chaired by S Connery (LPFT Chair). People Leaders have started to be involved in discussions relating to fragile services and how this aligns with the future service delivery model for the ICB. Providers contributing to system workforce plan. A refocus of the People Hub priorities with the change in SRO from the 01.08.2023 approved by CEO's. Regular monitoring through workforce dashboard/operational planning. People Promise and retention agenda is reducing the turnover of staff in the region.	Refocus of the People Hub/SRO/People Leaders and a worked up plan. A set criteria to determine the fragility of services based on workforce issues unclear/unknown - working on local intel at this stage. Absence of a clear and holistic overview. An holistic system level health and wellbeing offer.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month
A full review of the current system processes		Claire Low	

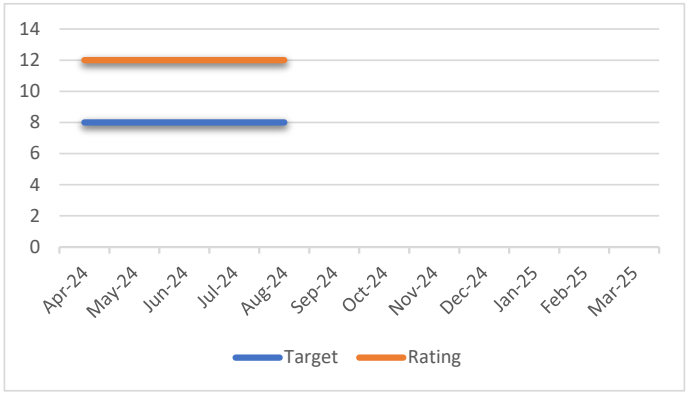
BAF Ref - 0004	**STRATEGIC OBJECTIVES** : Delivery of key 24/25 operational and financial objectives.	**PRINCIPAL RISK :** The ICB is unable to devise and implement a sustainable service improvement and financial recovery plan to remove unwarranted variation and consequently continues to operate without full autonomy.	**RISK DOMAIN :** Financial	**CURRENT SCORE 12** ⟺

Executive Risk Owner	Director of Finance	Assurance Committee	Finance & Resource Committee	Date added to BAF	01 April 2023

Risk Applies to ICB	Risk applies to ICS
✓	✓

CQC DOMAIN	RISK APPETITE
	3: Open

RISK RATING	Impact	Likelihood	Total
Initial	4	3	12
Current	4	3	12
Appetite	4	2	8



LAST REVIEW NARRATIVE:

Positve Assurance & Key Controls in Place	Gaps in Control and/or Assurance
In the latest annual review letter the ICB is commended for the strength of the financial governance process and the contribution this has made to system financial improvement, exit from NOF4 and that the system can credibly look forward to moving into NOF2. The Financial Recovery Programme (FRP) led by ICB DoF is in year 2 of operation and has coordinated partners to build a CIP plan that targets financial improvement of £84m. The programme is overseen by FRP Board which meets twice monthly and reports into the ICB Finance and Resource Committee (FaRC), with monthly reporting into the Lincolnshire Leaders Group. The ICB has developed a robust and detailed FRP tracker which reports against plan, in-year delivery, recurrent FYE and risk on each individual programme. The FRP Board provides robust challenge on YTD delivery and forecast with a clear explanation of risks. The ICB DDoF coordinates the production of a monthly system finance report which is received by FaRC with issues escalated to ICB Board, the same report is shared at partner Finance Committee or Boards. The ICS has a single Internal Audit function and has agreed a system-wide Internal Audit programme.	The ICB has a balanced financial plan for 24/25, and the ICB DoF has led intensive work with executive leaders of clinical services, HR, Finance and Operations to de-risk the plan unmitigated risks stand at £22m. CEOs are due to receive the culmination of a review of the work in July (titled 'Closing the financial planning gap'). The arrangements through which joint expenditure with LCC and other system partners have been resurrected following a period where no formal mechanisms existed; this was the subject of external audit review. The Better Care Fund, pooled expediture on MH and other shared endeavours will be overseen by the Joint Commissioning Oversight Group (JCOG) which will have reporting lines into BLLLT and the ICB Board through the ICB DoF who co-chairs the group. A review of effectiveness of the BCF is underway with an intial focus on 2 areas; Learning Disabilities and Intermediate care due in September. There is no formal medium term view of financial sustainability. The ICS has not set medium term objectives that can be quantified and compared to expected resource allocations over the medium term to test sustainability. The process by which this could be established is being led by the Director of Strategic Planning, Integration and Partnerships and this work is due to conclude in August.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month
Closing the financial planning gap work concluded, and agreement reached on how the 2024/25 financial plan is de-risked to go to FaRC for approval.	31/08/2024	Director of Finance	
Approval and resourcing of a review of BCF effectiveness 1st phase: Learning Disability/ Intermediate care	31/07/2024	Director of Finance	
Completion of medium term planning process for approval by ICB executive	31/08/2024	DoF/DoSPIP	

Item 5 (iv)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (iv)
Meeting Date:	Tuesday, 24th September 2024
Title of Report:	Revised Risk Management Strategy
Report Author:	Jules Ellis-Fenwick, ICB Board Secretary and Karen Bates, Assistant to the Board Secretary
Presenter:	Jules Ellis-Fenwick, ICB Board Secretary
Appendices:	Revised Risk Management Strategy

To approve ☒	For assurance ☐	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g., approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Board is asked to:

- Approve the Risk Management Strategy.

Summary

Background

TIAA, the ICB internal auditors, carried out a review of the adequacy and effectiveness of the ICB's risk management arrangements in 2023/24 including how it interfaces with the ICS wide risk management structures. The overall assessment was Reasonable Assurance but building on previous external audit reports, TIAA highlighted some improvements required to the ICB Risk Strategy.

The ICB governance team has been working to revamp the Risk Management Framework, Strategy and Policy to reflect the actions identified in the internal audit report, and the revised document was presented to the Audit and Risk Committee for consideration at its meeting held on the 31st July 2024. Some amendments were identified which the ICB Board Secretary was requested to action before the document was then circulated to the ICB Executive Team and Risk Management Group for comments.

The updated Risk Management Strategy was circulated to the Executive Team for comments in August and considered by the Risk Management Group at its meeting held on the 2nd September 2024. Some minor typographical amendments were noted along with comments in relation to strengthening the content, specifically in relation to in-direct and direct risks. These have been actioned.

The Audit and Risk Committee requested that the finalised document was presented to the Board at its September meeting, alongside the revised Board Assurance Framework, for approval.

The Board is asked to approve the revised Risk Management Strategy.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
No specific risks identified.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	No.
Does the report demonstrate patient and public involvement?	No.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Updates and progress reports on the development of the ICB's risk management arrangements have regularly been provided to the Audit and Risk Committee.

Is the report confidential or not?
Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

RISK MANAGEMENT STRATEGY

ICB document reference:	**ICB CORPORATE 013**
Name of originator/author:	Julie Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance & Karen Bates, Assistant to Board Secretary
Date of approval:	
Name of responsible Committee:	Senior Management Operational Delivery Group Audit & Risk Committee
Responsible Director/ICB Officer:	Matt Gaunt, Director of Finance
Category:	Corporate
EIA undertaken:	Yes
Date issued:	
Review date:	June 2024
Target audience:	All staff
Distributed via:	Website, Intranet and Board Portal

Document Control Sheet

Document Title	Risk Management Strategy
Version	4
Status	Draft
Authors	Julie Ellis-Fenwick and Karen Bates
Date	

Document history			
Version	**Date**	**Author**	**Comments**
1	1 February 2023	Julie Ellis-Fenwick and Karen Bates	Creation of framework, strategy and policy following creation of ICB.
2.	1 March 2023	Julie Ellis-Fenwick and Karen Bates	Strategy and Policy combined into one document.
3.	April 2023	Julie Ellis-Fenwick	Minor tweaks.
4.	May 2024	Karen Bates and Julie Ellis-Fenwick	Significant number of changes made to reflect comments received by TIAA as part of the internal audit review. Areas also updated and additional sections included to reflect good practice.
5.	August and September 2024	Karen Bates and Julie Ellis-Fenwick	Number of changes following review by Audit & Risk Committee members, Risk Management Group and Executive Team.

CONTENTS

1. INTRODUCTION

The NHS Lincolnshire ICB, hereafter known as 'ICB' is an organisation that is committed to creating a health and care system fit for the future, with transformed services that join up around people who use them. Its objectives drive work plans and decisions to enable the ICB to provide all stakeholders with assurance about the internal system of controls.

The ICB is a statutory organisation which forms part of the Lincolnshire Integrated Care System, hereafter known as 'ICS'.

Risk management plays a critical role in helping the ICB understand the impacts and manage the risks associated with its priorities and is fundamental to its success. This strategy sets out key principles that guide how risk management is embedded at all levels and how the ICB will ensure that risk is managed effectively and efficiently.

Whilst the strategy outlines the risk management arrangements for the ICB; it is important that these work in partnership with other key parts of the ICS.

The aim of the strategy is to:

- Ensure that risks to the achievement of the ICB's objectives are understood and effectively managed.
- Ensure that the risks to the quality of services that the organisation commission from healthcare providers are understood and effectively managed.
- Assure the public, patients, staff and other partner organisations, that the ICB is committed to managing risk appropriately; and
- Protect the services, staff, reputation and finances of the ICB through the process of early identification of risk, risk assessment, risk control and elimination.

Risk is an important feature within the different parts of the systems architecture e.g. Integrated Care Partnership, hereafter known as 'ICP', provider collaboratives, voluntary sector, health and care providers and Primary Care Networks, hereafter known as 'PCN'.

Partnership working can often lead to risks regarding risk ownership and accountability. It is important that there are clear inter-relationships regarding the management and ownership of risks between these elements.

The ICB recognises that risk management is an essential business activity that underpins the achievement of its objectives. A proactive robust approach to risk can:

- Reduce risk exposure through 'lessons learnt'
- Support informed decision making to allow for innovation and opportunity.
- Enhance compliance with applicable laws, regulations and national guidance.
- Increase stakeholder confidence in corporate governance and the ability to deliver.

This policy has been developed to ensure that risk management is fundamental to all of the ICB's activities and understood as the business of everyone. The policy is in line with and has adopted the following principles of risk management as set out in guidance provided by ISO 31000: 2018 standard.[1]

This strategy should also be read in conjunction with the ICB EPRR Policy and Framework.

[1] ISO 3100 helps organisations develop a risk management strategy to effectively identify and mitigate risks, thereby enhancing the likelihood of achieving their objectives and increasing the protection of their assets. https://www.iso.org/iso-31000-risk-management.html

2. PURPOSE

The policy describes the ICB's approach to the management of strategic and operational risks across the organisation. It also references how risk arrangements within the ICB will interface with other parts of the system and system partners.

The purpose of the guidance is to encourage a culture where risk management is viewed as an essential process of the ICB's activities. It provides assurance to the public, patients and partner organisations the ICB is committed to managing risk appropriately.

The purpose of the strategy is to:

- Define and set out the benefits of risk management
- Help the ICB to understand risk appetite and tolerance
- Set out the ICB's ambition to continuously improve its risk management arrangements
- Outline how the strategy relates to the ICB's wider strategic aims and objectives
- Outline the approach to implementation and monitoring
- Describe the relevant compliance and assurance arrangements regarding risk management within the ICB
- Ensure there is a robust system in place to manage risk effectively

The purpose of the risk management strategy is to ensure the ICB achieves its objectives and vision under the following four Integrated Care System (ICS) primary purposes:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

3. LEADERSHIP AND RISK CULTURE

Risk Management is both a statutory requirement and an indispensable element of good management at the ICB. Therefore, the ICBs governance, leadership and culture rely on efficient risk management, which is essential to achieving its objectives. It is a fundamental part of the ICBs approach to governance and essential to its ability to discharge its statutory functions.

The degree to which the ICBs risk management policy and best practices are being implemented is largely determined by its risk culture. This includes the general understanding, attitudes and behaviours of the ICB staff towards risk as well as how risk is handled within the organisation.

4. ACCOUNTABILITY

Risk management accountability is at the core of the ICBs approach to risk management and is central to the wider system of governance and internal control. The ICB has an effective risk management system in a clearly defined structure that:

- Contributes to the policy of accountability across the ICB and reviews and approves the Risk Management Strategy.
- Provides clear criteria for objective setting and ongoing performance management.
- Scrutinises the system of risk management at a level appropriate to each element of the structure and reduces the risk of blurred responsibility boundaries and the chance that key activities will be overlooked.
- Provides role clarity for individuals and a clear focus for day-to-day activity.
- Improves overall oversight, challenge and decision making and support a culture of risk awareness and positive risk-taking behaviour.

5. SCOPE

The strategy applies to all ICB staff members, including Board Members, appointees of the ICB and any individuals working within the ICB in a temporary capacity, or contracted-in under a contract for service arrangement (either as an individual or through a third-party supplier).

6. ROLES AND RESPONSIBILITIES

This section identifies the staff members and business functions with responsibilities, including the resources, to support the risk management function for the ICB.

ROLES	RESPONSIBILITIES
ICB Board	The Board has overall accountability for risk management and, as such, needs to be satisfied that appropriate arrangements are in place and that internal control systems are functioning effectively. The Board determines the ICB's risk appetite and risk tolerance levels and is also responsible for establishing the risk culture.
Chief Executive	The Chief Executive has the overall responsibility for risk management within the ICB, and maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding public funds and assets. As part of the BAF, the Chief Executive on behalf of the Board, will publish a Statement on internal control known as the Annual Governance Statement. This will give stakeholders confidence that the ICB can demonstrate it is adequately informed about the totality of their risks.
Executive Directors	Executive Directors are responsible for ensuring effective systems of risk management are in place and, commensurate with this Strategy, and compliance with relevant regulations for their respective directorate. Each Director can be a risk owner and accountable for: • Articulating the risk appetite statement for their risk domain or for which they are an Executive lead. • Demonstrating leadership, active engagement and support for risk management within their directorate. • Ensure corporate objectives are linked to strategic objectives and have clear outcomes and risks to achieving them are identified, as well as ensuring effective controls are in place and well represented on the BAF. • Ensuring that the Risk Management Strategy is consistently implemented throughout the ICB. • Holding risk owners accountable for progress on risk reduction and risk management. • Ensuring risk owners provide a monthly update on actions, progress and any changes to risk scores.
Non-Executive Members	As members of the Board and Committees, Non-Executive Members will ensure impartial approach to the ICB's risk management activities and should satisfy themselves that systems of risk management are robust and defensible.
Senior Information Risk Owner	The Director of Finance is the ICBs Senior Information Risk owner (SIRO) specifically for information risk management. The SIRO takes ownership of the ICB's information risks and acts as an advocate for information risk on the Board and in internal discussions and will provide written advice to the Accounting Officer on the content of the annual Statement of Internal Control (SIC) in regard to information risk.

Executive Team	The Executive Team is responsible for overseeing the implementation of the ICBs Risk Management Strategy, including defining, sponsoring, supporting, debating, and challenging key risk and risk management activity across the ICB. The Executive Team will review and monitor progress against the Strategy and play a key role in providing assurance to the Board and Audit & Risk Committee on its effectiveness, its application and the management of key risk areas. The Executive Team will: • Ensure that key and emerging strategic risks are identified, assessed, and managed by undertaking on-going analysis of risk information to assess risk criticality, common themes and trends and identify areas of emerging risk requiring further quantification or scenario analysis. • Ensure that there is an appropriate reporting structure in place to support the delivery and execution of the ICBs Risk Management Strategy. • Promote a risk aware culture and an environment that creates positive risk-taking behaviour and clear accountability. • Monitor the overall level of risk assumed by the ICB and the effectiveness of risk assessment, risk mitigation strategies and internal control processes, including monitoring progress of critical risk mitigation and the implementation and maintenance of effective controls. • Receive and review updates and recommendations from the Corporate Governance team on the management of significant risk and the effectiveness of the risk management process. • Request the attendance of ICB management and risk owners at meetings and receive presentations on specific key risks and strategy application effectiveness. • Ensure all contracts include appropriate consideration of risk exposure factored into the selection process.
Programme Leads	Programme Leads are responsible for leading risk management arrangements within their Teams, which includes, but is not limited to, ensuring that: • Risk Logs are in place to support delivery of team, project/programme objectives; • Operational risks are appropriately escalated from Risk Logs to the ICB Corporate Risk Register; • Mitigating actions are in place to manage risks in line with the ICB's risk appetite levels; and that • Staff are suitably trained in relation to risk management.
Risk Management Lead	The responsibility for the consolidation, challenge and reporting of all risk management information sits with the ICB Corporate Governance Team, and the provision of support guidance on the application of the strategy across the ICB. The Corporate Governance Team will: • Produce the Risk Management Strategy and Framework. • Support the development of risk management arrangements for the ICB including the reporting structure and reports, including maintenance of the corporate risk register and Board Assurance Framework. • Support the development of risk management resources and training materials fit for the ICB. • Support any audits or reviews on ICB risk management arrangements.
All staff	All staff must comply with this Risk Management Strategy and assisting in the risk management process by: • Proactively and promptly identify risks within their area of work and at

	meetings and adding risks to the relevant risk logs/registers. • Ensuring that risks have been assigned to a Risk Owner and Risk Lead to estimate the severity of the risk with regards to the Likelihood and Impact (LxI) on objectives at any level. • Reviewing existing controls and where there is a gap, agree on planned actions to strengthen the controls. • Describing risks using best practice. • Proactively reporting of incidents within 72 hours of becoming aware, including health and safety, data protection or information security breach. • Attending risk management training and development events to ensure a full understanding of their risk management responsibilities and expectations. This section sets out the functions and responsibilities of the ICB Committees.
Audit & Risk Committee	The Committee's core responsibilities in relation to risk management are set out below: • Review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives and highlight any areas of weakness to the Board. • Ensure that financial systems and governance are established to facilitate compliance with the DHSC's Group Accounting Manual. • Have oversight of system risks where they relate to the achievement of the ICBs objectives. • Seek reports and assurances from Directors and Managers as appropriate, concentrating on the systems of integrated governance, risk management and internal controls, together with indicators of their effectiveness. • Ensure that the ICB acts consistently with the principles and guidance established in HM Treasurys 'Managing Public Money.' • Identify opportunities to improve governance, risk management and internal control processes across the ICB.
Board Committees with Assurance Functions	Committees with assurance functions will scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives. Board Committees will provide regular assurance updates to the ICB in relation to activities and items within its remit and will have the following responsibilities in relation to risk management: • Scrutinise the structures in place to support planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern. • Oversee and monitor delivery of the ICB key statutory requirements. • Review and monitor risks in a timely manner. • Support the ICB Board and Audit & Risk Committee with regards to issues or alerts associated with the quality of the care commissioned and to triangulate or critically review this for action by the ICB, or providers from whom the ICB commissions. • Oversee the work programmes for the groups reporting into the Committee and ensure that escalation routes are clear for risks being managed at other levels.
Internal and External Auditor	Both Internal and External Auditors will provide assurance to the Audit & Risk Committee on the effectiveness of its system of internal control including the Strategy and its application across the organisation. It will also use the outputs from the Strategy to drive its assurance plan going forward throughout the

	year, to: • Develop risk based annual internal and external audit plans. • Review the effectiveness of controls in place to manage key risks identified. • Provide an annual review and opinion on the effectiveness of the ICBs risk management arrangements by review of the Strategy and its application on behalf of the Audit & Risk Committee and report findings.
Senior Management Operational Delivery Group (SMODG)	The Senior Management Operational Delivery Group will bring together Senior Management Members from across the ICB to consider operational delivery, governance, performance and risk of key priorities aligned to the ICB objectives and statutory duties. It will monitor and confirm/challenge to remove barriers to progress and delivery of outputs and outcomes against agreed objectives reporting directly to ICB Executive Team. SMODG will review of risk registers and 'calibration' of risks arising from Board and Committees, Single Point of Contact (SPOC), work-streams, programme leads/SRO's (ICB and non-ICB lead priorities) and assess adequacy of identified mitigations.
Risk Management Group	The Risk Management Group will have responsibility for undertaking a co-ordinated review of risk and ensuring that the ICB takes a consistent approach to risk assessment and risk measurement., including ensuring that the risk appetite set by the Board is appropriate and adhered to. A risk register will be maintained to record risks identified. The specific roles and responsibilities of the Risk Management Group are set out within its Terms of Reference, which include: • Delegated duties as the 'gatekeeper' for escalation and de-escalation of any key risks. • Responsibility for the management of risk monitoring and action.
Directorates	Each Directorate must ensure that any risks potentially impacting their service provision are identified, assessed and reported based on the corporate approach as defined within the Strategy. Specifically, actions include: • Identifying and assessing key risks within the Directorate for management through the risk management process. • Taking ownership of key risks as directed by the Executive Team. • Overseeing the progress of actions to manage risks identified and ensure the risks are kept up to date, with a review during directorate/team meetings at least quarterly. • Ensuring teams within their sphere of responsibility put into practice the requirements of the Strategy and hold them to account for this as appropriate. • Ensuring personal objectives of all team members have an appropriate focus on risk and risk management. • Ensuring appropriate resources are in place to deliver the requirements of the Strategy effectively within the area of responsibility. • Sponsoring a culture of risk awareness and positive team behaviour in relation to risk and risk management. • Review and challenge key risks, control effectiveness and the progress of mitigation actions through on-going dialogue. • Conducting routine emerging risk identification sessions within the teams.

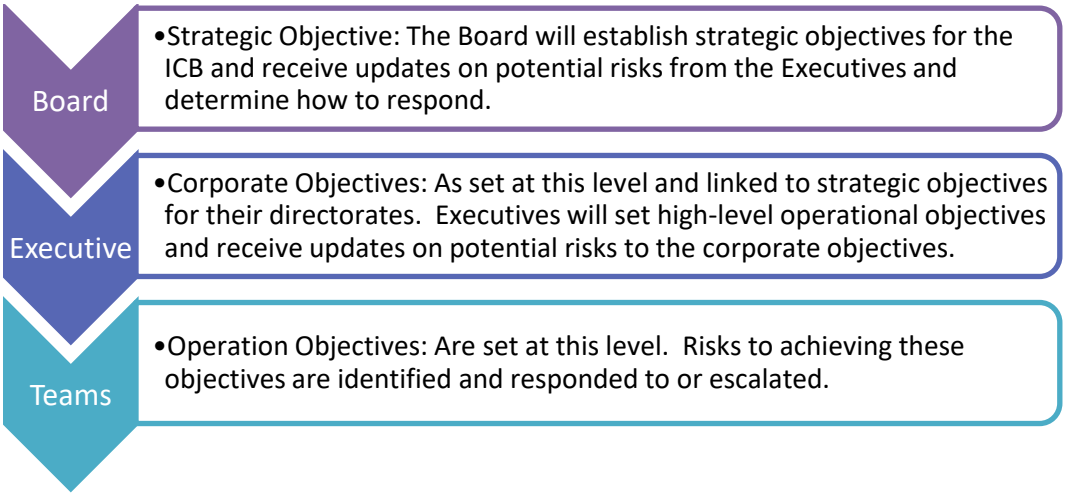
7. RISK MANAGEMENT PROCESS

Risk management is a multi-faceted process of continuous improvement. The main elements of the process are shown in Figure One and described in more detail throughout this Strategy.

8. OBJECTIVES FRAMEWORK

Objectives can be described into three levels within an organisation, strategic, corporate and operational objectives, which can be applied at different levels of the ICB including, strategic, organisation-wide, departmental, project and team.

Objectives set out the scope, context and criteria or risk appetite against which risks are identified and managed. This means that there is no risk where the objective is unknown or not defined. Therefore, understanding the context is important because risk management takes place in the context of the objectives and activities of the ICB.



The ICBs changing environmental factors can be a source of risk. By changing the scope of a programme of work, risk may be avoided, but if the risk relates to an ICB 'Must Do' this may not be an option.

Strategic, corporate and operational risks can be identified by anyone, anywhere and risk identification and management should be an integral part the ICB's day to day activity. Some specific ways of identifying risks include:

- Horizon scanning
- Formal risk assessment exercise
- Lessons learnt following an incident or a complaint
- Discussion at Board/Committee level
- Completing/reviewing a Project Business Case
- Performance discussions with providers

All risks should have a link to the ICB's objectives. The achievement of the ICB's objectives depends on the identification and successful management of risks.

There are a number of risk areas which are listed on the next page, and this list is not exhaustive.

9. RISK IDENTIFICATION

The first and perhaps most important task in developing the ICB risk profile is to find, recognise and describe risks that might help or prevent the ICB from achieving its objectives. Risks to achieving objectives can and should be identified through various methods, nothing that risks might be external or internal to the ICB, and new/emerging or continuous or residual. Some methods can include, but not limited to:

- Gap analysis and Key Performance Indicators (KPIs), a gap between the target outcomes and the actual performance against outcomes could highlight the existence of a risk.
- Horizon scanning for external and internal environmental factors that might threaten the achievement of objectives.
- Risks identified during discussion at Board, Committee or Team meetings should be documented and reported.
- Proactive exercise including 'top-down' assessment of strategic risks, facilitated involving the Board, Executive Team and wider management, as required 'bottom-up' risk reporting and risk discussions at a local level, as required, to ensure a consistent approach across the directorates.
- The finding from the Internal and External Audit reviews are risks and the ICB will manage these risks in line with associated management action recommendations.
- Incidents, claims, complaints, suppliers, partners, services commissioned, resources allocation, planning, procurement, conflict of interest, trends, patterns in events and risk assessment can potentially give rise to risks and should be appropriately managed or escalated.

Factors to be considered when identifying a risk include:

- Tangible and intangible sources of risk.
- Causes and events, threats and opportunities.
- Vulnerabilities and capabilities.
- Changes in the external and internal context.
- Indicators of emerging risks.
- The nature and value of assets and resources.
- Consequences and their impact on objectives.
- Limitations of knowledge and reliability of information.
- Time related factors.

The ICB can exert greater or lesser levels of control or influence over risks depending on their source and type. Some risks can be largely mitigated or eliminated entirely; however, this is not always possible. The ICB's risk management process is therefore tailored according to whether the risk can be solely controlled by the ICB - a direct risk - or it is a risk shared between the ICB and its partner(s) – an indirect risk. Both direct and indirect risks are included within the ICB risk registers/logs, however the means through which they are mitigated and monitored will vary according to who exerts control on the risk.

10. ARTICULATION OF RISK

It is important to understand the anatomy of risks. As defined, risk is an uncertainty that something impacting on objectives is likely to happen:

- NOT something that has happened (incident)
- NOT something that will happen or is already happening (issue)

Risk consists of a combination of three elements, including cause, event and effect. The risk description should follow the best practice model: IF (cause), THEN (risk event) and RESULTING IN (effect/impact) to help determine risk severity and how risks can best mitigated.

CAUSE	EVENT	EFFECT
What might trigger the event to occur eg 'IF' our financial performance is incomplete	An unplanned/unintended variation from an objective eg 'THEN' we may be unable to demonstrate value for money in all areas	How the organisation could be impacted should the event occur eg 'RESULTING IN' (1) a threat to future funding and (2) damage to the ICBs reputation

This allows careful consideration of the real risk; the principal cause that may give rise to the risk; and the effects for the ICB should the risk materialise.

11. RISK APPETITE OR TOLERANCE STATEMENT FRAMEWORK

Risk appetite is the art of taking risks and exercising control while considering differing views at a strategic, tactical and operational level. This provides consistency in the decision-making process, which will enable the ICB to take well-calculated risks when opportunities arise that will improve delivery, and conversely, to also identify when a more cautious approach should be taken to mitigate a threat.

According to Deloitte, effective risk appetite framework generally includes the following three key principles:

1) "Risk appetite should be aligned to the strategic objectives and considered a forward-looking view of an organisation."
2) "Board and Senior Management should be actively involved, and strong accountability structures and clear incentives and constraints should be in place."
3) "Risk appetite statements should be operationalized through use of the right level and type of information, fostering strong internal relationships, and establishing risk limits with actionable input for risk and business managers."

The Board Directors are responsible for making the risk appetite statements for each risk category, specifying the appetite level the ICB may or may not take, relative to objectives.

The table below illustrates the different levels of risk appetite, noting that the level of appetite increases and decreases depending on the various stages of willingness to accept the terms of impact on objectives. The full details of the Good Governance Institute Risk Appetite Matrix is detailed at Appendix C.

	Averse 1	Cautious 2	Open 3	Seek 4	Significant 5
Descriptors	Avoidance of risk is a key objective. Activities undertaken will only be those considered to carry virtually no or minimal inherent risk	Preference for very safe business delivery options that have a low degree of inherent risk with the potential and only a limited reward potential	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of reward	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, horizon scanning and respective systems are robust

The defined risk appetite will provide the Executive Leads (risk owners) with relevant information with which they may evaluate significance of risks to ICB objectives and support decision-making processes.

Risk appetite should be defined when setting strategic objectives and evaluating risks to achieving them. The following should be considered.

- The nature and type of uncertainties that can affect outcomes and objectives (both tangible and intangible) in relation to the ICBs risk domains.
- How consequences (both positive and negative) and likelihood of the risk occurring and its potential impact on our business will be defined and measured in relation to the ICBs risk matrix.
- How the level of risk is to be determined in relation to risk appetite and tolerance.
- How combinations and sequences of multiple risks will be considered in relation to the impact/ consequences table.

Examples on risk appetite or tolerance.

1. If the ICBs risk appetite level is '**eager**', to take risks on objectives that present a potential benefit, such as innovation, then the ICB is willing to accept the terms of risk. The ICB may decide that the level of control in place is adequate to manage that particular risk and will not necessarily need to strengthen those controls above all.
2. For **reputational risks**, the Board can state that "We have adopted a '**cautious**' stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, thereby enhancing our reputation for delivering high quality, cost-effective service.
3. The ICBs appetite for financial risk is operating within the risk tolerance position – '**cautious'**.

Where financial decisions are heavily scrutinised, with value for money being a key factor in decision making. The ICB will accept risks that may result in some small scale financial loss or exposure on the basis that these can be expected to balance out but will not accept financial risks that could result in significant reprioritisation of budgets.

12. ASSURANCE FRAMEWORK

Assurance is about providing evidence of adequate levels of confidence that risks to objectives are controlled. It is acknowledged that it is never possible to provide complete and absolute assurance, and as such the concept of positive or negative assurance is adopted.

Implementing an assurance framework, which makes sure that the different assurance procedures are focused to give the best outcomes in a reasonable and efficient manner, is an effective technique to manage how effectively performance and the related risks to objectives are managed. To construct an assurance framework the following conditions must be met:

- Clarity on the objectives and ownership of the assurance framework at Board level.
- Support and guidance from the Accountable Officer.
- Establishing the assurance framework initially inside a controlled perimeter.
- Avoiding technical jargon; processes should strive to create a common, readily understood language
- Simplicity – do not try to include too much in a single assurance map.

The assurance framework is an integral part of an ICBs risk management strategy rather than a stand-alone activity and is an integral part of the risk management strategy used to effectively achieve the ICBs objectives and outcomes. The Audit and Risk Committee is delegated regular assurance monitoring by the Board as well as oversight.

The aim of obtaining assurance is to ensure sufficient and appropriate evidence, to support confidence that a risk is well mitigated. The higher the level of assurance provided, the great the confidence in the risk management. The risk owners and leads will achieve this by conducting a more in-depth assessment of the assurance. The following are the two common levels of assurance that can be obtained:

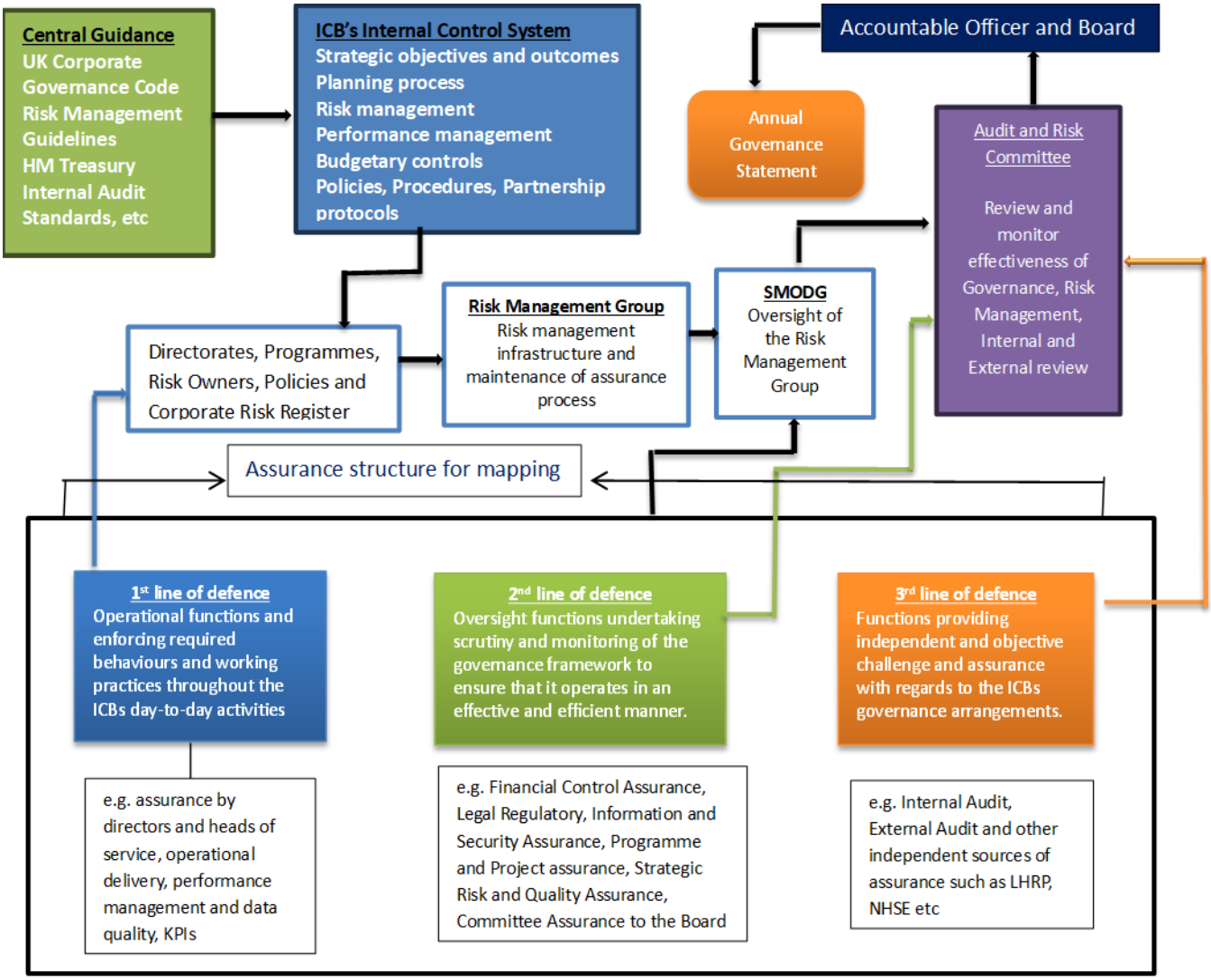
- Positive Assurance (+) as defined, this could mean that either a ‘reasonable’ or ‘substantial’ level of assurance is evidenced, not that there is an absolute level of assurance.
- Negative Assurance (-) as defined, could mean that there is either ‘no assurance’ or only a ‘partial/limited’ level of assurance.

To ensure the effectiveness of the ICBs risk management strategy, the Board and senior management need to be able to rely on adequate line functions, including monitoring and assurance functions, within the organisation. The ‘Three Lines of Defence’ model is used as a way of explaining the relationship between the oversight functions within the assurance process.

First Line of Defence – The internal control framework that enforces required behaviours and working practices throughout the ICBs day to day activities. For example: policies, processes, systems, procedures, protocols, professional standards, codes of conduct etc. Operational management has ownership, responsibility and accountability for assessing, controlling and mitigating risks together while maintaining effective internal controls.

Second Line of Defence – Oversight functions that: undertake scrutiny; facilitate and implement effective risk management practices by operational management; assist the risk owners in defining the target risk exposure; and report adequate risk related information through the organisation. For example: governance, compliance framework, financial control, quality, external performance and commissioning responsibilities reported to the Board.

Third Line of Defence – Functions providing independent and objective challenge and assurance with regard to the IXBs governance arrangement. Internal Audit, External Audit and other independent assurance providers and regulators.



13. STRATEGIC RISK MANAGEMENT

Strategic risks are high level risks that are proactively identified and threaten the achievement of the ICB's strategic objectives and key statutory duties. These risks are owned by members of the Executive Management team and are outlined within the ICB's Board Assurance Framework (BAF).

The BAF provides the Board with confidence that the ICB has identified its strategic risks and that there are robust systems, policies and processes in place that are effective in the delivery of their objectives.

The BAF plays an important role in informing the production of the Annual Governance Statement and is the main tool that the Board should use to discharge overall responsibility for ensuring an effective system of internal controls are in place.

The Board approves the strategic risks following agreement of the strategic objectives. The Board will review the fully populated BAF bi-annually to affirm that sufficient levels of controls and assurances are in place.

The BAF is reviewed and updated by the Executive Directors throughout the year. This involves a review of the effectiveness of controls and what evidence is available to demonstrate that they are working as they should. Any gaps in controls or assurances will be highlighted and actions identified.

The Audit and Risk Committee will receive targeted assurance reports, which will cover all of the ICB's objectives. This enables a focused review on specific sections of the BAF and allows for robust discussions on the actions in place to remedy any identified gaps in controls and assurances.

14. OPERATIONAL RISK MANAGEMENT

Operational risks are 'live' risks that the organisation is currently facing, which are by products of the day-to-day business delivery.

Operational risk management relies upon reactive identification of risk, which are 'dynamic' in nature. Operational risks are managed via the ICB's Corporate Risk Register.

The Corporate Risk Register is the central repository for all of the ICB's operational risks. Risks will feature across a number of ICB processes, however, it is important that these are captured centrally to provide a comprehensive log of prioritised risks that accurately reflect the ICB's profile.

The Corporate Risk Register will reflect both operational risks relevant to the ICB and operational risks associated with the delivery of system objectives/priorities.

The ICB's Corporate Risk Register will not capture operational risks which are owned by the ICS system partners that they are accountable for.

The Corporate Risk Register contains details of the risk, the current controls in place and an overview of the actions required to mitigate the risk to the desired level. A named individual (risk owner) is given responsibility to ensure the action is carried out by the due date.

15. RISK IDENTIFICATION, ASSESSMENT AND TREATMENT

Risk management is about the steps taken in a systematic way to enable the organisation to identify, assess and control risk.

Once a risk has been identified, it is important to establish the likelihood of a risk happening and the potential impact if it did occur. This is described as the original (inherent) risk and refers to a score before any action has been taken to mitigate the risk. A risk assessment form is completed for each identified risk (Appendix B).

This is measured by using the following Likelihood scoring criteria (consequences score) as detailed on the following page:

Consequence Scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

To assist with assessment and scoring of risk the suggested risk impact scoring criteria can be found at Appendix A. Once the likelihood and the impact score have been established, a total risk score can be determined in line with the scoring matrix below.

Colour grades for risks are used to quickly identify significant risk areas:

Risk (5 x 5) Matrix							
			Likelihood				
			Rare 1	**Unlikely 2**	**Possible 3**	**Likely 4**	**Almost Certain 5**
Consequence	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Rare	1	2	3	4	5

	1-3	Very low risk
	4-6	Low risk
	8-12	Moderate risk
	15-25	High risk

Instructions
1. define the risk explicitly in terms of the adverse consequence that might arise from the risk. Use table 1 to determine the consequence score for the potential adverse outcome
2. Use table 2 to determine the likelihood score for the adverse outcomes
3. Calculate the risk score by multiplying the consequence by the likelihood

Green – the mitigations are on schedule and the risk owner considers that the target score is achievable by the due date.

Amber – One or more of the mitigations are falling behind and there are some concerns that the target score may not be achievable by the due date unless shortcomings are addressed.

Red – Significant mitigations are falling behind and there are serious concerns that the target score will not be achievable by the due date and the shortcomings must be addressed and/or new mitigations put into place.

Risk Treatment

In selecting the most appropriate risk treatment options, balance the potential benefits derived about the achievement of the objectives against costs, effort, or disadvantages of implementation. Risk treatment options are not necessarily mutually exclusive or appropriate in all circumstances.

Therefore, it is worth considering one or more of the following:

- Avoiding the risk by deciding not to start or continue with the activity that gives rise to the risk
- Taking or increasing the change to pursue an opportunity
- Removing the risk source
- Changing the likelihood or consequences
- Sharing the risk (e.g. through contracts, buying insurance)
- Retaining the risk by informed decision

Risk treatment is the process of selecting and implementing measures to mitigate the risk to a reasonable level. Once the risk has been evaluated, a decision needs to be made as to whether they need to be mitigated or managed through the application of controls; these are often known as the 'four T' risk treatment as described below:

Treatment	Description
Terminate	Choose not to take the risk by terminating the activity that will cause it.
Treat	Take mitigating actions that will minimise the impact of the risk prior to its occurrence and/or reduce the likelihood of the risk occurring.
Transfer	Transfer the risk, or part of the risk, to a third party.
Tolerate	Accept the risk and take no further action.

A majority of operational risks should have the ability to reduce in impact and/or likelihood. High and extreme operational risks (scoring 15 or above) which are not deemed to be treatable will be highlighted to the Board.

Operational risks scored below 12, the responsible committee may agree that they can be tolerated. However, this would be subject to the committee being satisfied that no other actions can be undertaken.

16. RISK LOGS/DIRECTORATE RISK LOGS

Risk logs are used to record operational risks at individual team or programme level, which are not considered significant enough to be captured on the ICB's Corporate Risk Register. These risks will be identified in line with the team or programme level objectives which have been set. A log template is in place and is accessible (Appendix B)

If identified risks are considered to be required to be escalated, these must be escalated to the Corporate Risk Register via the relevant lead for that area.

Each directorate and, where deemed appropriate, distinct functions or programmes within a directorate, should maintain and review its own log of risks that impact on the delivery of their directorate level objectives. These should follow the Corporate Risk Register format and be discussed and reviewed at least monthly.

Risks that have been assessed to have a rating of 12 or above must be reviewed by the Executive Director for the directorate. Where the impact and likelihood are high, the Director will escalate the risk as a corporate risk for addition to the Corporate Risk Register.

16. RISK MANAGEMENT PROCESS – ESCALATION & DE-ESCALATION

The organisational management of risk forms part of the ICB's overall approach to governance. The key forums for the management of risk in the ICB are outlined below:

Risk Management Group

- Has delegated duties as the 'gatekeeper' for escalation and de-escalation of any key risks
- Has responsibility for the management of risk monitoring and action
- Will report to the Senior Management Operational Delivery Group on a monthly basis
- Will report to the Audit & Risk Committee on a quarterly basis

Senior Management Operational Group

- Has oversight of the Risk Management Group
- Will receive a monthly report

Audit & Risk Committee

- Is responsible for seeking assurance for the Board in order that the systems of internal control for managing risk is appropriate
- Receive a report of risks from the Risk Management Group on a quarterly basis

EPRR Oversight & Assurance Group

- Is responsible for the co-ordination and achievement of EPPR Core Standards and Legal duties across the ICB
- Will report to the Senior Management Operational Group and Risk Management Group for any identified risks for inclusion on the ICB Risk Register.

Escalation should be in accordance with the ICB Strategy. The ICB escalates risk for two reasons. Firstly, for information, and secondly when a risk requires action or resource/authority to proceed from an authorised source.

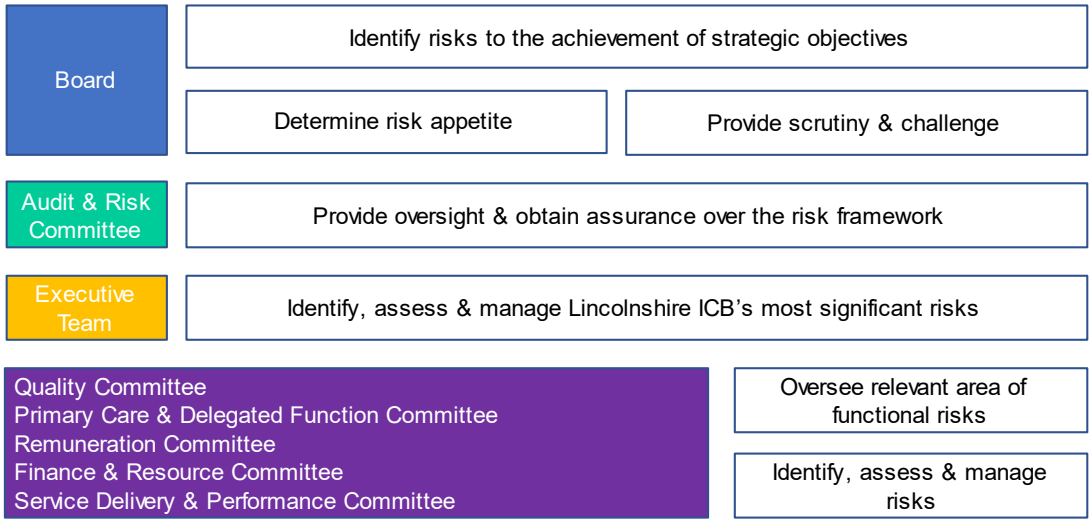
17. REPORTING AND MONITORING

The reporting of risk is the process of communicating real time risks. Monitoring risk is a continuous activity that results in the awareness of what is happening across the organisation. Reports should help the ICB to:

- Monitor agreed risk response plans/actions
- Track key milestones
- Evaluate the impact of controls and actions on the risk
- Identify new or unexpected risks

Reports should focus on what has changed to allow Executives and other decision makers make informed decisions

The diagram below shows the risk reporting for each of the ICB's committees, groups and teams.



Reports are prepared and reviewed at each Committee and operational group as below:

- **Board** – receive a report on the Corporate Risk Register every six months and will receive the BAF on a quarterly basis.
- **Audit & Risk Committee** – receive a report on the Corporate Risk Register at every meeting including the BAF once it has been reported to Board.
- **SQPEC** – receive a report on the risks on the Corporate Risk Register and any strategic risks on the BAF allocated to that Committee for review
- **Primary Care Commissioning and Delegated Functions Committee** – receive a report on the risks on the Corporate Risk Register and any strategic risks on the BAF allocated to the Committee for review.
- **Finance and Resource Committee** - receive a report on the risks on the Corporate Risk Register and any strategic risks on the BAF allocated to the Committee for review
- **Remuneration Committee** – receives a Corporate Risk Register report showing any risks relating to HR and OD.
- **Senior Management Operational Delivery Group** – receive regular reports from the Risk Management Group.
- **Service Delivery & Performance Committee** - receive a report on the risks on the Corporate Risk Register and any strategic risks on the BAF allocated to the Committee for review.

18. FRAUD RISK ASSESSMENT

The Government Functional Standard 013: Counter Fraud Management of counter fraud, bribery and corruption activity has been applied to NHS organisations since April 2021. The standard is part of a suite of standards that promotes consistent and coherent ways of working across government and

provides a stable basis for assurance, risk management and capability improvement.
The NHS Counter Fraud Agency (NHSCFA) is a health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS. The NHSCFA requires the organisation to undertake local risk assessments to identify fraud, bribery and corruption risks and to ensure these are recorded and managed in line with the strategy.

A separate fraud risk register will be maintained by the ICB and reported to the Audit and Risk Committee annually, to coincide with the Counter Fraud annual planning process.

19. RISK CLOSURE/ARCHIVING

Risks can be considered for closure if the risk no longer applies (i.e. the process that gave rise to the risk no longer exists) or the risk has reached its target level and no outstanding actions remain. Risk closure is decided by the Executives and there are two categories for closes risk which determine the level of ongoing review.

- Risk still exists but is within target level. These risks will be reviewed once a year to ensure they remain at target level.
- Risk no longer applies. These risks will not be subject to further review.

20. TOOLS AND TECHNOLOGY

The ICB Corporate Risk Register, and risk logs are held on an Excel database.

21. TRAINING

The ICB will proactively raise awareness of the Policy across the ICB, which will also be shared on the ICB internet and intranet, to provide ongoing support to Committees and individuals to enable them to discharge their responsibilities as set out above.

Embedding of the Risk Management Policy will be supported by a range of training options for all staff. This includes:

- An introduction to risk management as part of the induction process; and
- Updates delivered as part of mandatory training.

It is essential that all staff are aware of the Risk Management Policy and their role in implementing it.

22. EQUALITY AND DIVERSITY STATEMENT

The ICB pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Action 2010 in policy development and implementation, as a commissioner and provider of services, as well as an employer.

The ICB is committed to ensuring that the way we provide services to the public and the experiences of our staff does not discriminate against any individual(s) or groups on the basis of their age, disability, gender identity, marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

The ICB are committed to ensuring that the activities also consider the disadvantages that some people in the diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, roma and travellers.

As an employer the ICB are committed to promoting equality of opportunities in recruitment, training

and career progression and to valuing and increasing diversity within the workforce.

To help ensure that these commitments are embedded in the ICB day to day working practices, an Equality Impact Assessment has been completed and is attached to this policy.

23. REFERENCES

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- A Risk Practitioners Guide to ISO 31000:2018, (2018). The Institute of Risk Management
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- Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking, (2012). The Good Governance Institute
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- Code of Conduct for NHS Managers Department of Health, (2022)
- A Risk Matrix for Risk Managers, (2008). NPSA

24. GLOSSARY OF TERMS

The following terms are used throughout this document:

TERM	DEFINITION
Assurance	Evidence that controls are working effectively. Assurance can be internal (e.g. committee oversight) or external (e.g. internal audit reports).
Board Assurance Framework (BAF)	A Board Assurance Framework (BAF) is a structured way of identifying and mapping the main sources of assurance in an organisation. The BAF document is the key source of evidence that links the organisations strategic objectives to risk, controls and assurances and the main tool the Board will use to discharge its responsibility for internal control.
Controls	The measures put in place to control risks and reduce the impact or likelihood of them occurring.
Corporate Risk Register	A tool for recording identified operational risks and monitoring actions against them.
Current (or residual) risk score	The numerical assessment of the risk (impact v likelihood) after taking into consideration any mitigating controls and/or actions.
Governance	This is the systems and processes by which the ICB leads, directs and controls its functions to achieve its organisation objectives, safety of quality services and in which it relates to the wider community and partner organisations.
Hazard	The HSE defines a hazard as 'anything that may cause harm'.
Initial Risk Score	The numerical assessment of the risk (impact v likelihood) prior to considering any additional mitigating controls and/or actions.
Integrated Care Board (ICB)	The ICB is the statutory NHS organisation within the ICS which holds responsibility for NHS functions and budgets.
Integrated Care Partnerships (ICP)	The ICP is a statutory committee which brings together all ICS system partners to produce a health and care strategy.

Integrated Care System (ICS)	The ICS is a partnership that brings together providers and commissioners of NHS services across a geographical area with local authority and other local partners to collectively plan health and care services to meet the needs of the population.
Internal Controls	These are the ICB policies, procedures, practices, behaviours and organisations structures to manage risks and achieve objectives.
Operational Risk Management	Risk management processes which focus on the operational risks which the organisation is potentially facing. It relies upon the identification of risks, which are 'dynamic' in nature and are managed via additional mitigations. Operational risk management processes are centered around the Corporate Risk Register.
Operational Risks	These risks are by products of day to day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives. The ICB's operational risks include corporate risks and system risk.
Risk	There are many definitions of risk, however, this policy has adopted the definition set out in ISO 31000 in that a risk is the 'effect of uncertainty on objectives'. The effects can be negative, positive or both. It is measured in terms of impact and likelihood.
Risk Assessment	An examination of the possible risks that could occur during an activity.
Risk Culture	The values, beliefs, knowledge and understanding of risk, shared by a group of people with a common purpose.
Risk Logs	Risk logs are tools for capturing operation level risks at team/ directive/programme which may impact on the delivery of local objectives.
Risk Management	The arrangements and activities in place that direct and control the organisation with regards to risk.
Risk Mitigation	How risks are going to be controlled in order to reduce the impact on the company.
Risk Profile	The nature and level of the threats faced by an organisation
Risk treatment	The process of selecting and implementing suitable measures to modify the risk.
Strategic Objectives	Strategic objectives are a clear set of organisation goals that help establish priority areas of focus. They need to be specific enough that their achievement can be assured, and progress measured. They should have direct alignment with the BAF and the ICB's performance management process.
Strategic Risk Management	Risk management processes which support the achievement of the organisation's strategic objectives. The focus is on the proactive identification of 'high level' risks which are managed by an established controlled framework. The risk management process is centered around the BAF.
Strategic Risks	Potential, significant risks that are proactively identified and threaten the achievement of the organisations strategic objectives.

Appendix A

Table 1 - Consequence score (severity levels)				
Consequence/ score	**Descriptor**	**Risk to patients**	**Organisational impact**	**Personal injury**
5	Catastrophic	Death Multiple fatalities or permanent injuries or irreversible health effects.	Permanent loss of service/ facility. Loss of several key staff. Total loss of public confidence. Significant financial loss.	Death An event which impacts on a large number of patients.
4	Major	Major injury leading to long-term incapacity/disability.	Key objectives not met. Major financial loss.	HSE defined major injury including amputation/fracture.
3	Moderate	An event which impacts on a small number of patients.	Suspension of some operational activity for sustained period. Schedule slippage. High financial loss.	Serious injury to one or more persons.
2	Minor	Minor injury or illness requiring minor intervention.	Low staffing level that reduces service quality. Medium financial loss.	Minor injury or illness requiring minor intervention.
1	Rare	Minimal/no injury.	Minimal/no impact. Low financial loss.	Minimal/no injury.

Table 2 – Likelihood score (risk occurring during the next year)		
Likelihood score	**Probability**	**Description/Frequency**
5	Almost certain	Will undoubtedly happen/recur, expected to occur in most circumstances.
4	Likely	Will probably happen/recur but is not a persisting issue.
3	Possible	Might happen or recur occasionally.
2	Unlikely	Do not expect it to happen/recur but is possible it may do so.
1	Rare	Probably never happen/recur only in very exceptional circumstances.

Appendix B - NHS Integrated Care Board Risk Assessment Form

Assessor(s)

Name:		**Designation/ Role:**		**Date:**	

Risk Analysis and Description:

Source of Risk: (How identified)									
Risk Description:									
Cause(s): (Due To /Hazards)									
Effect(s): (Resulting in)									
Consequence(s)									
Risk Ratings: (See guidance)	**INITIAL/INHERENT**			**CURRENT (With Control/Mitigation)**			**TARGET**		
	Consequence	**Likelihood**	**Rating (CxL)**	**Consequence**	**Likelihood**	**Rating (CxL)**	**Consequence**	**Likelihood**	**Rating (CxL)**
Assessed Scores									

Risk Context:

3 Line Defence:		**1st Service Assurance** (*functions that own and manage risks*)	**2nd Corporate Assurance** *(functions that oversee or who specialise in compliance or the management of risk)*	**3rd Independent Assurance** *(functions that provide independent assurance)*	**Risk Type:** *(Strategic (BAF), Corporate (CRR), Care Group, Department)*	
Risk Appetite: High, Medium, Low						

Risk Management Responsibilities

Executive Lead: *(Designation)*		**Control Owner** *(Designation)*			
Assurance Committee/ Management Committee or Meeting		**Review Frequency:** *(See guidance)*		**Review Due:**	

Action and assurance:

What is already being done? *(controls/mitigation)*	**Do you need to do anything else to control this risk?** *(Actions needed)*	**Risk Rating** *(LX C with all control/mitigation in place)*	**Assurance** *(how is/will the control/mitigation be tested)*	**Action by whom and when?**

X Consequence = * Risk Score

Likelihood

1 Negligible	1 Rare
2 Minor	2 Unlikely
3 Moderate	3 Possible
4 Major	4 Likely
5 Catastrophic	5 Almost Certain

1-3	• **Acceptable risk required no immediate action** • **Review annually** • **Place on the appropriate section of the Risk Register.**
4-6	• **Action planned within 1 month to reduce risk** • **Commenced within 3 months** • **Place on the appropriate section of the Risk Register**
8-12	• **Action planned immediately** • **Review Monthly** • **Place on the appropriate section of the Risk Register**
15-25	• **Immediate action required** • **Placed on Corporate Risk Register**

Risk Scoring Matrix

Likelihood ➢ Consequence ⮟	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
5 Catastrophic	5 Mod	10 High	15 Ext	20 Ext	25 Ext
4 Major	4 Mod	8 High	12 High	16 Ext	20 Ext
3 Moderate	3 Low	6 Mod	9 High	12 High	15 Ext
2 Minor	2 Low	4 Mod	6 Mod	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Mod	5 Mod

APPENDIX C – Good Governance Institute Risk Appetite Matrix

	0 NONE Avoidance of risk is a key organisational objective.	**1 MINIMAL** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	**2 CAUTIOUS** Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	**3 OPEN** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**4 SEEK** Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	**5 SIGNIFICANT** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.

REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Item 6 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (i)
Meeting Date:	Tuesday, 24th September 2024
Title of Report:	ICB Constitution - amendments
Report Author:	Gerry McSorley, ICB Chair Mr John Turner, Chief Executive Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Dr Gerry McSorley, ICB Chair
Appendices:	ICB Constitution

To approve ☒	For assurance ☐	To receive and note ☒	For information ☐
Recommendation or particular course of action, e.g., approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The ICB Board is asked to:

- Approve the amendments to the ICB Constitution.
- Approve submission of the revised Constitution to NHS England for approval.

Summary

On the 26th July 2024 NHS England published updated governance guidance for ICBs to take account of wider legislative developments and issues that have arisen in implementation. All ICB governance leads are aware of the updated guidance and have been engaged in its development.

As a result of the updated guidance, all ICBs are required to make amendments to their Constitutions, which are required at the earliest opportunity for the following specific reasons (acknowledging an ICB may need a transition period before revising Non-Executive Board Member portfolios).

- Ensuring one of the Non-Executive Board Members is identified as the Deputy Chair (cannot be the Audit Committee Chair): made a requirement of all ICBs following the unexpected resignation of an ICB Chair and no Non-Executive being ready to chair meetings.
- Ensuring one of the Non-Executive Board members is identified as the senior independent member: to bring clarity in particular to which Non-Executive Member should support the NHSE Regional Director on the appraisal and Fit and Proper Person compliance of the Chair, consistent with arrangements for NHS Trusts set out in the Code of Governance for providers.
- Expressing the Chair's period of office as a maximum, rather than a fixed term: to ensure drafting is compatible with the appointment where necessary of interim Chairs by NHS England with Secretary of State approval.
- Confirming that a proposal for the Chair or a Non-Executive to serve on the Board for longer than six years will be subject to rigorous review and they will not serve as a Board member for

longer than nine years in total: to ensure objectivity is maintained, aligned to the Code of Governance for providers.
- Updating references to procurement rules: to take account of the introduction of the Provider Selection Regime.
- Removing clauses related to ICB establishment and updating cross-references to legislation.

The ICB Board Secretary has been through the changes and updated the ICB Constitution (as tracked throughout the document).

The Board is asked to approve the proposed amendments to the ICB Constitution for submission to NHS England for formal sign-off.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The ICB's governance arrangements ensure appropriate oversight and decision-making with regard to achievement of the core aims.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.

Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
No specific risks identified in relation to this paper.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	No.
Does the report demonstrate patient and public involvement?	No.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board
CONSTITUTION

Version 4 (as approved October 2024)

Document Control Sheet

Document Title	ICB Constitution
Version	4.0
Effective Date	1st July 2022
Author(s)	Jules Ellis-Fenwick, ICB Board Secretary
Date	July 2022

Document history			
Version	**Date**	**Author**	**Comments**
1.	July 2022	Jules Ellis-Fenwick, ICB Board Secretary	
2.	October 2022	Jules Ellis-Fenwick, ICB Board Secretary	Changes made in line with amendments to the NHS Health and Social Care Act
3.	June 2023	Jules Ellis-Fenwick, ICB Board Secretary	Amendments made to the number of Board Members.
4.	August 2024	Jules Ellis-Fenwick, ICB Board Secretary	Changes made in line with amendments to the NHS Health and Social Care Act

CONTENTS

1. Introduction

1.1 Background/ Foreword

Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population.

ICSs are part of a fundamental shift in the way the health and care system is organised. Following several decades during which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement.

They exist to achieve four aims:

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

Each ICS is comprised of an Integrated Care Board (ICB), NHS Providers, the local authorities, and other local partners in a given geographical area. An Integrated Care Board has the function of arranging for the provision of services for the purposes of the health service in accordance with the National Health Service Act 2006 and the Health and Care Act 2022.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long-term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible.

The Integrated Care Board and each responsible local authority whose area coincides with or falls wholly or partly within the Board's area must establish a Joint Committee known as an Integrated Care Partnership. The ICP must prepare an Integrated Care Strategy setting out how the assessed needs in relation to its area are met. The Terms of Reference for the ICP and the Health and Wellbeing Board, a local authority function, will be aligned to this Constitution to ensure the ICS meets the health and care needs of the population in its area and delivers its agreed vision of 'Better Lives for the people of Lincolnshire'. The name of the ICS is 'Better Lives Lincolnshire'.

The following partner organisations are part of the Lincolnshire ICS:

- East Midlands Ambulance Service NHS Trust (EMAS)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire County Council (LCC)

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Lincolnshire Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The geographical area covered by the ICB is Lincolnshire which is served by seven District and Borough Councils (Borough of Boston, District of East Lindsey, City of Lincoln, District of North Kesteven, District of South Holland, District of South Kesteven, District of West Lindsey and led by one upper tier Local Authority which are fully coterminous and supported by the registered primary care practice populations in Lincolnshire.

1.3.2 The upper tier Local Authority is Lincolnshire County Council.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This Constitution is published at www.lincolnshire.icb.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs.

Examples include, but are not limited to, the Equality Act 2010 and the Children Acts.

Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014):
d) Adult safeguarding and carers (the Care Act 2014):
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000):
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The NHS Lincolnshire ICB was established on 1st July 2022 by 'The Integrated Care Boards (Establishment) Order 2022', which made provision for its Constitution by reference to this document.

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and

b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

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

b) Where the changes are thought to have a material impact then consultation will need to take place with the ICB Chair and relevant Partner organisations as detailed in Section 1.1. The proposed changes will then be presented to the ICB for approval prior to submission to NHS England.

c) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) Standing Orders– which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB Committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

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

b) **Functions and Decision map –** a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions –** which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook –** This brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes:
- The above documents (a - c).
- Terms of reference for all Committees and Sub-Committees of the board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a Joint Committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any Joint Committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a Joint Committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- The up to date list of eligible providers of primary medical services under clause 3.6.2
- Scheme of Reservation and Delegation
- Committee Terms of Reference Review Dates
- Financial Procedure Limits
- Committee Handbook (including Terms of Reference templates, Board paper templates)

e) **Key policy documents –** which should also be included in the Governance Handbook or linked to it – including:
   - Standards of Business Conduct and Conflicts of Interest Policy and Procedures
   - Policy for Public Involvement and Engagement

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in Section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website www.lincolnshire.icb.nhs.uk

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board Members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary members.

2.1.4 The membership of the ICB (the Board) shall meet as a unitary Board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 As per NHS England Policy, the ICB has appointed the following additional Ordinary Members:

a) three Executive members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing (Chief Nurse)

b) At least two Non-Executive Members
c) One Executive Board Mental Health Member
d) Director for System Delivery

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS Trusts and Foundation Trusts who provide services within the ICB's area and are of a prescribed description.
- The Primary Medical Services (General Practice) providers within the area of the ICB and are of a prescribed description.
- The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has Three Partner Members.

a) Local Authority
b) NHS Trusts and Foundation Trusts
c) Primary Medical Services

2.2.2 The ICB has also appointed the following further Ordinary Members: to the board

a) Four additional Non-Executive Members (in addition to the two Non-Executive Members detailed under Section 2.1.5
b) Executive Mental Health Member detailed under Section 2.1.5.
c) Director for System Delivery detailed under Section 2.1.5

2.2.3 The Board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) One Partner Member NHS and Foundation Trusts
d) One Partner Member Primary Medical Services
e) One Partner Member Local Authority
f) Six Non-Executive Members (one of which, but not the Audit Committee Chair, will be appointed Deputy Chair, and one of which, who may be the Deputy Chair or the Audit Committee Chair, will be appointed as the Senior Non-Executive Member.
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) Executive Board Mental Health Member
k) Director for System Delivery

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The Board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The Board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair.

Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

They are:

a) Senior NHS Directors of the ICB (separate to those listed in Section 2.1.5 and as set out in the ICB Governance Handbook)
b) Chair of the Integrated Care Partnership
c) Senior Healthwatch Representative
d) Director of Public Health or Senior Public Health Representative
e) Representative of the Voluntary and Care Sector

2.3.3 Observers will receive advanced copies of the notice, agenda, and papers for board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and/or observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the Standing Orders.

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test".

b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles).

c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

d) All individuals appointed to roles on the Board are responsible for familiarising themselves with the eligibility and ineligibility requirements confirming their eligibility prior to appointment and immediately notifying the Chair of the ICB of a change of circumstances that may render them no longer eligible.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a Board Member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted -

a) in the United Kingdom of any offence, or

b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A healthcare professional, meaning an individual who is a member of profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2022, or or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under -

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) The Chair will be independent.

b) They must meet the required criteria of the Job Description.

c) They must be eligible to work in the UK.

d) They must meet the 'fit and proper person test'.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.

b) Any of the disqualification criteria set out in 3.2 apply.

c) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.

d) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.

e) They are providers of health services commissioned by the NHS.

f) They are the spouse or partner of a member of the ICB.

3.3.4 The term of office for the Chair will be a maximum of three years or end at such time they cease to be eligible for appointment. The total number of terms a Chair may serve is three terms. The Chair will be subject to a rigorous review after six years to ensure their on-going independence.

3.4 Deputy Chair and Senior Non-Executive Member

3.4.1 The Deputy Chair is to be appointed from amongst the Non-Executive Members by the Board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-Executive Member is to be appointed from amongst the Non-Executive Members of the Board subject to approval by the Chair.

3.5 Chief Executive

3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) They must meet the required criteria of the Job Description.
c) They must be eligible to work in the UK.
d) They must meet the 'fit and proper person regulation.

3.5.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.5.3(a), they hold any other employment or executive role.
c) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.
d) They operate ((unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
e) They are providers of health services commissioned by the NHS.
f) They are an employee of Lincolnshire County Council.
g) They are the spouse or partner of a member of the ICB.

3.6 Partner Member(s) - NHS Trusts and Foundation Trusts

3.6.1 This Partner Member is nominated jointly by the NHS trusts and/or Foundation Trusts which provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met, the Level of Services Provided Condition

a) East Midlands Ambulance Service NHS Trust (EMAS)
b) Lincolnshire Community Health Services NHS Trust (LCHS)
c) Lincolnshire Partnership NHS Foundation Trust (LPFT)
d) United Lincolnshire Hospitals NHS Trust (ULHT)

3.6.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area

b) They must meet the required criteria of the Role Profile.
c) They must be eligible to work in the UK.
d) They must meet the 'fit and proper person test'.

3.6.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply.
b) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.
c) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
d) They are an employee of Lincolnshire County Council.
e) They are the spouse or partner of a member of the ICB.

3.6.4 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.6.1.a will be invited to make one nomination.
- The nomination of an individual must be seconded by one other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.6 The term of office for this Partner Member will be three years or end at such time they cease to be eligible for appointment. The total number of terms they may serve is two terms. The re-appointment of Board Members is set out at paragraph 3.16.

3.7 Partner Member(s) - Providers of Primary Medical Services

3.7.1 This Partner Member is nominated jointly by providers of Primary Medical Services for the purposes of the health service within the Integrated Board area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.7.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) They must work in an organisation that holds a contract for core Primary Medical Services, including GP, Dental, Ophthalmic or Pharmaceutical Services and are commissioned by the ICB to provide services.
b) They must be a registered practitioner working in the ICB footprint.
c) They must meet the required criteria of the Role Profile.
d) They must be eligible to work in the UK.
e) They must meet the 'fit and proper person test'

3.7.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.
c) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
d) They are an employee of Lincolnshire County Council.
e) They are the spouse or partner of a member of the ICB.
f) They are locum or agency staff members.

3.7.5 This member will be appointed by the Panel convened by the Chief Executive subject to the approval of the Chair.

3.7.6 The appointment process will be as follows:

a) Joint Nomination
- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make one nomination.

- The nomination of an individual must be seconded by one other eligible organisations and eligible organisations can 'second' a maximum of three nominations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, (must be more than 50%) the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c).
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.3 and 3.7.4.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this Partner Member will be three years or end at such time they cease to be eligible for appointment. The total number of terms they may serve is two terms. The re-appointment of Board Members is set out at paragraph 3.16.

3.8 Partner Member(s) - local authorities

3.8.1 This Partner Member is nominated jointly by the local authority whose area coincides with, or include the whole or any part of, the ICB's area. The local authority is:

a) Lincolnshire County Council

3.8.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be a senior Councillor or the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.8.1
b) They must meet the required criteria of the Role Profile
c) They must be eligible to work in the UK.
d) They must meet the 'fit and proper person test'.

3.8.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply

b) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.

c) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.

d) They are the spouse or partner of a member of the ICB.

3.8.4 This member will be appointed by the Chief Executive and subject to the approval of the Chair.

3.8.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.8.1.a will be invited to make one nomination.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3

c) Chair's approval

The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.8.6 The term of office for this Partner Member will be three years or end at such time they cease to be eligible for appointment. The total number of terms they may service is two terms. The re-appointment of Board Members is set out at paragraph 3.16.

3.9 Medical Director

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

b) Be a registered Medical Practitioner.

c) They must meet the required criteria of the Job Description.

d) They must be eligible to work in the UK.
e) They must meet the ‘fit and proper person test’.

3.9.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply.
b) On taking up the post they must not also be an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.
c) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
d) They are providers of health services commissioned by the NHS.
e) They are an employee of Lincolnshire County Council.
f) They are the spouse or partner of a member of the ICB.

3.9.3 This member will be appointed by the Chief Executive as per the Assessment, Selection and Appointments Process set out under section 3.17 and subject to the approval of the Chair.

3.10 Director of Nursing (Chief Nurse)

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse.
c) They must meet the required criteria of the Job Description.
d) They must be eligible to work in the UK.
e) They must meet the ‘fit and proper person test’.

3.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply.
b) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.
c) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
d) They are providers of health services commissioned by the NHS.
e) They are an employee of Lincolnshire County Council.
f) They are the spouse or partner of a member of the ICB.

3.10.3 This member will be appointed by the Chief Executive as per the Assessment, Selection and Appointments Process set out under section 3.17 and subject to the approval of the Chair.

3.11 Director of Finance

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) They must be a qualified accountant.
c) They must meet the required criteria of the Job Description.
d) They must be eligible to work in the UK.
e) They must meet the 'fit and proper person test'.

3.11.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission.
c) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
d) They are providers of health services commissioned by the NHS.
e) They are an employee of Lincolnshire County Council.
f) They are the spouse or partner of a member of the ICB.

3.11.3 This member will be appointed by the Chief Executive as per the Assessment, Selection and Appointments Process set out under section 3.17 and subject to the approval of the Chair.

3.12 Non-Executive Members

3.12.1 The ICB will appoint Six Non-Executive Members.

3.12.2 These members will be appointed by the ICB Chair as per the Assessment, Selection and Appointments Process set out under section 3.17.

3.12.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB.
b) Not hold a role in another health and care organisation in the ICS area.
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee.
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
e) They must meet the required criteria of the Job Description.
f) They must be eligible to work in the UK.
g) They must meet the 'fit and proper person test'.

3.12.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply.
b) They hold a role in another health and care organisation within the ICB area.
c) They are an officer or employee of the Department of Health, or a member or employee of the Care Quality Commission, or officer or employee of NHS England.
d) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
e) They are providers of health services commissioned by the NHS.
f) They are an employee of Lincolnshire County Council.
g) They are the spouse or partner of a member of the ICB.

3.12.5 The term of office for a Non-Executive Member will normally be either two or three years and the total number of terms an individual may serve is two terms after which they will no longer be eligible for re-appointment. The Chair of the ICB will determine the length of term on appointment and subsequent re-appointment to the post.

3.12.6 Initial appointments may be for a shorter period in order to avoid all non-executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.12.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-Executive Member up to the maximum number of terms permitted for their role.

3.12.8

3.13 Other Board Members

3.13.1 Executive Board Member Mental Health

a) This Member will fulfil the eligibility criteria set out at 3.1
b) This Member will fulfil the criteria set out in 2.2.4
c) Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.
d) This Member will be appointed by the Board subject to the approval of the Chair.

3.13.2 Director for System Delivery

This member will fulfil the criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule IB to the 2006 Act.
b) They must meet the required criteria of the Job Description.
c) They must be eligible to work in the UK.
d) They must meet the 'fit and proper person test'.

3.13.3 Individuals will not be eligible if:

a) Any of the disqualification set out in 3.2 apply.
b) They are an officer or employee of the Department of Health, or a member of employee of the Care Quality Commission.
c) They operate (unless they are a statutory NHS Body), own or partially own an organisation that provides social services to the local authority.
d) They are providers of health services commissioned by the NHS.
e) They are an employee of Lincolnshire County Council.
f) They are the spouse or partner of a member of the ICB.

3.13.4 This member will be appointed by the Chief Executive as per the Assessment, Selection and Appointments Process set out under section 3.17 and subject to approval of the Chair.

3.12.5 There are no other Board Members.

3.14 Board Members: Removal from Office

3.14.1 Arrangements for the removal from office of Board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.14.2 With the exception of the Chair, Board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance.
b) If they fail to attend a minimum of 75% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances.
c) If they fail to declare an interest, provide false information or participate in a decision-making process where special favour is shown to unfairly award a contract, or abuses his/her/their position for the purpose of benefit to themselves, family or friends.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute (including, but not limited to dishonesty, misrepresentation (knowingly or fraudulently, defamation of any member of the ICB (being slander or libel); abuse of position or

seeking to manipulate a decision of the ICB in a matter that would ultimately be in favour of that member whether financially or otherwise.

e) Are deemed to have failed to uphold the Nolan Principles of Public Life.
f) Are subject to disciplinary proceedings by a regulator or professional body (to be suspended in the first instance in accordance with Section 3.13.3)
g) They have failed or refused to undertake any training which the ICB requires to all Members to undertake.

3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.14.2 apply.

3.14.4 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.14.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.14.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

3.13.6.1 terminate the appointment of the ICB's Chief Executive; and
3.13.6.2 direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.15 Terms of Appointment of Board Members

3.15.1 With the exception of the Chair and Non-Executive Members arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB website at www.lincolnshire.icb.nhs.uk and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England.

3.15.2 Remuneration for Non-Executive Director members will be set by a separate Remuneration Panel comprised of the following:

- ICB Chair
- Chief Executive
- Director of Finance
- Director of Nursing
- Medical Director
- HR Lead

3.15.3 Other terms of appointment will be determined by the Remuneration Committee.

3.15.4 Terms of appointment of the Chair will be determined by NHS England.

3.16 Re-appointment of Board Members

Subject to satisfactory appraisal and the approval of the Chair, the ICB may approve the re-appointment of relevant Board Members up to the maximum number of terms permitted for their role.

3.17 Assessment, Selection and Appointment Process (subject to approval by the ICB Chair)

Director of Finance, Director of Nursing, Medical Director. Non-Executive Directors and Director for System Delivery

a) All vacancies for the roles will be assessed in the first instance to evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a job description of the role and capabilities required for the role.

b) The role will then be advertised in line with ICB HR processes seeking applications.

c) Individuals who submit an application shall be assessed against:

- How they have met the minimum full range of competencies (skills, knowledge, experience and attributes) detailed in the role description.
- Whether they have any conflicts of interest which may exclude them from being a Board Member.
- Whether they have confirmed their awareness of the Disqualification Criteria which would prevent them from being a Board Member.
- Whether the proposed appointee meets the 'fit and proper person test'.

d) The full list of applications will be considered by an Appointments Panel which will be convened by the Chief Executive.

e) The Appointments Panel shall assess the suitability of the applications against the requirements of the role and decide which of the candidates will progress to interview stage. Candidates who do not meet the specified criteria will not be shortlisted.

f) Where applicable, shortlisted applicants will be expected to participate in a stakeholder engagement event to meet groups of key stakeholders. Feedback from these sessions will be shared with the Appointments Panel.

g) The Appointments Panel shall arrange a process to interview candidates that have successfully passed the initial assessment process. This will include a formal interview to ascertain whether the

candidate will be able to contribute and play an active part in the Board meetings and discussions.

h) The Interview Panel Members will be determined based on the type of role being interviewed.

i) Only candidates assessed as having demonstrated the minimum full range of competencies set out in the role description will be put forward for appointment.

j) In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

k) The Chair will determine whether to approve the appointment of the most suitable candidate as identified under j).

4 Arrangements for the Exercise of our Functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a Code of Conduct and behaviours which sets out the expected behaviours that members of the Board and its Committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB Code of Conduct and behaviours is published in the Governance Handbook.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care;
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and;
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England;
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a Committee or Sub-Committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB.

Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a Joint Committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook and on the ICB website and intranet.

4.4.2 Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the Board;
b) those functions that have been delegated to an individual or to Committees and Sub-Committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published on the ICB website at www.lincolnshire.icb.nhs.uk

4.5.3 The map includes:

a) Key functions reserved to the Board of the ICB;
b) Commissioning functions delegated to Committees and individuals;

c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint Committees and arrange for its functions to be exercised by such Committees. Each committee may appoint Sub-Committees and arrange for the functions exercisable by the Committee to be exercised by those Sub-Committees.

4.6.2 All Committees and Sub-Committees are listed in the SoRD.

4.6.3 Each Committee and Sub-Committee established by the ICB operates under Terms of Reference agreed by the Board. All Terms of Reference are published in the Governance Handbook.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to Committees and Sub-Committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All Committees and Sub-Committees that fulfil delegated functions of the ICB, will be required to:

a) Provide a written report to the Board or relevant Committee following each meeting outlining the key matters discussed, any points for escalation, assurance and/or decision and/or any new areas of risk. This may involve the relevant Chair of the Committee and/or Sub-Committee attending the Board or Committee 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.

4.6.5 Any Committee or Sub-Committee established in accordance with clause 4.6 may consist of or include persons who are not ICB Members or employees.

4.6.6 All members of Committees and Sub-Committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a Committee or Sub-Committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of Committee and Sub-Committees are required to act in accordance with this Constitution, including the Standing Orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following Committees will be maintained:

a) **Audit Committee:** This Committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The Committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Non-Executive Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee:** This Committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit Committee.

4.6.9 The Terms of Reference for each of the above Committees are published in the Governance Handbook.

4.6.10 The Board has also established a number of other Committees to assist it with the discharge of its functions. These Committees are set out in the SoRD and further information about these Committees, including Terms of Reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

4.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all Committees and Sub-Committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the ICB Governance Handbook and on the ICB website and intranet.

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website www.lincolnshire.icb.nhs.uk and included in the Governance Handbook.

6.1.3 All Board, Committee and Sub-Committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Standards of Business Conduct and Conflicts of Interest Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.

b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.

c) Support the rigorous application of conflict of interest principles and policies.

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.

e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the following principles:

a) Require all staff, officers and office holders to comply with the Conflicts of Interest Policy.

b) Require relevant staff to proactively declare any interests at the point they become involved in decision making.

c) Adopt a range of actions for managing any breaches of the Conflicts of Interest Policy.

d) Ensure a record of action taken is maintained for an audit trail.

e) Ensure that all relevant decision-making staff and all Board Members receive training on the identification and management of conflicts of interest, including completion of the mandatory model through the Electronic Staff Record (ESR).

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB

b) Members of the Board's Committees and Sub-Committees

c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website at www.lincolnshire.icb.nhs.uk

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality

for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, Committee and Sub-Committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;

b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);

c) comply with the ICB Standards of Business Conduct and Conflicts of Interest Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct and Conflicts of Interest policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Accountability and Transparency

7.1.1 NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Principles

The principles of transparency will be demonstrated by:

a) The ICB Board holding meetings in public with papers published in advance in accordance with paragraph 7.3 below.
b) Ensuring information addressed to the public, stakeholders, partners, and staff should be concise, easily accessible and easy to understand, and that clear and plain language and, additionally, where appropriate, visualisation be used.
c) Provision of full and honest accounting of all facts, information, and context essential to ensuring an informed and equitable decision making process.
d) The ICB acting in a manner that is open and honest.

7.3 Meetings and publications

7.3.1 Board meetings, and Committees comprised entirely of Board Members will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest. Arrangements will accord with the Public Bodies (Admissions to meetings) Act 1960, the Freedom of Information Act 2000 and the General Data Protection Regulation (GDPR) 2018.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests
- Key policies

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the 'Joint Forward Plan') The plan will, in particular:

a)

a) describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.
b) explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards) and sections 223GB and 223N (financial duties).
c) set out any steps that the ICB proposes to take to implement the the Lincolnshire Joint Health and Wellbeing Strategy.
d) 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.
e) set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.4 Scrutiny and Decision Making

7.4.1 At least three Independent Non-Executive Members will be appointed to the Board including the Chair; and all of the Board and Committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Compliance with the ICB Procurement Policy which reflects the Health Care Services (Provider Selection Regime) Regulations 2023.

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)

b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)

c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and

d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8 Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) Inviting advisers to attend Remuneration Committee meetings such as the Chief Executive, Director of Finance, Senior HR Advisor and external advisors.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published in the Governance Handbook but in summary the main role is to:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including Board members) and Nnon-Executive Members.

8.1.6 The duties of the Remuneration Committee include:

For the Chief Executive, Directors and Other Very Senior Managers:

a) Determine all aspects of remuneration including, but not limited to, salary (including any performance-related bonuses) pensions and cars.

b) Determine arrangements for termination of any employment or other contractual terms and non-contractual terms.

For all staff:

c) Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).

d) Oversee contractual arrangements.

e) Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z54(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board

b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and

c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) Ensure that local consultation with the local population for whom the Integrated Care Board has core responsibilities is undertaken in the development of forward and system plans. In line with the national requirements this will include engaging or consulting, as appropriate, on service developments and proposals to change services. These activities may include open events, surveys and workshops/focus groups and formal public consultations.

b) Provide the Health and Wellbeing Board with a draft of the plan or (as the case may be) the plan as revised.

c) Consult the Health and Wellbeing Board on whether the draft takes proper account of the Joint Lincolnshire Health and Wellbeing Strategy published by it which relates to the period (or any part of the period) to which the plan relates.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.

c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

d) Build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

g) Use community development approaches that empower people and communities, making connections to social action.

h) Use co-production, insight and engagement to achieve accountable health and care services.

i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements include:

a) The ICB has agreed a set of arrangements for engaging with people and communities which are set out in the Policy for Public Involvement and Engagement.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB Board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution
Chair	An individual appointed by NHSE to act as Chair of the ICB.
Chief Executive	An individual appointed by NHSE who is responsible for improving outcomes in population health and healthcare, working with colleagues, the community and partners to deliver a long-term strategy.
Committee	A Committee created and appointed by the ICB Board.
Director of Finance	A qualified accountant employed by the ICB and is responsible for all matters relating to the financial leadership and financial performance of the ICB.
Director of Nursing (Chief Nurse)	An individual employed by the ICB and, along with the Medical Director, is accountable for all matters relating to the development and delivery of the long-term clinical strategy of the ICB. They are also responsible for the delivery of statutory and non-statutory functions such as quality assurance/improvement and safeguarding.
Forward Plan Condition	The 'Forward plan Condition' as described in the Integrated Care Boards (Notification of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Integrated Collaborative Commissioning	Integrated Collaborative commissioning is when two or more NHS or ICS organisations come together to commission services which are delivered across the system for patients.
Integrated Care Partnership	The Joint Committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Joint Committee	A single Committee formed by two or more organisations to exercise functions on behalf of one or more organisations.
Level of Services Provided Conditions	The 'Level of Services Provided Conditions' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Medical Director	An individual employed by the ICB.
Non-Executive Member	An Independent individual who is appointed by the ICB (they are not an employee).
NHS England	NHS England leads the NHS in England and sets strategic direction for the NHS through the NHS Long Term Plan, and funds key priorities for improvement. NHS England was established by Parliament in 2012 as an independent statutory body.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description. • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Provider Collaborative	A provider collaborative is a formal collaboration built on common ground between one or more NHS body or ICS Organisation. Goals may range from sharing experiences and best practices to generating cost savings and operational or clinical efficiencies.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Register of Interests	As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest and will Members of the ICB and will publish registers as follows: a) Members of the ICB b) Members of the Board's Committees and Sub-Committees c) Its employees
Sub-Committee	A Committee created and appointed by and reporting to a Committee.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of the NHS Lincolnshire Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 1st July 2022.

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per Section 1.6 in the Constitution for making amendments.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These standing orders apply to all meetings of the Board, including its Committees and Sub-Committees unless otherwise stated. All references to board are inclusive of Committees and Sub-Committees unless otherwise stated.

3.3. All members of the board, members of Committees and Sub-Committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Chief Executive, Chair of the Audit Committee and/or senior governance adviser will provide a settled view which shall be final.

3.5. All members of the Board, its Committees and Sub-Committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1. Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2. In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third or more of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of the meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the board.

4.2.2. If the Chair is absent or is disqualified from participating by a conflict of interest, the Deputy Chair shall preside over meetings in the Chair's stead.

4.2.3. If both the Chair and Deputy Chair are absent, or disqualified from participating, then a Member of the ICB shall be chosen by the assembled Members present, or by a majority of them, and shall preside over the meeting.

4.2.4. The Board shall appoint a Chair to all Committees and Sub-committees that it has established. The appointed Committee or Sub-committee Chair will preside over the relevant meeting. Terms of reference for Committees and Sub-Committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.lincolnshire.icb.nhs.uk

4.4. Petitions

4.4.1. Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak and vote on their behalf, but the accountabilities and liabilities associated with the role may not be delegated to a deputy.

4.5.2. The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.5.3. The Chair should be notified in writing prior to the meeting of the attendance of the nominated deputy.

4.5.4. Any deputy will need to ensure they meet the eligibility criteria for ICB Members and do not fall under the disqualification criteria as identified in Section 3.2. The confirmation to the Chair (as per 4.5.3 above) should also

provide assurance to the Chair that the nominated individual fulfils the requirements of the role and is not disqualified.

4.5.5. The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings

4.6.1. The Board of the ICB and its Committees and Sub-Committees may meet virtually using telephone conferencing facilities where available or on a virtual basis via digital systems such as Microsoft Teams or other electronic means when necessary unless the terms of reference prohibit this.

4.7. Quorum

4.7.1. The quorum for meetings of the Board will be seven members (50%) including:

a) Chair or Deputy Chair
b) Either the Chief Executive or the Director of Finance
c) Either the Medical Director or the Director of Nursing
d) At least one independent member (Non-Executive Member)
e) At least one Partner Member

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

c) A nominated deputy permitted in accordance with Standing Order 4.5 will count towards quorum for meetings of the Board.

4.7.3. For all Committees and Sub-Committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8. Vacancies and defects in appointments

4.8.1. The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member[111]

4.8.2. In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- Wherecircumstances are such that a Board Member may be absent for some time due to sickness (as an example) a formal deputy must be identified and approved by the ICB Chair.

4.9. Decision making

4.9.1. The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2. Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 2.3.2. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3. Where necessary Boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

Urgent decisions

4.9.4. In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.9.5. The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive (or

relevant lead Director in the case of Committees) in consultation with one of the ICB Non-Executive Members and one Partner Member and subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6. The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit Committee for oversight.

4.10. Minutes

4.10.1. The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1. In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the Board and all meetings of Committees which are comprised entirely of all Board Members, at which public functions are exercised will be open to the public.

4.11.2. The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with the Chief Executive and Chair of the Audit Committee.

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents

6.1 Use of Seal

The ICB may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- Chief Executive
- Director of Finance
- Any senior officer authorised by the Chief Executive

A seal is typically required to be applied to a document where it states, ‘Executed as a Deed’.

The ICB seal will be kept in a secure location by the ICB Board Secretary.

6.2 Execution of a document by signature

The following individuals are authorised to execute a document on behalf of the ICB by their signature:

- Chief Executive
- Director of Finance
- Any senior officer authorised by the Chief Executive

Item 6 (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (ii)
Meeting Date:	Tuesday, 24th September 2024
Title of Report:	ICB Annual Report and Accounts 2023/24
Report Author:	Mrs Emma Rhodes, Deputy Director of Finance and Mrs Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Dr Gerry McSorley, ICB Chair
Appendices:	ICB Annual Report and Accounts 2023/24

To approve ☒	For assurance ☐	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The ICB Board is asked to:

- Receive the Lincolnshire ICB Annual Report and Accounts, including the Annual Governance Statement and Remuneration Report for the year 1st April 2023 to 31st March 2024.

Summary

NHS Bodies are required to publish, as a single document, an Annual Report and Accounts (ARA). The Department of Health and Social Care Group Accounting Manual (DHSC GAM) 2023/24 sets out the requirements for the content of the ICB Annual Report, which must follow the three-part structure as detailed below:

- The Performance Report, which must include an overview and performance analysis.
- The Accountability Report, which must include a Corporate Governance Report, Remuneration and Staff Report and Parliamentary Accountability and Audit Report*.
- The Annual Accounts

**This section is not applicable to ICBs as they do not report directly to Parliament.*

The Health and Care Act 2022 requires ICBs to:

- Explain how the ICB has discharged its general duties per sections 14Z34 to 14Z45 and 14Z49 (general duties of ICBs)
- review the extent to which the ICB has exercised its functions in accordance with plans published under forward plans and capital resource use plans.
- review the extent to which the ICB has exercised its functions consistently with NHSE's latest statement about how functions relating to inequalities information should be exercised.
- reviewing any steps the ICB has taken to implement any joint local health and wellbeing strategy it is required to have regard to.

Additional Requirements for ICBs

The 2023/24 GAM sets out additional requirements for ICBs relating to the reporting of gender distribution, business information and details of members, the membership body and governing body.

The Accountable Officer is required to sign and date the Performance Report, Accountability Report and the Statement of Financial Position.

The ICB was required to submit the full audited Annual Report and Accounts by 9.00 am on Friday, 28th June 2024. The final documentation was submitted a day earlier on the 27th June 2024.

There is no requirement for Trusts or ICBs to hold an AGM this year to present the Annual Report and Accounts. Both may submit an Annual Report and Accounts to a Public Board meeting to meet with statutory requirements; hence presentation of the document at today's Board meeting.

The Board is requested to receive the ICB Annual Report and Accounts for 2023/24 and note the full document will be published separately on the ICB website.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The requirements on the content of the Annual Report covers off all four key aims of the ICB and comprehensive information will be included to that effect.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	
Risk and Assurance	
No specific risks identified in relation to this paper and the Annual Report and Accounts.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	The report includes a section on Financial Summary and also the ICB Annual Accounts (Financial Statements).

Does the report highlight any quality and patient safety implications?	Yes, as reflected in the main body of the Annual Report.
Does the report highlight any health inequalities implications?	Yes, as reflected in the main body of the Annual Report.
Does the report demonstrate patient and public involvement?	Yes, as reflected in the main body of the Annual Report.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Yes, there is a section on environmental matters and climate change within the Annual Report.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an equality impact assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:

Not applicable.

Is the report confidential or not?

Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board

Annual Report and Accounts

1st April 2023 to 31st March 2024

NHS Lincolnshire Integrated Care Board

Annual Report and Accounts

1st April 2023 to 31st March 2024

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Statement by the ICB Chair and Chief Executive

We welcome you to the second Annual Report for the NHS Lincolnshire Integrated Care Board which covers the period 1st April 2023 to 31st March 2024.

As has been widely reported and commented on, the NHS across the country has faced a significant number of challenges and pressures over the past year including the need to fully recover NHS services from the impact of the Covid-19 pandemic, to reduce waiting for health care, to better meet the health needs of our population, to manage the additional demands associated with the industrial action which occurred, to better address health inequalities and to focus on more preventative work.

The NHS in Lincolnshire has been equally impacted by these challenges, but nonetheless has continued to make significant positive progress on a wide range of issues, much of which is reflected in this report. We want to place on record our sincere thanks and appreciation for the hard work, professionalism and commitment of NHS staff in our county (in primary care, in Lincolnshire's hospitals, community and mental health services, in the East Midlands Ambulance Service, and in the ICB itself). This is hugely valued.

The NHS in Lincolnshire works very closely with a wide range of partners across our Integrated Care System, including colleagues in local government, the care sector, the third sector, the further and higher education sectors and the police service. By working closely with our partners we know that we can have the best possible combined positive impact on the health and wellbeing of the people of Lincolnshire. We are hugely grateful for the support and input of all of our partners, many of whom are also experiencing significant challenges.

The role of the ICB is to provide strategic leadership across the Lincolnshire health and care system, and to convene and work with partners to improve the health and wellbeing of our population, and the quality of care which people receive. In doing so we are guided by the views of the population and patients we serve, of our clinicians, our partners, and the health needs of our population, as well as national Government in how best we can deploy our resources, which includes just over £1.8bn of taxpayers money.

Whilst this Annual Report, alongside the Annual Reports of our partners, describes many achievements, we would particularly wish to highlight significant progress in 2023/24 in:

- Improving performance in terms of
  - Reducing A&E and ambulance waiting times.
  - Cutting waiting times for planned care.
  - Cutting waiting times for cancer care.
  - Delivering health checks for people with learning disabilities and people with serious mental illness.
- The opening of Grantham's 24/7 Urgent Treatment Centre in October 2023.
- The opening of the new Peter Hodgkinson Mental Health Inpatient Unit in Lincoln.
- Securing £38m additional funding for the development of two new Community Diagnostic Centres (CDCs) in Skegness and Lincoln; and the expansion of the Grantham CDC (resource received by the ICB as the lead for the programme but transferred to United Lincolnshire Hospitals NHS Trust (ULHT) as the lead provider).
- The continued roll out of the Community Mental Health Transformation Programme.
- The launch of Pharmacy First in January 2024.
- The continued strong performance across Lincolnshire of the flu and Covid-19 booster vaccination campaigns.
- The launch of NHS Lincolnshire's Autism Strategy.
- The implementation of the General Practice Recovery Programme, and the continued professionalism and commitment of GP practices across the county in seeking to meet the increased demands upon them.
- The launch of the NHS Lincolnshire Frailty Strategy.
- Our continued strong focus on health inequalities.

We are proud to be associated with these and many other improvements across health and care in Lincolnshire, yet at the same time will continue to focus on further improving the care which people receive. Our priorities include continuing to improve Urgent and Emergency Care services, implementing our Dental Strategy (supported by the national Dental Access Recovery Programme), reducing waiting times for planned care and cancer care, and focussing more on prevention. These are some of the significant ongoing challenges we are determined to address.

We were delighted in November 2023 to receive formal notification from NHS England that the NHS in Lincolnshire had exited from the nationally mandated Recovery Support Programme. This was achieved due to a very strong partnership and work programme across the NHS in the county.

We were also pleased to note that the staff survey results for our partner NHS Trusts continued to show impressive progress, and that the ICB was rated the 2nd (out of 42) most recommended ICBs to work in by ICB staff.

The NHS in Lincolnshire, working with partners, is actively implementing a number of important changes in how NHS provider colleagues work, including:

- Establishing new 'Community and Primary Partnerships' (CPPs) to supercharge neighbourhood and community level work.
- Strengthening shared strategic and operational decision making through a group provider model between United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS), working alongside and in partnership with Lincolnshire Partnership NHS Foundation Trust (LPFT) and Primary Care.
- Progressing our informal partnerships and relationships to develop shared corporate service functions across NHS organisations.

Alongside this, the ICB has made good progress towards reducing running costs by 30%, including a 20% reduction in 2023/24.

Our partnership with the University of Lincoln has continued to go from strength to strength. We are delighted that the Lincoln Medical School has appointed its first Dean (Professor Jamie Read), and that the University secured £11m in research monies to focus on the needs of our rural and coastal population. Our Lincolnshire Academy of Clinical Excellence has also been established at the University.

On a wider front, the NHS in Lincolnshire fully supports the proposal for a combined Authority for Greater Lincolnshire, which we believe will bring significant benefits to the health and wellbeing of the county.

We would also like to express our thanks to those ICB Board Members who left us during 2023/24, namely Sir Andrew Cash and Professor Sir Jonathan Van Tam. Both Andrew and Jonathan made valuable contributions to the ICB during their time with us and we wish them all the best for the future.

Looking forward into 2024/25, we are in no doubt that there are many challenges ahead as we seek to both improve health and care, and the NHS in the county. In doing so we will continue to work closely with all of our partners. We do so in good heart, knowing that we have strong foundations in place, a dedicated and professional workforce, fantastic partners and a shared commitment to make Lincolnshire better still – for patients, our population, our workforce, our partners, and for the taxpayer.

Thank you for your interest in this Annual Report, which has been prepared in accordance with the National Health Service Act 2006 (as amended 2012) Directions by NHS England in respect of Integrated Care Board's Annual Reports.

Dr Gerry McSorley
Acting ICB Chair

Mr John Turner
Chief Executive
(Accountable Officer)

Performance Report

Performance Overview

The purpose of the overview is to give a brief summary of the ICB, its purpose and activities, demographic profile, how we work in the health system, and with whom we have contracts. It also summarises our performance against key targets, risks to achieving our strategic objectives and what our main challenges have been this year. We have provided more detail on all these areas later in the report.

Who we are

The NHS Lincolnshire Integrated Care Board (ICB) is a statutory body which came into being on the 1st July 2022 with the general function of arranging for the provision of services for the purposes of the health service in England in accordance with the Health and Care Act 2022.

The ICB is responsible for commissioning, or buying, the majority of healthcare services for the population of Lincolnshire. Those services include planned care, cancer care, emergency care, mental health, learning disability and autism, maternity services, and community and GP services for our 819,837 registered patients dispersed across 81GP practices. We commission services from a wide range of providers in and outside of Lincolnshire.

Lincolnshire is the fourth largest county in England covering an area of 5,921 square kilometres with a resident population of 778,000 (Census 2023) with a 49% male and 51% female breakdown. It is rural, with no motorways, little dual carriageway and 80 kilometres of coastline. Residents are dispersed across the the city of Lincoln, market towns, rural and coastal areas.

A map of the geographical area covered by NHS Lincolnshire Integrated Care System (ICS) is detailed opposite.

The geographical area covered by the ICB is Lincolnshire which is served by seven District and Borough Councils. The upper tier Local Authority is Lincolnshire County Council.

The ICB has a Board which is made up of: Chair and Chief Executive, Director of Finance, Medical Director, Director of Nursing, Director for System Delivery, Non-Executive Directors and Partner Members

The ICB has regular participants at its Board meetings as set out below:

- Chair of the Health and Wellbeing Board
- Public Health Representative
- Director of Strategic Planning, Integration and Partnerships
- Director for Primary Care and Community and Social Value
- Director for Health Inequalities and Regional Collaboration
- Healthwatch Representative
- Voluntary and Care Sector Representative

For the period 1st April 2023 to 31st August 2023 the ICB Interim Chair was Sir Andrew Cash. For the period 1st September 2023 to the 31st March 2024 the Acting ICB Chair was Dr Gerry McSorley. The ICB Chief Executive (Accountable Officer) is Mr John Turner who has overall responsibility for managing the work of the ICB.

Details of the names of the Board Members can be found under the Corporate Governance section of this report.

Lincolnshire COUNTY COUNCIL *Working for a better future*

- Single County Council.
- Responsible for the Lincolnshire Health and Wellbeing Board - aims to reduce health inequalities and improve people's health and wellbeing.
- Delivers adult social care, children's care, support for carers, help to live at home, health and wellbeing programmes, safeguarding and support with disabilities.

Lincolnshire District Councils

- **City of Lincoln**
- **Boston Borough**
- **East Lindsey**
- **West Lindsey**
- **North Kesteven**
- **South Kesteven**
- **South Holland**

NHS Lincolnshire Integrated Care Board

Single NHS ICB planning, commissioning and developing healthcare services for the population of Lincolnshire.

Voluntary Engagement Team
Linking Diversity to Health and Care

- The Voluntary Engagement Team is a partnership working together to further opportunities for the voluntary sector in the county.

Lincolnshire Care Association

- The Alliance is general practices unified voice at a system level, membership consists of all of the PCN (14) Clinical Directors in Lincolnshire

Lincolnshire Primary Care Network Alliance

- Supports care and supports providers to ensure there is a sustainable choice of quality care services within Lincolnshire

NHS Lincolnshire Community Health Services NHS Trust

NHS Lincolnshire Partnership NHS Foundation Trust

NHS United Lincolnshire Hospitals NHS Trust

One provider of community services, one provider of mental health services and one provider of acute hospitals services - with a track record of developing relationships and working together.

Our Purpose and Activities

Our vision and priorities shape who we are, how we work and help us to make the right decisions of behalf of people in Lincolnshire.

Our goal is to ensure that everyone living in Lincolnshire has the best possible health and wellbeing they can. To achieve this, we work alongside our health and care partners to provide people with access to quality healthcare and reduce the health inequalities that exist today.

The ICB uses its resources and powers to achieve demonstrable progress on the four key aims of an ICS (as detailed in the next column), collaborating to tackle complex challenges, including:

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long-term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible.

We involve local patients, carers, the public and organisations such as Healthwatch Lincolnshire to help us better understand local need and commission high-quality care that is safe, effective and focused on the patient experience – as set out in the NHS Constitution and the ICB Constitution.

There is no area within the Lincolnshire geographical area described as a 'Place' as per the terminology set out in NHS England and Improvement national guidance. As a consequence, there are no 'Place' plans in Lincolnshire. Integrated health and care at a local level in the county is primarily based on the Primary Care Network (PCN) geographical footprints.

Our Integrated Care System

The Health and Care Bill 2022 created ICBs and established in law the role of Integrated Care Partnerships (ICPs) as the Committee where health, social care, the voluntary sector and other partners come together as an ICS.

ICSs depend on collaboration and a focus on local populations as the driving forces for improvement.

They exist to achieve four aims:

- improving outcomes in population health and healthcare.
- tackling inequalities in outcomes, experience and access.
- enhancing productivity and value for money.
- supporting broader social and economic development.

The ICB is part of the 'Better Lives Lincolnshire' alliance, the name we use to describe Lincolnshire's Integrated Care System (ICS). ICSs are partnerships of organisations that work together to plan and deliver joined up health and care services which improve the lives of people who live and work in the area they serve.

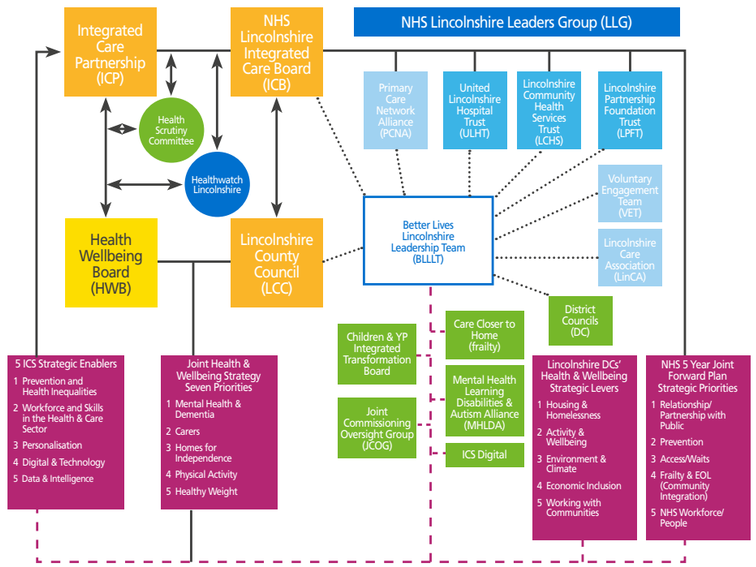
The following partner organisations are part of the Lincolnshire ICS:

- East Midlands Ambulance Service NHS Trust (EMAS)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire County Council (LCC)

The Better Lives Lincolnshire Leadership Team (BLLLT) is co-chaired by the Chief Executive Officers (CEO) of Lincolnshire County Council and the ICB. Its membership includes the CEOs from LPFT, LCHS and ULHT, two district council CEOs, Director of Adult Social Care, Director of Public Health, CEO of Lincolnshire Care Association, representatives from the Lincolnshire Voluntary Engagement team, and the Primary Care Network Alliance Clinical Director. The ICS structure is shown below.

Our vision and priorities shape who we are, how we work and help us to make the right decisions on behalf of people in Lincolnshire. The emerging shared ambition for Better Lives Lincolnshire, by 2030, is a simple one, as highlighted on the next page.

Lincolnshire Health and Social Care: It's Strategies and the ICB's part in those



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

Our aims are:

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

In addition to BLLLT, we have the Lincolnshire NHS Leaders Group (LLG) which provides high level governance oversight of key shared priorities and concerns within the NHS in Lincolnshire and provides direction when agreed. The membership of LLG consists of the Chairs and CEOs of the ICB and NHS Trusts, Chair/Vice Chair of the Lincolnshire PCN Alliance, EMAS Chair and CEO, and the ICB Medical Director.

The work of the LLG is based on the principles of joint working and partnership, transparency, support, challenge, and good governance. It meets once a month and the LLG Chair role is shared on a rotational basis by the Chairs of the NHS organisations.

The work of LLG is primarily concerned with key matters within and across the NHS in Lincolnshire. Partners in the Lincolnshire ICS will be informed and engaged as appropriate (e.g., through the Health and Wellbeing Board (HWBB), ICB, BLLLT). Where appropriate LLG agrees key system matters and/or decisions.

Our main partners and providers

The ICB commissions services for its patients from a number of organisations, including:

- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- Northern Lincolnshire and Gooles Hospitals NHS Foundation Trust (NLAG)
- North West Anglia NHS Foundation Trust (NWAFT)
- East Midlands Ambulance Service NHS Trust (EMAS)
- All GP practices in Lincolnshire

NHS 111 - the local provider of NHS 111 is Derbyshire Health United.

Non-Emergency Transport Services are provided by East Midlands Ambulance Service NHS Trust.

Other key partners include:

Public Health

We have continued our close working with Public Health colleagues based within Lincolnshire County Council on a number of areas including the development of the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and social prescribing, which are referred to later in the report.

The Consultant in Public Health (or an appropriate deputy) regularly attends ICB Board meetings.

Healthwatch Lincolnshire

Healthwatch Lincolnshire is the independent consumer champion for health and social care in Lincolnshire, putting patients at the heart of health and social care services. Their role is to give local people a voice to influence and challenge how health and social care services are provided locally. Healthwatch provides the ICB with regular feedback from patients on their experiences of accessing NHS services and assists the ICB to carry out surveys and consultations when we are making key decisions about the services we commission.

Representatives from Healthwatch regularly attend and participate in Board, Primary Care Commissioning Committee and Quality and Patient Experience Committee meetings.

Find out more about Healthwatch Lincolnshire here: www.healthwatchlincolnshire.co.uk

A structure of the Lincolnshire Integrated Care System is detailed to the left.

Health and Wellbeing Board

The ICB also works closely with the Health and Wellbeing Board which is a forum that brings together key leaders from the NHS, Public Health and care systems to work together to improve the health and wellbeing of the people of Lincolnshire and reduce health inequalities.

Board members collaborate to understand communities' needs, agree priorities and encourage commissioners to work in a more joined up way, and the Board has a duty to encourage integrated working for the purpose of advancing the health and wellbeing of the people of Lincolnshire.

The Chair of the Health and Wellbeing Board regularly attends and participates in the ICB Board meetings and the ICB Chief Executive is the Vice Chair of the Health and Wellbeing Board.

Further details can be found here: www.lincolnshire.gov.uk/health-wellbeing/health-wellbeing-board

Voluntary Sector Services

The voluntary sector supports volunteers and voluntary and community organisations across Lincolnshire and will often provide assistance to the ICB to ensure the voluntary/third sector are informed about local health services and involved in any key decisions we make about the services we commission.

The Deputy Chair of the Lincolnshire Voluntary Engagement Team regularly attends and actively participates in the ICB Board meetings.

Our Strategies and Plans

Joint Health and Wellbeing Board Strategy and Integrated Care Partnership Strategy

The NHS in Lincolnshire and the wider ICS Partnership have a long history of joint working and governance arrangements going back over a decade. This includes a range of joint governance arrangements in the Lincolnshire NHS to ensure all statutory organisations fulfil the duty to have regard to wider effect of decisions taken in the provision and delivery of health and care services.

During 2023/24 the ICB worked with Lincolnshire County Council to support the development of the refreshed Joint Health and Wellbeing Board Strategy (JHWS) and the revised Integrated Care Partnership Strategy.

In line with the Health and Care Acts of 2012 and 2022, there is a requirement to have both a Health and Wellbeing Board (HWB) and an Integrated Care Partnership (ICP). Whilst each is required to publish its own strategy, as the County Council shares the same geographical boundary as the ICB, our local ambition is to align the HWB and ICP by connecting the JHWS and the ICP strategy whilst avoiding duplication or gaps. Each strategy retains its own identity with:

- the JHWS focusing on 'the what' – i.e. the population health and wellbeing priority areas the health and care system will focus on, based on the evidence in the Joint Strategic Needs Assessment (JSNA); and
- the ICP strategy setting out 'the how' – i.e. the strategic enablers that the health and care system will focus integration efforts on, to support the delivery of the JHWS and its priorities, and the system's overarching ambition and aims.

Given the linkages between the strategies, the two documents will be published together along with a shared single introduction, which includes:

- a foreword from Councillor Sue Woolley and Mr John Turner as Chair and Vice Chair of the HWB and ICP,
- contextual information about Lincolnshire, including health and wellbeing detail linked to the JSNA, and
- an overview of shared ambitions and aims, and information on how the two strategies fit together.

Both the strategies were approved in March 2024 at the respective Health and Wellbeing Board and Integrated Care Partnership meetings. The Health and Wellbeing Board also reviewed the NHS Joint Forward Plan Delivery Plan at the March 2024 meeting and confirmed it took proper account of Joint Local Health and Wellbeing Strategy.

Lincolnshire's Joint Forward Plan

Lincolnshire ICB's commitment to involvement is evident throughout the development of our Joint Forward Plan which we co-produced with patient representatives, stakeholders, clinicians, and staff, basing it on a strong foundation of insight and intelligence. Engagement was undertaken in three phases to allow consideration of feedback at each stage of development and review. It considered Lincolnshire's unique landscape and demographics, reaching out into various communities and groups as well as areas of deprivation and health inequalities.

Lincolnshire Health and Social Care structure as shown on the previous page, includes information on strategies and the ICB's part in those.

- We embedded the patient voice in the development and decision-making process with patient representatives as key members of our Joint Forward Plan Steering Group, working alongside Healthwatch, Local Authority representation and leads from our provider trusts and primary care teams.
- Patient representatives attended clinical and organisational workshops to review outputs and ensure alignment of public engagement feedback with the emerging priorities.
- Working in partnership, Healthwatch Lincolnshire has supported the engagement process, undertaking a public survey in the first phase of engagement to identify priorities and staff webinars to test these during the last phase.
- The ICB engagement team carried out extensive community engagement in the first phase of engagement to understand what was important to the population of Lincolnshire and this was considered by staff, partner organisations and patient representatives at the workshop to identify emerging priorities.
- Further community engagement was undertaken during the second phase of engagement to test these priorities with the public and gain an understanding of what outcomes could be achieved for our communities.
- Following publication of the document we built on this approach with a third phase of continual engagement, involving the wider Lincolnshire population and those under-represented in the earlier phases of engagement, on the document as a whole, the priorities and ongoing monitoring and evaluation of our work being undertaken to achieve these. This has demonstrated our approach to ensure regular and transparent communications to everyone involved in the engagement and development of the Joint Forward Plan.

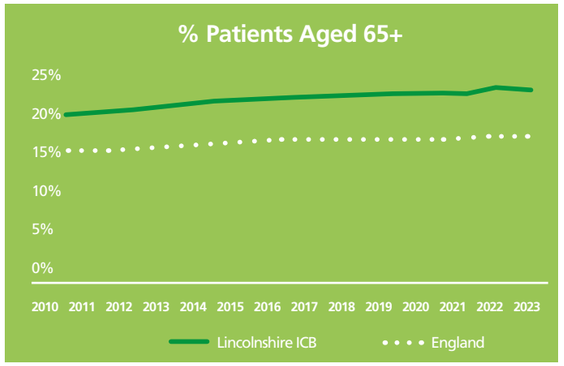
Social, community and human rights issues

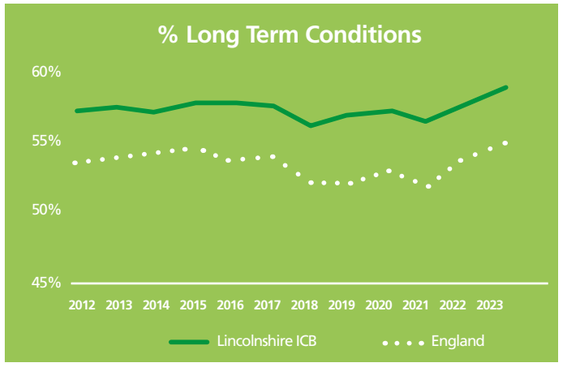
The ICB places a high priority on ensuring that it discharges it obligations as a good corporate citizen and takes into consideration its responsibilities towards serving and meeting the needs of local people, including safeguarding their human rights.

We ensure equality and diversity run through our work as described in detail in our section on equality, diversity and inclusion included later in this report.

Key Risks

The population represented by Lincolnshire ICB has a higher level of complex health issues such as diabetes, coronary heart disease, and Chronic Obstructive Pulmonary Disease (COPD) than the national average. Similarly the percentage of our population over the age of 65 and index of deprivation continue to be above the average in England. The COVID-19 pandemic starkly exposed these existing inequalities, and whilst they are key to our planning also continue to place pressure on the majority of our services. The key issues and risks to the organisation achieving its objectives are described in the Annual Governance Statement of this report. Those identified below provide an example of the ICB's population clinical risks.





Going Concern

The ICB has adopted a 'Going Concern' approach in the preparation of its annual financial statements, despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014 as made by the ICB's External Auditors.This follows the interpretation in the Government Accounting Manual of Going Concern in the public sector.

In summary this interpretation provides that where a body can show anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that function in published documents (such as financial allocation plans), there is sufficient evidence of Going Concern. The only exception to this approach would be for public sector organisations which are classed as trading bodies. ICBs being funded by direct allocation through NHSE are not trading bodies.

Performance Summary – Chief Executive

2023/24 has been an incredibly challenging year for the NHS nationally as it continued to focus on the recovery of services following the Covid-19 pandemic, and this has been echoed within Lincolnshire. Much of this has impacted on some elements of performance throughout 2023/24, however, we are beginning to see elements of recovery.

As the NHS remains under significant pressure, we continue to see extra demands on health services, whether from disrupted routine operations, higher mental health needs and increased demand for emergency care. In particular, staff have faced another busy winter alongside the ongoing industrial action which continues to impact service delivery.

Thanks to the professionalism and commitment of those staff, the staff, the ICB continued to provide care to over 40,000 urgent and emergency care patients each week. However, we also recognise that we still have a big recovery challenge ahead to get waiting lists down to pre-pandemic levels.

Performance Analysis

NHS Constitutional Targets

The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. NHS Lincolnshire ICB seeks compliance with the constitution in conjunction with our healthcare providers by setting plans to deliver and requiring providers to provide remedial action plans where standards are not delivered.

The assessment of performance for each target is based on the following:

- Achieved/Not Achieved - Performance at or above the standard
- Improved/Not Improved- Performance improved from last year or remained the same/deteriorated

Indicator	Standard	Latest Period	2023 Performance (Year to Date)	Latest Performance	Trend
A&E Waiting Time	<4 Hours	Not Achieved	69.6%	71.8%	Improved
Ambulance Catergory One	< 7 Minutes (life threatening)	Not Achieved	00:09:05	00:09:13	Not Improved
Ambulance Category Two	< 18 Minutes (emergency calls)	Not Achieved	00:51:15	00:43:06	Not Improved
Ambulance Category Three	< 2 Hours (urgent calls)	Not Achieved	02:53:36	03:00:33	Improved
Ambulance Category Four	< 3 Hours (less urgent calls)	Achieved	02:57:15	02:44:04	Not Improved
Referral To Treatment	< 18 Weeks	Not Achieved	53.4%	51.8%	Improved
Patients Waiting 65 Weeks for Treatment	-	-	2,749	644	Improved
Patients Waiting 78 Weeks for Treatment	-	-	380	20	Improved
Diagnostic Test Waiting Time	< 6 Weeks	Not Achieved	64.6%	73.9%	Improved
Cancer - Faster Diagnosis Standard	< 28 Days	Not Achieved	60.6%	74.5%	Improved
Cancer - First Treatment From Decision	< 31 Days	Not Achieved	88.3%	89.3%	Improved
Cancer - To First Definitive Treatment	< 62 Days	Not Achieved	48.1%	61.1%	Improved
Cancer - 62 Day Backlog	-	-	243	207	Improved
Mental Health - Patients Accessing NHS Talking Therapies	Patients Accessing Service	Not Achieved	21.9%	23.6%	Improved
Mental Health - First Episode Psychosis Treatment	<2 Weeks	Achieved	0.75	85%	Improved

How We Report Performance

A publicly available ICB Integrated Performance Report is considered by the ICB Board at its meeting, which provides up to date detail of performance against all the ICB constitutional standards and key targets across urgent care, cancer, planned care, mental health, primary care and a chapter on further key Quality measures e.g. mortality rates, hospital infections and learning disability health checks. The report sets out reasons for areas of underperformance along with key actions being taken to improve performance.

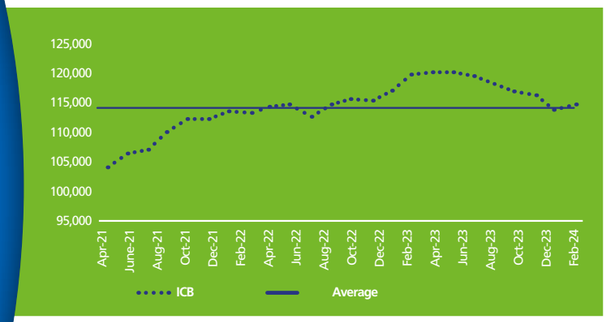
The performance report is published as part of the Board papers on the ICB website.

Referral To Treatment Time (RTT) Performance

The ICB works with a wide range of providers to increase capacity and improve the time patients wait for treatments. Recovery from the Covid-19 pandemic remained challenging and more recently industrial action has caused unprecedented disruption to routine services. This is resulting in record numbers of patients waiting for appointments, as well as those who have waited over a year for treatment nationally. This picture has been reflected in Lincolnshire, which has followed the national trend, however, significant progress has been made in virtually eliminating patients waiting over 104 weeks (2 years). Across 2023/24 the main focus was on eliminating the number of patients having to wait over 78 weeks (18 months) unless complex and reducing the number of patients waiting over 65 weeks (15 months).

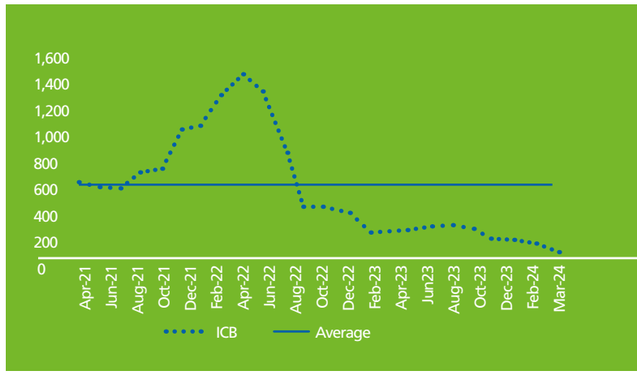
The total waiting list size for Lincolnshire patients at all hospitals continued to increase during the first half of 2023/24 peaking at 120,325 in August 2023 due to reduced capacity as a result of industrial action and increases in patient complexity. However, there are signs that this is beginning to reduce as visible in the run chart below and was 114,268 in March 2024.

Total Waiting List



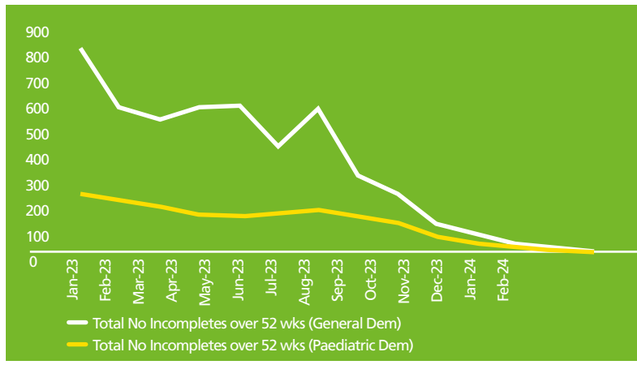
We continued to strengthen our oversight of patients waiting over 78 weeks with our main acute providers, and the number of patients waiting over 78 weeks has reduced from a peak of 1419 in December 2022 to 20 in March 2024.

Percentage of patients waiting over 78 weeks



The ICB Elective Activity Coordination Hub (EACH) has continued to work in partnership with our main providers on a process of validation to support reduction in long-waiting patients and over all waiting lists. This includes calling patients to reassure them that they are on the waiting list, determine if they still require an appointment, offer them the most appropriate appointment for their needs and to transfer clinically suitable patients to alternative providers where waiting times are shorter if appropriate. Over 27,500 patients have been contacted by the EACH over the period 2022-24 which has significantly contributed to the reduction of patients waiting over 78 weeks across all clinical specialties. Plans are in place to continue with this support to aid achieving the 65-week target. Dermatology has seen the greatest reduction with virtual elimination in the number of patients waiting over 52 weeks at the main provider.

Dermatology Patients Waiting Over 52 weeks For Treatment (Incompletes)



In addition, the EACH has continued to engage with GP practices to ensure they are fully utilising the service for all new routine and urgent planned care referrals to ensure patients are directed to the most appropriate place of care. The EACH have processed 110,000 referrals to date in 2023/2024 (March 2024).

Out-Patient Transformation

Emphasis continues to be placed on increasing Advice and Guidance (A&G) to GPs to help reduce patient referrals where appropriate, providing more virtual appointments and offering more Patient Initiated Follow Ups (PIFU) to prevent unnecessary patient journeys and utilise clinical time more efficiently. As a system we are performing above plan for A&G with every month's utilisation being above 30% against a 16% target and have sustained a consistent position of above 28% for Virtual Consultations against a 25% target.

Work is ongoing to engage with clinical teams to increase the PIFU position and expand this option to other providers. The system continues to be engaged in the Midlands Elective Delivery Programme, both sharing, and learning from, best practice for certain clinical specialties to ensure we are maximising opportunities to deliver best clinical outcomes and experience for patients.

Community Wax Removal (Microsuction) Service

Ear, Nose and Throat (ENT) services are one of the most challenged specialties locally in line with national trend. To reduce waiting times and increase patient access, a new community ear wax removal service (microsuction) commenced in August 2023. This service supports those patients requiring wax removal to attend a community service closer to home in a GP surgery or community provider rather than in a hospital setting. The clinical pathway focusses on enhanced self-care initially to ensure only those patients with greatest clinical need are referred into the new service. A hospital service also remains available for patients with complex needs.

Community Optometrist Triage Assessment and Treatment Service (COTATS)

COTATS has extended its reach from 27 optometrists to 38 accredited optometrists across 31 optical practice locations with further optometrists in the process of joining. The ICB is now managing the recruitment process to target areas with gaps in service provision, particularly along the East coast.

The service triaged 6,346 referrals from 1st April 2023 to 31st March 2024 and diverted 3,373 (53.2%) of referrals away from the hospital eye service into the Community Optometrist Triage Assessment and Treatment Service (COTATS), Community Surgical Scheme (CSS) or back to Optical Practice with advice and guidance. The COTATS service received 3,053 referrals.The ICB has supported the COTATs optometrists to implement Non-Medical Prescribers (NMPs) and anticipates, having four practicing NMPs by the end of the financial year with four more taking up training opportunities.

The ICB has also been working with the Midlands Eyecare Transformation Network (METN) to implement an Electronic Eyecare Referral service. The system (called Cinapsis) is being implemented across all 11 ICBs in the Midlands to ensure consistency. This system will electronically connect all the optical practices (73) in Lincolnshire to the NHS and will ensure that all optical practices follow a standardised pathway using referral templates (developed in consultation with the local hospital eye service and local optical committee). In addition, it will enable optical practices to track where their referral went whilst providing an auditable referral pathway. 95% of all optical practices went live on Cinapsis before the end of the March 2024. The ICB is working with the remaining optical practices (two providers covering four sites) to support them to get online.

Diagnostics

The Community Diagnostic Centre (CDC) programme of work continues at pace, with some significant achievements over the past 12 months. The plans to provide additional tests at the Grantham CDC have now been implemented, with the new DEXA machine now delivering activity, the new MRI and CT unit commencing activity in March 2024, and a number of additional physiological measurement tests due to commence in Quarter One 2024/25. These services will run alongside the existing plain film, NOUS, ECHO, AAA and diabetic eye screening services, which are now all well-established on this site.

In conjunction with the delivery of services at the Grantham CDC, MRI activity is also being delivered in temporary units on the new Lincoln and Skegness CDC sites, whilst the CDCs are in the construction phase. Both of these new CDC buildings (which are owned by ULHT along with the Grantham site), are due to be completed in Quarter Three 2024/25, following which they will be ready to deliver the full range of CDC tests before the end of the financial year.

To date the CDC programme in Lincolnshire has successfully delivered an additional 78,388 diagnostic tests (as at 3rd March 2024) since CDC activity commenced in November 2021.

Over the course of the last three years the Lincolnshire CDC programme has been successful in attracting in excess of £42m in capital investment into the county, alongside significant revenue investment.

In January 2024, the number of diagnostic tests being carried out across the system was approximately 6.2% higher compared to the same month last year. This was coupled with a 9.8% reduction in the total number of patients waiting for diagnostic tests, and an increase in compliance for the number of patients waiting less than six weeks from 58.6% in January 2023 to 69.5% in January 2024.

Over the past twelve months, echocardiology has seen particular success with a marked improvement in the number of patients on the total waiting list reducing from 8,212 in January 2023 to 3,659 in January 2024, and the number of patients waiting less than 6 weeks for their diagnostic test rising from 17.5% to 42.3% over the same period.

As a system, we continue to work towards achievement of 95% of patients being seen within six weeks for their diagnostic tests by the end of March 2025.

Summary

Whilst the ICB and the wider system continues to work well together to improve services and reduce waiting times, there are some considerable risks to maintaining this position and being able to meet the future national performance ambitions. Industrial action and urgent care demands have an impact on available clinical capacity, with appointments and procedures occasionally having to be rescheduled. This is always done as a last resort and processes are in place to clinically prioritise and ring fence planned care capacity wherever possible. Wider workforce challenges are well documented within Lincolnshire as well as nationally. As we look to continue with the Community Diagnostic Centre expansion, workforce availability is the highest national risk and could constrain ambitions if services are not able to be staffed. Diagnostic networks, academies and systems are all working together at regional and national levels to implement plans to support the increase of trained clinicians into the NHS.

Cancer

The past financial year has seen substantial advancements in the management and care of cancer patients. Despite facing the significant challenges that stemmed from the Covid-19 pandemic, our concerted efforts have yielded substantial improvements in cancer care delivery and patient outcomes.

This report highlights the key achievements and initiatives that have led to our cancer services at ULHT being removed from the NHS recovery plan tiering system. ULHT having been in Tier One which is considered to be of greatest concern. Being removed from Tier One is reflective of the Lincolnshire systems strong recovery trajectory.

Headlines:

National Recognition: Our cancer care services have made a leap in performance, moving out of the national tiering system, signalling a robust recovery from Covid-19 related backlogs.

Backlog Reduction: We've successfully reduced our 62-day backlog by nearly 35%, bringing the number from 286 patients down to 187.

Diagnosis Efficiency: The 28-day Faster Diagnosis Standard (FDS) performance has seen a remarkable increase from 56.9% to 74.4%, meaning more patients are quickly learning their diagnosis status.

Reduction in the number of patients over 104 days: The number of patients waiting over 104 days for a diagnosis and/or treatment has been cut from 114 to 42.

Overall Cancer Pathway Improvement: The total number of patients on a cancer pathway has been reduced from 3806 to 3279, enhancing patient care and service efficiency.

Significant Backlog Reduction in Key Areas: Colorectal and urology tumour sites have halved their backlogs, showing significant progress in areas that previously had much higher backlogs.

Innovative Lung Cancer Pathway: The introduction of a new lung cancer pathway has more than halved the need for CT radiation exposure among patients, advancing patient safety.

Galleri Trial Success: The Galleri trial has maintained a 95.4% retention rate in its second year, indicating high patient engagement and trust.

Gynaecology Service Funding: An award of funding to the gynaecology service has enabled a shift towards a nurse-led model, optimizing consultant availability.

Enhanced Post-Menopausal Bleeding Pathway: The new pathway ensures high-risk patients receive prompt attention, while low-risk patients are appropriately triaged, improving resource allocation.

Investment in trainee roles: Funding has been secured to train our own therapeutic radiographer, this approach addresses critical recruitment challenges and ensures the sustainability of our high-quality radiotherapy service.

Investment in HPB Pathways: The successful recruitment of three dedicated HPB specialist nursing staff marks a significant milestone in our journey towards increasing services for HPB patients within Lincolnshire. These skilled professionals will play a vital role in supporting patients, streamlining processes, and ensuring timely interventions, ultimately improving patient outcomes and experiences. The deployment of these specialised nurses in both inpatient settings and outreach clinics in Lincoln and Boston underscores our commitment to providing localised, accessible care to our community. Their presence will not only expedite consultations but also foster continuity of care and personalised support for patients throughout their treatment journey.

Looking Forward: Building on this year's successes, we continue to strive for excellence in cancer care. Our goals for the upcoming year include further backlog reductions, continued enhancement of patient pathways, and the implementation of new service models to provide the highest quality of care to our patients. We are committed to maintaining this momentum.

Living with Cancer Programme

The Lincolnshire Living with Cancer Programme developed its fourth Strategy during February – April 2023 to set out our approach and objectives for 2023 – 2025. This was adopted by Lincolnshire ICB in September 2023. The strategy is founded on patient experience and sets out how the programme will implement personalised care for people living with cancer, whilst meeting the requirements of national and local policy and strategic drivers.

The programme was impacted by several system-wide risks. Staffing and performance pressures in ULHT and financial pressures across the ICB led to vacant posts. Furthermore, the nationwide cost-of-living crisis has led to an increased number and complexity of patient support request for our LWC Community team.

The Living with Cancer Team both in ULHT and the ICB rose to these challenges. In ULHT, a willingness to work collaboratively with the ICB was consolidated and Personalised Stratified Follow Up Pathways were implemented in breast, prostate, colorectal and endometrial cancers. These will be embedded and fully operationalised during 2024 – 2025. An Integrated Cancer Workforce Development Strategy 2023 – 2025 was adopted by the Lincolnshire system in September 2023 which aims to recruit, retain and support the cancer workforce. Patients' needs are being identified at different points on pathways by carrying out a holistic needs assessment (HNA), but there is further work to do with some cancer pathways to ensure patients have access to a HNA within 31 days of their cancer diagnosis.

Our objectives in the community team were met. Good relationships with practitioners across Lincolnshire, fostered by extensive community integration and networking, supported the Living with Cancer Community Team to respond to 100% of patient support requests within two working days. The potential impact of the cost-of-living crisis on cancer patients was identified, and a suite of interventions were developed. These included financial support pages curated on the Lincolnshire Cancer Support website with signposting to other services. Collaboration with Citizens Advice Bureau, East Lindsey Foodbank Network, Greater Lincolnshire Foodbank Network, The Bread and Butter Project, Anglian Water and National Energy Action aimed to alleviate financial burden for people affected by cancer.

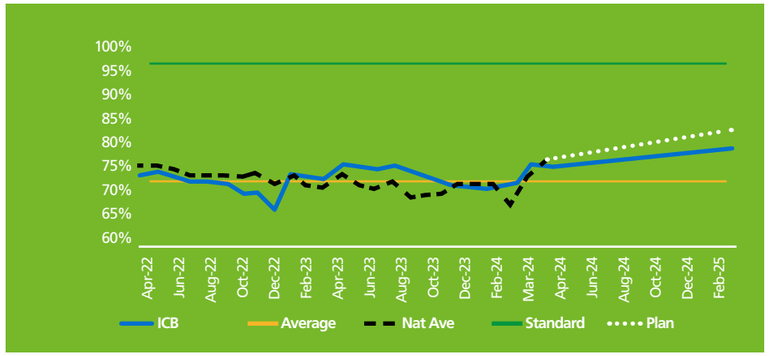
Celebrations

- 99.6% of HNAs carried out are translated into personalised care and support plans.
- 83.7% of patients have a wellbeing check in primary care within three months of diagnosis.
- 91.2% of patients have a cancer care review in primary care within 12 months of diagnosis.
- 3.2 Whole Time Equivalents (WTE) Clinical Psychologists funded by Macmillan and East Midlands Cancer Alliance are now in post in in LPFT. Lincolnshire Psycho-Oncology Service launched 02/10/2023.
- Level 4 Cancer Rehab programme 'Fighting Fit' is now active, with eight sessions in Lincoln, Mablethorpe, Gainsborough, Grantham, Boston, and Bourne. More than 200 people have been referred.
- Approximately 2000 community assets have been mapped to support people living with cancer and help them to self-manage in their own communities.
- Set-up of support groups in kidney, lung, secondary breast and colorectal cancers.
- The Cancer Digital Strategy 2023 – 2025 was adopted by Lincolnshire ICB in September 2023.
- The Lincolnshire LWC approach has been recognised nationally and internationally as innovative practice, with presentations delivered at the Macmillan Professionals Conference in Glasgow in November 2023 and the International Psych-oncology Symposium World Congress in Milan in September 2023. A peer reviewed paper in the Journal of Cancer Policy was published in December 2023 https://www.sciencedirect.com/science/article/pii/S2213538323000693
- 356 people affected by cancer took part in our engagement during February to April 2023 to help us develop our strategy.
- Our Macmillan LWC Co-production Group and Mablethorpe Co-production Group continue to co-produce elements of the programme. The Lincolnshire Cancer Expert Reference Group also helps us by scrutinising the programme.
- In May 2023, the LWC Team was awarded the Co-production Team award at the Lincolnshire 'It's All About People' conference.

Urgent Care

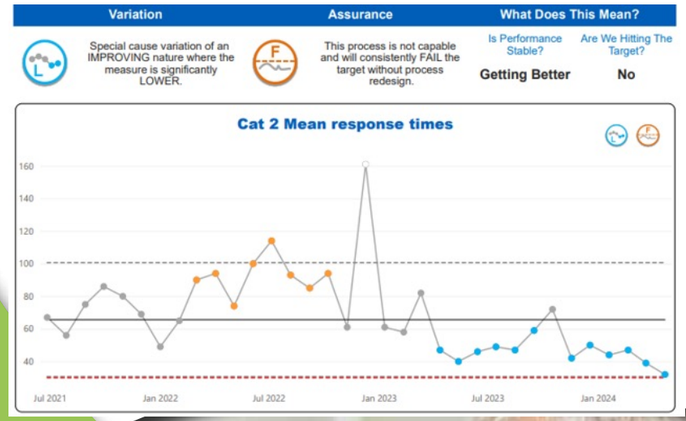
The core standard for Urgent and Emergency Care (UEC) is that patients should be seen and discharged from A&E within four hours. The national target for 2023/24 is 76% of patients being seen and discharged within the four hour timeframe, by March 2024. There have continued to be challenges with the delivery of this target.

A&E admission, transfer, discharge within 4 hours



The second key metric that has been monitored and has been a priority for improvement in 2023/24 is the Ambulance Category 2 mean response time.

Cat 2 Mean Response Times

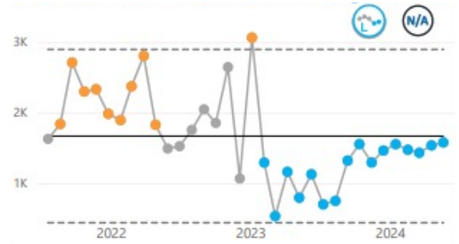


Although the EMAS Trust performance has not delivered the 30 minute average, the Lincolnshire ICB position is improved from the previous year. The Lincolnshire system has continued to experience pressure within urgent care throughout 2023/24, including managing multiple periods of Industrial action.

Attendances have remained high, with some elements of front door demand being above originally planned levels. For the constitutional 4-hour A&E target, Lincolnshire performance has remained close to the national performance, although the latest reported percentage of patients being seen within 4 hours was 65.7% compared to 70.9% nationally. The number of patients waiting over 12 hours in department remains high.

Ambulance Handover Delays at our acute sites have been less in 2023/24 than we had seen in previous years, and the number of hours lost for EMAS crews as a result have also reduced, freeing up crews to respond to people in the community.

Hours Lost due to handover delays - ULHT



The requirement in 2023/24 was to maintain acute bed occupancy levels of no more than 92% to support flow, and for the majority of the year the system has delivered this but with a peak recently during pressured periods.

Acute bed occupancy (daily average)

The UEC programme in 2023/24 has focused on delivery of the national plan for recovering urgent and emergency care, including the full implementation of the 10 High Impact Interventions. This has included increased hours of operation on both main acute sites for Same Day Emergency Care (SDEC) Units, including establishment of frailty SDEC. We have commenced provision of a Frailty Assessment Unit to support our frail patients without admission to hospital, and this provision will be further expanded in 2024/2025. There has been a continued focus on patient flow and discharge from all of our bedded services, and this has included workstreams to reduce variation in inpatient care and length of stay, full implementation of Care Transfer Hubs and use of new Active Recovery Beds to support people in their transition home. The system-wide work on a review of the Intermediate Care model in Lincolnshire has started and will inform decision making around provision and patient care both post discharge from hospital and where they have stepped-up into services throughout 2024/25. The system has delivered its plan for virtual ward provision, achieving the planned levels of capacity and occupancy. We now have a variety of specialties providing virtual ward care as an alternative to a hospital admission, or to help people return home at an earlier date. The Urgent Community Response Service continues to support people to remain in their own home, responding to their needs within two hours, and over the winter period we have piloted a Health Care Professional Single Point of Access (HCP SPA) to support our professionals to access services that support patients either at home or by directly accessing acute services where they do not need to attend the emergency department. One of the new services piloted over winter to support people with respiratory needs without attending hospital, was the Acute Respiratory Infection Hubs. Following evaluation, these are likely to be fully implemented again in 2024/25.

The system is committed to continued delivery of the 2023/24 additional capacity funded through the various allocations across UEC and Better Care Fund (BCF) with evaluations of all elements ongoing to further refine service delivery models for maximum effect to support patients.

Adult Mental Health and Dementia

Physical Health Checks for those with a Serious Mental Illness (SMI)

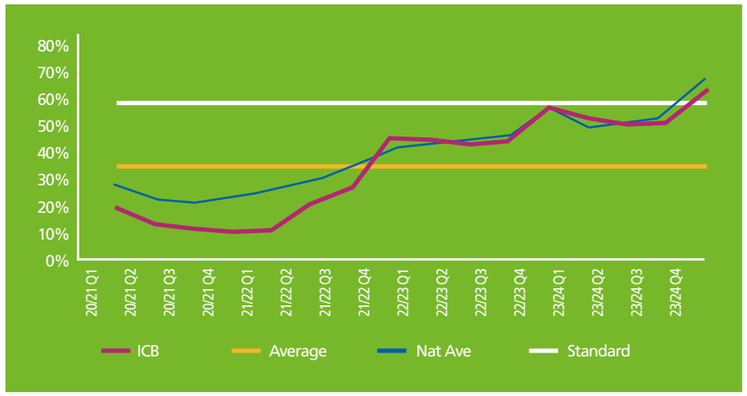
People with an SMI, such as schizophrenia or bipolar disorder, are at greater risk of a range of medical conditions compared to the general population. They experience physical illnesses more frequently and, in some cases, more severely; and they also have a considerably shorter life expectancy compared to those without a severe mental illness. Premature mortality in adults with an SMI has increased over recent years. Based on data from 2018 to 2020, in England, people with SMI were around five times more likely to die prematurely than those who do not have a SMI. This level of inequality is seen for both males and females.

The Lincolnshire workstream around this therefore seeks to ensure:

- Completion of recommended physical health assessments for those with an SMI at least annually.
- Delivery of, or referral to, appropriate recommended evidence-based interventions.
- Embedding personalised and strength-based conversations and approaches into the Physical Health Check, to improve health and wellbeing outcomes.

The number of Physical Health Checks and the achievement rate increased steadily since October 2023, the achievement rate was 64.5% in March 2024, the best performance in the last 12 months. Performance is in line with both the Midlands and national average. The achievement rate refers to the number of Physical Checks carried out as a % of those on the SMI Register.

SMI - Physical Health Checks and Achievement Rate



At the end of March 2024 we had delivered health checks in primary care to 64.5% of our SMI population, which is an increase on the same point last year. There is, however, a challenge to ensure we reach everyone that this applies to and to ensure a meaningful conversation takes place. We need to look at new ways of engaging and raising awareness of the importance of the checks being carried out, alongside ensuring we have tailored, accessible interventions which help make a difference to outcomes for people. People need to be put at the centre of their care and identify what is important to them. We therefore have a dedicated programme involving multiple stakeholders from various sectors to inform the way this moves forward, engaging with people with lived experience, carers, and workforce to develop a model that meets the outcomes desired.

We have work to do to ensure our primary care mental health registers do capture the cohort accurately, to avoid the risk of people falling through the gaps. We anticipate that developing a new model, working in collaboration with partners to address the shortfall over the next couple of years, would ensure a robust approach to achievement of improved outcomes for the population.

Adult Community Mental Health Transformation

Lincolnshire was an early implementer site for community mental health transformation for adults and older adults and as such all 14 PCNs now meet the criteria for being 'fully transformed'. The programme continues to embed the model and has had significant investment in workforce and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector.

Dedicated focus services including Community Rehabilitation, Adult Eating Disorders (AED) and Personality and Complex Trauma (PACT) services continue to be rolled out across the county as part of the transformation programme, to support targeted cohorts of individuals to gain support across the entire continuum of care and in line with Adult and Older Adults Community Mental Health Framework, preventing people from falling through the gaps or experiencing cliff edges of treatment. Community Rehabilitation is mobilised across two thirds of the county with plans to recruit to the final third by the end of the calendar year 2024. The AED service has begun mobilisation to embed working at a primary care level and to seek to invest into a specific VCFSE offer to support those individuals experiencing eating disorders at a community level. The expansion of these dedicated focus services will improve access but, as the expansion of these are to be delivered across the financial year, we do not expect to see full year impact on the access target until 2025/26.

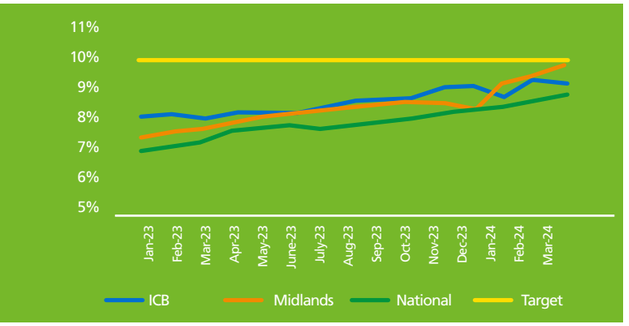
Locality mental health teams are being developed through plans to align community mental health teams with integrated place-based teams and Primary Care Networks. Data is now flowing through Mental Health Services Data Set to capture activity across the VCFSE and Primary Care Mental Health Practitioners. This data source will continue to grow to reflect meaningful activity undertaken and begin to demonstrate the social return on investment for the community wellbeing hubs and community connector roles. We will continue to work towards the data counting towards the 2+ contacts target to reflect more fully the activity being undertaken, although this is proving challenging. Data also continues to be monitored to support meeting the four week wait target with information sharing agreements and system interoperability being prioritised.

The 2024/25 plan continues to build on the success in 2022/23 and 2023/24 and has been developed in response to the primary care mental health profiles that were developed and are currently being iterated at a locality level to demonstrate demand across the continuum of care. These profiles are aligned to the population health data set to enable needs led services to be developed to manage capacity and to support the work to address health inequalities being identified.

Perinatal mental health services

This team had achieved access in line with planned access rates for five consecutive months in 2023/24. The Perinatal Access rate increased steadily since April 2023 from 8.1% to 8.9% in December, above the Midlands average (8.3%) and national average (7.8%). Performance, however, remains below the 2023/24 Plan. This continues to be monitored closely going forward.

Perinatal - Access Rate



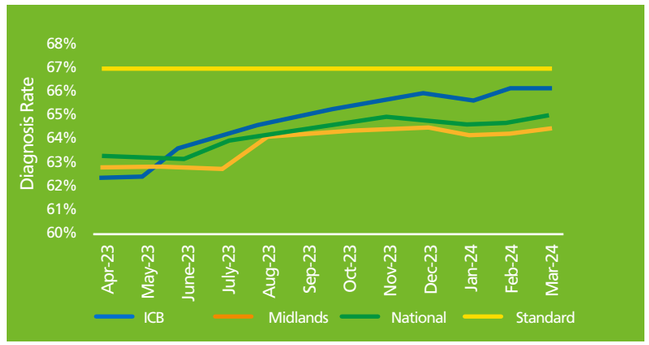
One of the challenges is that the number of live births in Lincolnshire has steadily decreased since 2013, from 10.4 live births per 1,000 population down to 8.6 per 1,000 in 2020. (OHID). Further data has indicated further decreases in the birth rate of 8.06% in 2021, 7.78% in 2022 and 7.35% in 2023 (last quarter predicted). As such, achieving the expected targets for number of people supported through specialist perinatal services is not expected to be achieved and we do not expect our workforce to grow beyond current establishment due to the continued birth rate decline, but will continue to recruit to vacancies.

The Perinatal Trauma and Loss Team that was launched on 1st February 2024 will support improved access going forward. There will be continued activity to promote the service availability and awareness of referral pathways.

Dementia

The Dementia Diagnosis Rate (DDR) is a nationally reportable target currently set at 66.7% of people over 65 estimated to have dementia expected to have a formal diagnosis. **Performance is higher than both the Midlands and national average, February 2024 performance improved to 65.8%, the best performance since Sept 2019 (65.9%) and higher than pre Covid-19 levels.**

Dementia Diagnosis Rate



Demand for older people mental health and dementia services continues to rise year on year in line with known predictive demographics of Lincolnshire as an ageing county. Lincolnshire currently has around 180,000+ over 65s. This is predicted to increase by 46% to 250,000 by 2041 (ONS). In comparison, the working age adult population is predicted to remain static during this same timeframe.

Within this increase the cohort of over 75s will see the greatest increase of circa 87% (from 75,800 to 140,600). This cohort is the high-risk group for dementia with prevalence increasing with age. In addition, Lincolnshire also has a larger young-onset dementia population than average (and higher than regional neighbours with larger populations). This is due to the largest age cohorts in Lincolnshire currently being those between 50-64 years. Aligned to this, dementia prevalence is comparatively higher in Lincolnshire than the national average (8% in over 65s compared to 5-6% nationally).

Projections indicate Lincolnshire will experience an increased prevalence of dementia between 2021 and 2030 of 23%, with the actual number of people with a diagnosis of dementia due to increase by 50% in that timeframe from a current estimate of about 11,500 to over 17,000. Even at current prevalence levels demand could be up to 36% higher if all cases of dementia were being identified and supported. Negative impact would be seen on all performance and service experience outcomes as well as impact older adult community mental health teams in terms of their capacity to deliver.

Given this data and known trajectory, demand will continue to grow proportionally both for core diagnostic services and for associated care and management of complex post-diagnostic needs. Undiagnosed and unmanaged dementia can also have direct impacts on this cohort's capacity to manage other co-morbid long-term conditions and increased frailty, with associated impacts on the individuals and associated system services/pressures, with recent population health analysis showing that of people with known dementia in Lincolnshire, 64% also have hypertension, 33% depression, 22% stroke and 25% diabetes. As such, Lincolnshire is looking to develop the memory assessment service to a standalone model (in line with our regional partners) which would enable dedicated staff specifically employed and trained to deliver against the full diagnostic and post-diagnostic memory assessment service pathway. This would provide sufficient capacity to enable consistent delivery and monitoring of the pathway, and enable predictive performance trajectories and improved outcomes for people and the broader system looking to upskill and grow its workforce with dedicated roles to support future needs. It will also support readiness and the changes in clinical practice required to deliver disease modifying treatments – including the use of emerging biomarkers, treatment delivery and safety monitoring, and develop a clinical pathway that would meet the needs of patients to access new treatments.

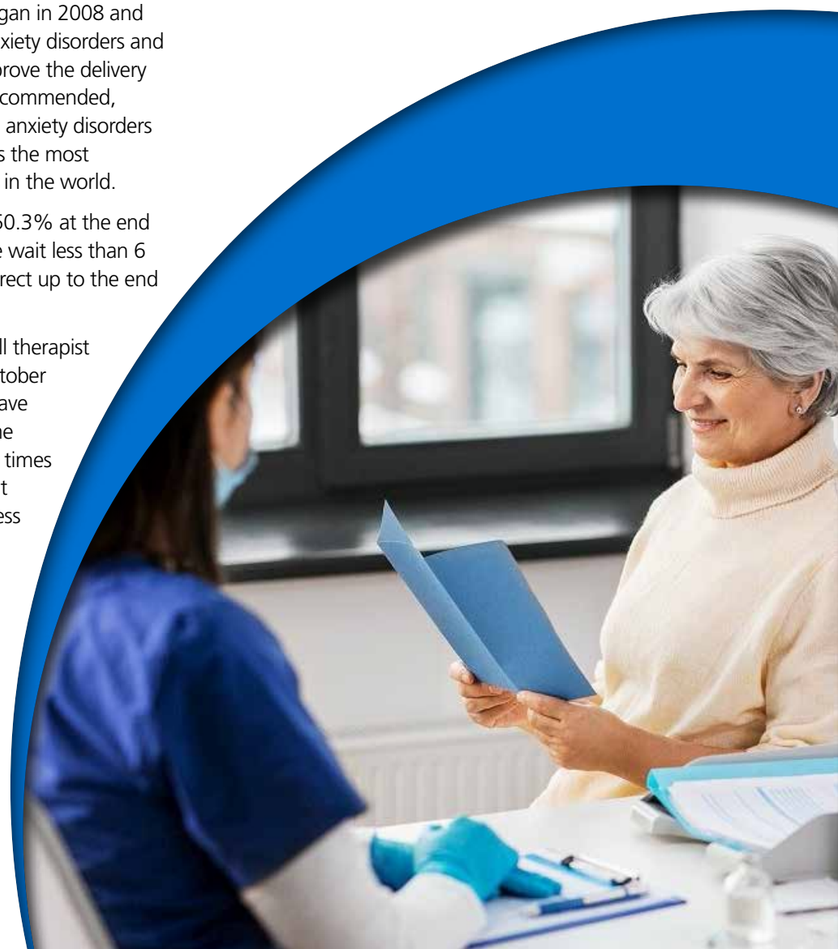
NHS Talking Therapies for anxiety and depression

The NHS Talking Therapies programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. It developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS and is widely recognised as the most ambitious programme of talking therapies in the world.

NHS Talking Therapies Recovery rate is at 50.3% at the end of February in Lincolnshire. 96% of people wait less than 6 weeks from referral to treatment (data correct up to the end of Feb).

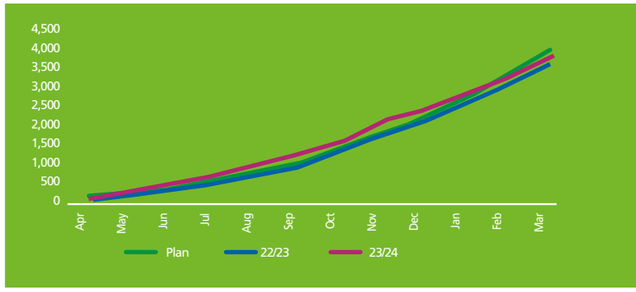
We have successfully recruited to almost all therapist roles, with a number of new starters in October 2023 and March 2024. They will initially have reduced capacity whilst training, but in time contribute significantly to reduced waiting times and increased access. A significant element of the service impacting on increasing access rates is for two thirds of the extra referrals coming from our long-term conditions pathway. Access to training has also been a challenge to ensure we have enough staff working in this part of the service but is being prioritised.

The main risk relating to this service is the wait to second treatment, with mitigation in place of outsourcing treatments and maximising our capacity.



Learning Disability Annual Health Checks

Annual Health Checks support people with a Learning Disability stay well by helping to find health problems earlier and giving time to agree on the right care. The ICB has worked closely with primary care and system partners to refocus efforts on improving access to Annual Health Checks for people with a Learning Disability since 2020/21. A dedicated ICB team was tasked with supporting improved performance by linking with system stakeholders and GP practices, providing direct support to practices and developing real time performance monitoring. As a result, an additional 1,450 annual health checks were delivered in 2023/24 when compared to 2019/20.



Key Achievements

Emergency Planning, Resilience and Response (EPRR)

As a new category one responder, the ICB continues to uphold its civil duties under the Civil Contingencies Act (2004).

The annual EPRR self-assessment against a set of core standards provides an assurance that NHS organisations are working to meet their EPRR statutory duties and obligations. The ICB declared substantial compliance against the core standards which is a significant improvement from being non-compliant in 2022 as we moved from a category two to a category one responder.

The ICB has coordinated several incident responses over the past year. Some incidents have been confined within the NHS and others have required joint working with other Local Resilience Forum (LRF) members. Adverse weather has been prevalent over the winter period, in particular flooding. ICB commanders have coordinated the health response to those vulnerable persons within flood impacted communities ensuring a suitable response according to need.

The EPRR team continues to support commanders by providing specialist advice, this was utilised in the multi-agency response to a significant number of people suffering from suspected carbon monoxide poisoning in August 2023. EPRR capabilities have continued to be used to enhance coordination in response to multiple incidences of industrial action across the local NHS.

Lessons from either exercises or responses continue to be embedded within the ICB and across the Local Health Resilience Partnership (LHRP) where a dedicated workstream has been formed to focus on the identification and sharing of lessons.

The training offer for ICB commanders remains aligned to EPRR Minimum Occupational Standards (MOS) with 100% of commanders having attended the ICB commander training. It is now also mandatory for all Strategic and Tactical Commanders to attend multi-agency coordination training. It is here where commanders can train alongside LRF member counterparts, such as Police and Fire Service, in preparation for a multi-agency response.

Shortly after the ICB was formed, the organisation was assessed against the NHS EPRR Core Standards. There are 47 standards applicable to the ICB and these range from EPRR governance structures to specific response arrangements such as Adverse Weather.

Following a thorough review of the EPRR work programme and investment in resource to ensure we were able to meet our new legal duties as a category one responder, the ICB has now achieved substantial compliance in 2023/24. A significant amount of work was undertaken to achieve this level of compliance whilst also responding to live incidents throughout the year.

Following the Lincoln Emergency Department Fire in 2022, the ICB increased its cadre of commanders. 100% of commanders have now received bespoke training aligned to the EPRR Minimum Occupational Standards. This training acknowledges the ICB's system leadership role and link to multi agency coordination.

Working with our Acute Trust to consult people and communities on changes to paediatric services

Over the last five years, engagement has been continuous, and the Family Health Division at ULHT has had a number of discussions with representatives of the community served by Pilgrim Hospital, Boston to discuss the developing models of care. Their honest feedback on experiences in hospital was extremely helpful in enabling us to develop an appropriate proposed service model. Following this, a full public consultation on the future of the paediatric service at Pilgrim Hospital was developed jointly with ULHT and the ICB and ran for 12 weeks from June to September 2023.

Lincolnshire's Health Scrutiny Committee received regular updates on the proposals and supported the process. Following discussions with NHS England on the proposal it was agreed to commission the Clinical Senate to undertake a clinical review of the service change which was considered as part of the final decision making.

Both Equality and Quality Impact Assessment were undertaken, reviewed and approved through the ULHT's Quality Committee, attended by members of the ICB, and subsequently reviewed and ratified by the ICB Director of Nursing. The service proposal and supporting documentation including a detailed summary of the background and series of changes made to the model since 2018 were presented to the ICB Executive team by the Managing Director of the Family Health Division at ULHT. The ICB Executive were in full agreement to support the proposal and agreed for them to be presented to the ICB Board for approval, subject to the ULHT Boards support for the change which took place in November 2023.

Engagement to increase bowel cancer screening

The aim of the Health Inequalities Bowel Cancer Project is to increase the uptake of bowel cancer screening for the 20% most deprived populations in four G.P practice areas. This was supported by an extensive and targeted engagement campaign including a general public survey, surveys sent via text messages to specific patient cohorts, phone calls directly with patients, letters sent to patients and teams getting out and about in communities to talk to people in the areas affected. Our hugely successful engagement has seen over 2,400 responses from people sharing their experiences of completing bowel cancer screening tests as well as feedback from others who have not completed the tests. This has enabled us to understand the reasons why and identify how we can remove any barriers and encourage completion.

Increasing diversity in participation in research

Working in partnership with Lincolnshire Voluntary Engagement Team (LVET), The University of Lincoln, EveryOne, Healthwatch and Just Lincolnshire, the ICB secured £100,000 of national funding to increase diversity in participation in research. Our aim is to develop a sustainable, resilient, local research network of groups and community partners who will support their communities and the wider system to identify opportunities to get involved in and shape research and engagement activities.

We will work with community leaders and organisations to uncover the benefits of being involved with research and co-produce training and development resources so that they are better able to share the importance of research in bringing about change. By bringing together community partners, university researchers, Trust research and development leads, and ICS engagement teams we will build on existing activity to identify, train and support community involvement in research in excluded and underserved communities, amongst those experiencing health inequalities and those who have not wanted, or known how, to get involved.

During 2023, strong foundations for the project were established and will continue to be embedded and delivered throughout 2024.

Connecting with younger people

We recognise the importance of proactively involving Lincolnshire's younger people in the work that we do, and the different ways we need to work to reach out to them. Their insight, innovative ideas and experiences are crucial to consider if we are going to develop services for the future. We reach out to younger groups and communities through all of our programmes of work, such as during development of Lincolnshire's Joint Forward Plan, where a sixth form debating society shared their thoughts and ideas on our emerging priorities. This developing partnership will enable more direct involvement with younger groups and students on future projects. The Involvement Team also attended various college induction days and Freshers Fayres across Lincolnshire, talking to students, providing opportunities to get involved in various ICB engagement activities and many of them signed up to receive our fortnightly newsletter to receive updates on our work and surveys. It was also a great opportunity to discuss the importance of involvement of our people and communities with some staff and lecturers in health and social care and public services courses.

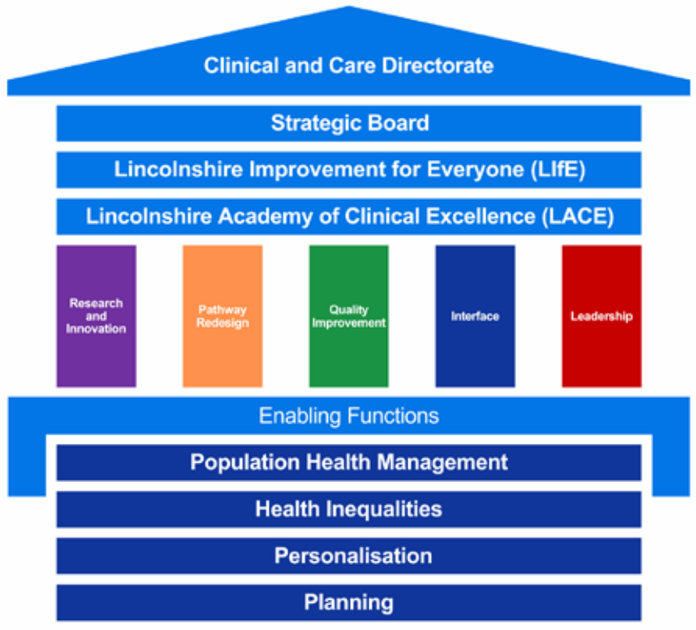
Duty to obtain appropriate advice

The ICB has established the Clinical and Care Directorate (CCD). This includes senior clinicians and care sector leaders from medicine, nursing, allied health professionals, and adult and children's care services supported by a management team. Senior colleagues from the ICB are also part of the core membership. We invite other clinicians, dependant on the pathway redesign topic, who are not part of the core membership but have the relevant expertise. The outputs are shared widely, including through the Primary Care Advisory Group which includes all of primary care not just general practice.

The CCD aligns with the five principles set out in the NHSE guidance: 'Building strong integrated care systems everywhere' (September 2022).

- Integrating clinical and care professionals in decision-making at every level of the ICS
- Creating a culture of shared learning, collaboration, and innovation, working alongside patients and local communities
- Ensuring clinical and care professional leaders have appropriate resources to carry out their system role/s
- Providing dedicated leadership development for all clinicians and care professional leaders.
- Identifying, recruiting, and creating a pipeline of clinical and care professional leaders.

The CCD will be the collective voice of all health and care professionals in Lincolnshire. It will provide evidence-based decision-making by well-led clinical professional groups. The infographic depicts the structure and alignment of the elements included within the CCD.



The Strategic Board is a leadership committee of the CCD and sets Lincolnshire's clinical direction and acts as an advisory group and a source of clinical expertise to the ICS, ICB and MHLDAA. Members of the Strategic Board are senior clinicians who are invited to represent components from the ICS.

The ambition is the development of a cohesive approach to improvement, learning, research, and innovation at a Lincolnshire ICS system level under the banner of LIfE: Lincolnshire Improvement for Everyone.

The CCD has been structured with the five key component parts, which include:

- Research and Innovation
- Pathway redesign
- Quality Improvement
- Interface
- Leadership

The first three parts make up the fundamentals of the Lincolnshire Academy of Clinical Excellence (LACE). These elements work closely together to ensure research, innovation, pathway redesign and quality improvement are at the heart of transforming clinical excellence and improving patient outcomes. Interface is a forum for primary and secondary care clinicians to improve patient flow and care with the aim of reducing duplication, following best practice, and therefore improving patient care. The leadership program will enable senior medical colleagues to develop together to lead clinical change in our system. We hope to create a pipeline for this development to secure succession planning.

The purpose is improving the health and wellbeing of people in Lincolnshire, by supporting the delivery of our long-term population health improvement goals as well as care delivery. The added value of working as a system facilitating stronger collaboration across organisations and more effective scaling of innovation; using existing assets and the expertise that exists in Lincolnshire. Shifting the focus from assurance to improvement, which is everyone's business, adopting learning health and care system concept, understanding the relationship between investment and outcomes. The end-product will be a Lincolnshire framework which drives more effective improvement, agreeing common language and principles.

The proposed framework will focus on two main elements:

- Creating the conditions for change: identifying goals, priorities and resources; building relationships and trust; seeing diverse expertise as an asset; developing shared system leadership
- Enabling the planning and delivery of changes across the system

The Better Lives Lincolnshire Leadership Team endorsed the approach.

The ICB are being supported by Q Health Foundation and the NHS Confederation to provide support and peer learning to develop our Quality Improvement strategy for Lincolnshire. The ICS are establishing a working group to develop the strategy.

LACE is the facilitator of clinical care pathway reviews for the ICS, bringing together clinical and operational experts with people with lived experience, to review and redesign care pathways, using a variety of methods and techniques such as evidence synthesis and quality improvement tools.

We look in detail at the data, including population health analysis, health inequalities and personalisation. Alongside this, we collate clinical evidence by searching the clinical database and clinical papers. We also seek advice from national, regional, and local experts in the area of interest.

We are developing strong links with the University of Lincoln and the Health Innovation East Midlands (HIEM) to formulate the process of evidence synthesis. This will be a fundamental part of service redesign, starting with gathering current clinical evidence, best practice and inviting leading clinical experts to inform pathways.

We draw all elements together and provide guidance to teams regarding improvement options which include low, medium and high complex pipelines. There are five stages to the highly complex pathway which contains the following steps:

- Seeking approval from the Strategic Board
- Establishing stakeholder and expert engagement
- Detailing the current position and areas for improvement
- Mapping the future state and building a high-level strategy and plan
- System sign-off and ownership of the strategy and plan

Colorectal

As an example, we have recently completed the redesign of the colorectal pathway. We had an uptake of FIT testing below 30% for new Two Week Wait referrals for suspected colorectal cancers. With the methodology described, and with the help of the Chair of the British Gastroenterology Society, we have redesigned that pathway. The result has seen an increase in the adoption of FIT testing to well above 80% and often nearing 100%.

ADHD

LACE is currently undertaking a detailed review of ADHD services for adults in Lincolnshire at the request of the ICB's Mental Health, Learning Disabilities, Autism & CAMHS Commissioning Team.

Working with the Chief Commissioning Manager and his team, LACE are partway through the five stages of its most complex review pipeline, facilitating a series of workshops involving local clinical, operational and commissioning experts as well as people with lived experience, all coming together to form The Expert Reference Group (Stage 2). The Strategic Board, having approved the review (Stage 1), has received verbal updates on its progress and will receive a copy of the final strategy and dossier for sign-off prior to its implementation (Stage 5).

Workshops 1 and 2 of the review (Stage 3) have focused upon exploring the current position using detailed local data analysis, best practice guidance via evidence synthesis carried out by Health Innovation East Midlands, and clinical standards' and personalisation gap analyses, carried out by the current, independent providers. A survey of people with lived experience of ADHD and using local healthcare services, was also carried out. All of this intelligence, which was presented and reviewed at the workshops, was then supplemented by the experts during a series of activities to deepen the understanding of the issues and causes that would benefit most from a quality improvement approach.

Workshop 3 (+ Workshop 4 = Stage 4) began focusing upon the desired future state or vision for services by agreeing an aim statement underpinned by three objectives. The major elements of the current and desired future pathway were agreed and mapped in relation to each other. Workshop 4, not yet delivered, will focus upon agreeing outcomes and outcome measures for each of the elements of the care pathway.

The outputs from workshops 3 and 4 will form the basis of a high-level strategy which the commissioning team will use to inform their commissioning intentions going forward once approval has been granted by the Strategic Board.

The three workshops already undertaken, have been well attended with good representation from independent service providers, NHS staff from across the system, university, and public health staff. Attendees were very engaged in the workshops and the post-workshop feedback via anonymous surveys, has been extremely positive.

ADHD is the first pathway to follow the complex review pipeline. It was commissioned by the Mental Health, Learning Disabilities, Autism & CAMHS Commissioning Team. It has been a testbed for the LACE method and pipeline of activities for detailed reviews. There have been four workshops (one, two and three completed) including clinical and operational experts as well as people with lived experienced, which together comprise the Expert Reference Group. Several private providers attended and were engaged in the workshops. Detailed exploration of the issues, data, evidence base, solution generation resulted in a high-level strategy being produced by March 2024.

There are many pipelines now commencing, some led by the LACE team, some led by other improvement teams/individuals across the system. The oversight and progress of these programmes of work are aligned with the Strategic Board. The approach the CCD is taking is integral to the success of integration to improve patient outcomes locally.

Duty to promote innovation

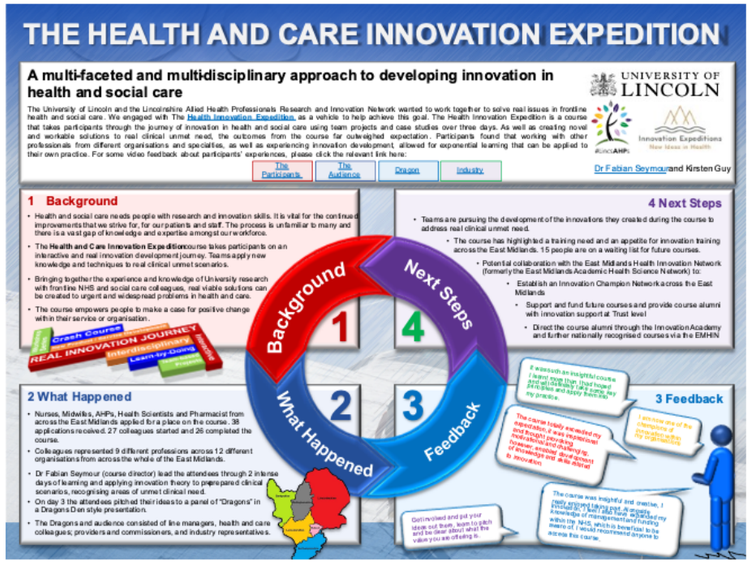
Our ICS has close links with the Health Innovation East Midlands (HIEM). In May 2024, a two year fixed term ICS Innovation Lead post, in partnership with HIEM, will support innovation across our system and link with ICS counterparts within the East Midlands. HIEM was established by NHS England in 2013, as one of 15 organisations across England acting together as the innovation arm of the NHS. Bringing together partners from across all sectors involved in health and care including the NHS, social care and Public Health, patients, research, third sector and industry, to identify, test and spread new technologies and better ways of working.

The work of all the Health Innovation Networks is broadly split between three different but complementary commissions:

- NHS England (covering our core work around innovation).
- NHS Improvement (supporting safer care through our Patient Safety Collaboratives).
- Office for Life Sciences (helping innovators to spread their great ideas and technologies, and in doing so support economic growth).

We are looking forward to exploring a support package and working ever more closely with HIEM who continue to support our health and care organisations to adopt and spread innovative ways of working that will mean our services can treat more patients more quickly and achieve better outcomes.

This would enable sharing of best practice from national and regional teams, to evaluate at a local clinical level and into front line practice.



Feedback poster from the 2023 Health and Care Innovation Course - full version available on the ICB website.

In June 2024, we will be delivering our second Health and Care Innovation Course in partnership with the University of Lincoln, and newly for this year, Health Innovation East Midlands (HIEM). This four-day course is open to nurses, midwives, Allied Health Professionals (AHPs), pharmacists and health scientists from across the East Midlands. Using Health Innovation Expedition: New ideas in Health & Social Care as the innovation vehicle, attendees are empowered to innovate more effectively and are given the tools to navigate the complexities of getting ideas developed, adopted, and spread throughout the NHS and social care settings. Attendees work on innovative solutions to current clinical challenges in four workshops.

Day four is the final workshop and will consist of a Dragons Den style showcase where group ideas will be pitched to relevant national, regional and local partners. The Feedback Poster from the 2023 Health and Care Innovation Course is shown in the diagram above.

We are delighted to be developing an ICS Research and Innovation Strategy, which will be published in April 2024. Including Innovation demonstrates our collective commitment to innovation in addition to research. Although different specialities, there are many benefits to dovetailing our strategy. Please see further details in the research section below.

HIEM Blood Pressure Optimisation programme

The Blood Pressure Optimisation programme aims to support local systems in identifying patients with hypertension, providing the right care to reduce the incidence of heart attacks, strokes, and dementia.

HIEM is supporting primary care staff within East Midlands Primary Care Networks (PCNs) to implement the Proactive Care Framework for hypertension to optimise clinical care and self-management for people with high blood pressure and other CVD risk factors.

The Framework offers:

- Risk stratification to prioritise which patients to see first.
- Use of the wider workforce to support remote care and self-care.
- Supporting patients to maximise the benefits of remote monitoring and virtual consultations where appropriate.

In addition, we are working collaboratively with Integrated Care Systems to improve existing case finding initiatives to increase the detection of people with hypertension.

Improving care for patients with lower limb wounds

Project summary

East Midlands Academic Health Science Network (EMAHSN) locally supported the Academic Health Science Network (AHSM) Transforming Wound Care national adoption and spread programme. The programme aim is to ensure that all patients with lower limb wounds receive evidence based care which leads to:

- faster healing of wounds.
- improved quality of life for patients.
- reduced likelihood of wound recurrence.
- uses health and care resources more effectively.

The programme uses the evidence, learning and recommendations from the National Wound Care Strategy Programme (NWCSP).

EMAHSN took part in Phase 1 of the programme and supported LCHS to establish a dedicated Lower Limb Wound Clinic Test and Evaluation Site.

The challenge

Most wounds to lower limbs heal within a few weeks. Chronic lower limb wounds are those below the knee that are slow or fail to heal. Chronic lower limb wounds account for at least 42% of all wounds in the UK, with leg ulcers being the most common type (34% of the total wound population, compared to 7% pressure ulcers and 8% diabetic foot ulcers).

A large proportion of the total wound care spend is for these chronic lower limb wounds because of their slower healing rates. In 2019, there were an estimated 739,000 leg ulcers in England, with estimated associated healthcare costs of £3.1 billion per year.

Based on evidence from the National Wound Care Strategy Programme, the prevalence of total leg ulcers is expected to increase by around 4% annually, to over 1 million by 2036, if there is no intervention. This is driven by an increase in leg ulcers that either recur after healing or do not heal.

The solution

The three key elements of the programme are:

- People: the delivery of training to all staff supporting patients with wounds.
- Processes: implementing a new evidence-based model based on the recommendations of the NWCSP.
- Technology & design: supporting data collection and provision of care through a new digital wound management system.

Atrial Fibrillation

The Atrial Fibrillation (AF) programme focused on improving the detection and treatment of AF in primary care. It was active in the East Midlands from 2016 and was selected as a national programme to implement across the 15 AHSNs between 2018 and 2020.

It facilitated collaboration between GPs and other clinical support groups, such as pharmacists, to deliver more timely treatment and evaluation of these approaches.

Impacts

Between April 2016 and March 2020, the programme achieved the following in the East Midlands:

- Deployed 925 devices to participating GP practices and support services to increase detection.
- Supported the treatment of an additional 25,127 people diagnosed with AF.
- Supported our East Midlands health system to achieve a 90% anticoagulated rate of people diagnosed with AF by March 2020 (against a national target of 90% by 2029).
- Contributed to the avoidance of 1,005 AF-related strokes.
- Contributed to the avoidance of 254 AF-related deaths.
- Potentially saved a number of strokes, and hence achieved cost savings.

The examples outline successful innovations that are being tested across the East Midlands, HIEM has funded a system role to support Innovation. This role will support the learning and upscaling of these innovations across Lincolnshire to improve outcomes for patients.

The Director of Public Health is a core member of the Clinical Directorate and is the key link to the JSNA, as well as the conduit of the clinical voice in the JHWS. Through that mechanism, we installed WHZAN technology into our care homes that enable much greater support to care home staff for remote monitoring. This improves the standard of care we can offer to care home residents.

Duty in respect of research

We have the ambition to be the leading county for rural and coastal research.

Lincolnshire's history in research to date has been focused on individual Trust level and general practice-based work. We have pockets of research delivery excellence in cardiology, haematology, mental health, pre-hospital, gambling, and addiction, and we have ambitions to ensure equity and increased opportunities to be involved in research from a public and workforce perspective. The Clinical Research Network (CRN) East Midlands is first for recruitment to Primary Care studies, out of the other 15 Local Clinical Research Networks (CRNs) and Lincolnshire is 3rd in the East Midlands with over 8,000 recruited within 2023/24.

Research and Innovation forms an integral part of LiFE (Lincolnshire Improvement for Everyone) and moving forwards this will be integral to the synthesis of the evidence required to make positive, impactful change. In terms of evidence synthesis informing pathway redesign, please see the examples in the section above.

Duty to obtain appropriate advice

Facilitated by our ICB we have established an ICS Research Leaders Group which builds on established research partnerships within our ICS. The Group meets monthly with representation from research leaders across the NHS, Lincolnshire County Council, Universities (University of Lincoln and Bishop Grosseteste University), voluntary sector and wider partners. Its purpose is to provide strong and effective leadership and partnership working across the health and care system, with a commitment to maximising shared research opportunities to deliver better health and wellbeing outcomes to the people of Lincolnshire. We are developing an ICS dashboard that will allow the group to demonstrate impact and monitor research and innovation activity across the ICS to ensure a co-ordinated approach that will maximise opportunities for Research and Innovation. This group will have strategic and operational functions and will oversee the development of the ICS Research and Innovation Strategy.

In April 2024 we launched our Research and Innovation Hub.

Research and Innovation Hub
LiFE
Lincolnshire Improvement for Everyone
Improving the Health and Wellbeing of people in Lincolnshire

Our Research and Innovation Hub is be a virtual place that brings together the Lincolnshire Public, our workforce and our colleagues at our universities to drive research and innovation in our county for benefit of our rural and coastal community. A Hub website is in development and will initially be public facing. It will be a resource where the Public can find out about health and care research, why it is important, what is happening nationally, regionally and in Lincolnshire, and how to get involved. Sitting within the Lincolnshire ICB website, it will be a 'one stop shop' for Research and Innovation in the county. The public content has been co-produced with the public during two workshops which were very well attended. The website will continue to evolve to include sections for our workforce, researchers, and our research leaders. The Research and Innovation hub launched in April 2024 with attendees from all our ICS, local and regional partners, national speakers and the Lincolnshire public. It will be a launch pad for our collective ambition for Research and Innovation to drive excellence in rural and coastal health and wellbeing.

At the Hub launch we also published our first ICS Research and Innovation Strategy. Our strategy has been co-produced during a series of collaborative workshops with senior leaders in our system, partners and our public. Our five year strategy is ambitious and reflects our commitment to ensuring that research and innovation are embedded in our core business rather than being an add-on.

Our four strategy principals align with national and local priorities and goals:

1. Reflects the needs of our rural and coastal community
2. Collaborative, co-ordinated and trusted partnerships
3. Research, Innovation and Evidence embedded in everything we do.
4. Delivered by a sustainable, capable and confident workforce

The Implementation plan will follow later in 2024 and will set out the road map for achieving our collective goals and vision.

Lincolnshire has a novice but emerging research and innovation workforce and therefore building capacity, capability and confidence is vital. Since November 2023 the ICB has secured nearly £50K from our local and regional partners to support our innovative capacity and capability initiatives for our workforce and public. As an example, the ICB, Lincolnshire County Council and the University of Lincoln have developed a foundation research training programme which will be offered to all colleagues from Lincolnshire County Council and across all Lincolnshire Health and Social Care organisations. The programme has been created following survey feedback from our Allied Health Professionals (AHPs) and Lincolnshire County Council (LCC) workforce. The programme has been joint funded by the CRN, Lincolnshire County Council and United Lincolnshire Hospitals NHS Trust.

- Starting at the end of March 2024, the training will involve eight online sessions over five months culminating in an in-person celebration marketplace event to explore the 'what next'.
- No prior knowledge of research required.
- For all staff (registered and unregistered).

The programme aims to demystify research and ignite passion and interest, to grow research skills and knowledge across Lincolnshire, for the benefit of

the Lincolnshire population and our workforce.

Our Allied Health professional (AHP) council are very much part of our research cultural shift and want to increase their participation in delivering and developing research. We have a trailblazing paramedic colleague working in our local ambulance service already doing primary research. He is the first paramedic in the country to be awarded a prestigious Advanced Clinical and Practitioner Academic Fellowship (ACAF). We have recently launched our (Council) Community for Allied Health Professionals in Research (CAHPR) hub and have growing community of research aware, interested and active (and engaged) non-medical clinicians creating a diverse, multi-professional research workforce within the county.

We now have a medical school and are working closely with the University of Lincoln to coordinate the research activity in our ICS. We have a national exemplar site, the Institute of Rural and Coastal health, which directly addresses one of the key challenges we face which is health inequalities in those areas of our county.

We have a formal Memorandum of Understanding (MOU) with the University and supported the successful E3 bid for the University of Lincoln to establish England's first integrated/ transdisciplinary research centre for Coastal and Rural Health Research. This centre will tackle serious and urgent geographical inequities impacting on physical, mental, social, and economic health and wellbeing. A national powerhouse will be created to generate critical intelligence and tested solutions for implementation. The centre will build on the excellence and demonstrated success of the Lincoln International Institute for Rural Health (LIIRH) through synergised and scaled up connections with Lincoln's Community and Health Research Unit (CaHRU), and the Development, Inequality, Resilience and Environments (DIRE) group from the Department of Geography. This is part of the strategy to significantly increase our research capacity.

Additional initiatives are for another bid for Health Determinants Research Collaborations led by our Director of Public Health.

Medicines Optimisation Team

The ICB Medicines Optimisation (MO) Team, like most teams within the NHS, has experienced a challenging and constantly changing health landscape over the last few years.

Over the past 12 months, the Lincolnshire Medicines Optimisation (MO) team has achieved significant milestones, reflecting the dedication to enhancing healthcare practices and patient outcomes in Lincolnshire. A few of the key successes include answering 300 clinical queries from general practice staff and associated organisations and the launch of an Opioid toolkit aimed at patients and professionals called 'Pain Star', which facilitated a reduction in the prescribing spend in Lincolnshire.

There has also been a significant amount of collaborative work across the year including working with the acute trust to publish various shared care agreements and guidelines. Collaboration with the national NHS England Team enabled the successful delivery of Antimicrobial TARGET training, and the prescribing of shorter, 5-day course antibiotics over 7-day courses has increased since the training improving Anti-Microbial Resistance within Lincolnshire ICS. The MO team worked with primary care team to improve access and capacity within general practices by working with community pharmacy contractors to roll out Pharmacy First Service across Lincolnshire with 100% of pharmacies providing face-to-face services signed up.

The Lincolnshire MO team has developed a work plan for 2024/25 that should deliver similar cost efficiencies to 2023/24 as well as improving prescribing in priority areas such as antimicrobial stewardship, diabetes and reducing the carbon impact of inhaler use in Lincolnshire, along with work transitioning Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) into an Area Prescribing Committee (APC).

Over the past 12 months, the MO Team has achieved significant milestones, reflecting the dedication to enhancing healthcare practices and patient outcomes in Lincolnshire. A few of the key successes include answering 300 plus clinical queries from General Practice staff and associated organisations and the launch of an Opioid toolkit aimed at patients and professionals called 'Pain Star'. Medicines Optimisation work achieved a reduction in the prescribing spend in Lincolnshire in 2023/24.

In November 2023, our cancer team attended the Lincolnshire Sport & Physical Activity Awards 2023, along with representatives from the Lincoln City Football Club Foundation, having been jointly nominated for efforts delivering the Fighting Fit Programme. The programme supports people living with or recovering from cancer in Lincolnshire and the team emerged as the winners and were honoured to receive the Impact on Health Award.

Nursing Times Award

The NHS in Lincolnshire was shortlisted last October for a prestigious Nursing Times Award for its collaborative work to redesign and improve healthcare for heart failure patients in the county. LCHS, ULHT and the ICB were jointly shortlisted for the HRH The Prince of Wales Award for Integrated Approaches to Care, and the work undertaken included a significant contribution from primary care partners in the county. The organisations worked collaboratively, making a massive impact on the healthcare of heart failure patients across Lincolnshire, part of which included setting up a direct admissions pathway for patients requiring hospitalisation.

Lincolnshire Military Maternity Project

In September 2023, the ICB was delighted that the NHS Lincolnshire Military Maternity Project was shortlisted for a highly coveted Health Service Journal Award in the Military and Civilian Health Partnership category. The project stood out as a real success story and was one of 223 projects and individuals to be shortlisted from more than 1,400 original entries. The NHS Lincolnshire Military Maternity Project launched in July 2022 and is the first of its kind in the country, representing a significant step forwards in addressing the unique needs of military families, especially the difficulties they can face accessing care and navigating the healthcare system, due to the demands of military life, postings and separations from loved ones.

Defence Employer Recognition Scheme

On a military-related theme, in August 2023, the ICB was awarded the Defence Employer Recognition Scheme silver award, in recognition of its support to defence and for the Armed Forces Community in Lincolnshire. Having previously been awarded the bronze award and also having signed up to the Armed Forces Covenant, the silver award represents a step up in the ICB's commitments, including that it is proactively supporting those who are serving or have served, as well as other members of the Armed Forces community, to work for the local NHS.

75th Birthday of the NHS

In July 2023, it was the turn of the ICB to bestow an award. Earlier in the year it launched a birthday card competition across all primary schools in Lincolnshire, asking them to design a card to celebrate the 75th birthday of the NHS. Emily Richardson, a pupil from the Ellison Boulters CofE Academy was the winner and won herself and her class a trip to the tri-services centre in Lincoln, which is the home to police, ambulance, fire and rescue.

Cancer Team

The ICB's Cancer Team was recognised on more than one occasion in the last year, joining over 200 volunteers from Boston Borough for a 5K Your Way Move Against Cancer group event at Boston Stump, all of who accepted an invitation from the Mayor of Boston, Cllr Anne Dorrian, to celebrate and recognise their contributions to the local community.

GP Practices

We are extremely proud of our GP practices, particularly to be able to recognise and celebrate their achievements through our General Practice Nursing and HCA Awards, which honour healthcare staff from across Lincolnshire. Held in April 2023, last year's awards recognised innovation, the Registered Professional of the Year, the NAA/HCA of the Year, Outstanding Contribution to Education, the Team of the Year, and the Patients' Choice Award, all of which demonstrated the dedication and commitment to delivering outstanding care that makes a huge difference to the communities they serve.

Sexual safety in healthcare – organisational charter

The ICB Board at its meeting held in November 2023 considered the *NHS England sexual safety in healthcare-organisational charter.* Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. The ICB Board confirmed its endorsement and sign up to the sexual safety charter and the the ten pledges and who has signed up can be found here:

https://www.england.nhs.uk/long-read/sexual-safety-in-healthcare-organisational-charter/#organisations-that-have-signed-the-charter

Primary Care, Communities and Social Value

The key ambitions of the Primary Care, Communities and Social Value Directorate are to:

Improve access to integrated primary care, by creating new and innovative models of care which will deliver the ambitions for improved access detailed within the 'Delivery plan for recovering access to primary care', improve quality of patient experience and outcome, and create enhanced resilience of services and workforce. Transforming for tomorrow whilst delivering today.

In partnership with PCNs, develop integrated community-based, multi-professional and multi -agency teams with a view to delivering person-centred care, targeted to meet the identified need of local communities.

To implement integrated pathways of care for patients with long-term conditions including children and young people, people with mental health conditions and those with long-term conditions including frailty and, people at the end of their lives to support proactive identification, early intervention, personalised care planning and seamless management of deterioration.

Key to achieving these ambitions is integration across service and organisational boundaries, working in partnership with our staff, patients and the public to co-design pathways of care and to drive up experience and outcomes, adopting an approach of continuous improvement and learning and maximising the benefit of our investments to ensure we gain greatest impact.

Over the last year the ICB, together with colleagues from across primary care, has supported developments to provide improved access to healthcare services, promote continuity of care for people with longer-term needs and increase proactive and preventative interventions that enables people to stay healthy.

Primary Care Network (PCN)

The 81 GP practices in Lincolnshire work together as 14 Primary Care Networks (PCN). PCNs build on existing primary care services by working together with community partners to provide greater provision of proactive, personalised, co-ordinated and integrated care. Across Lincolnshire, PCNs are engaged in a number of different projects including development of services for people with long-term conditions such as diabetes and heart disease, older people, high intensity users and people suffering with mental health issues. PCNs are central to supporting population health management and are continuing to develop to ensure they can support the change in communities from reactively providing appointments to treat illness, to proactively caring for the people and the communities they serve. PCNs continue to play a crucial role in vaccination programmes across Lincolnshire, delivering 72% of all Covid-19 vaccinations across the Spring and Autumn campaigns. The ICB will work closely with PCNs to develop vaccination services across Lincolnshire as we look to deliver the ambitious targets set out in the Lincolnshire Vaccination Strategy.

The ICB team has been working with PCNs to support PCN Development. A Development Programme has been commissioned and available to all PCN managers in 2023/24 with uptake from all PCN managers who were in post at the start of the programme. An induction pack has been created for new PCN managers and is available for use as an aide memoir.

Primary Care Access and Recovery Plan

The Primary Care Access Recovery Plan (also known as the Delivery Plan for Recovering Access to Primary Care) was published in May 2023 and sets out an ambitious package of measures to tackle the "8am rush" for patients to contact their GP practice for an appointment and help improve satisfaction with access to their GP practice.

The national plan covers four key areas:

1. Empowering patients to manage their own health
2. Implementing Modern General Practice Access
3. Building Capacity
4. Cutting bureaucracy

ICBs were required to develop Primary Care System Level Access Improvement Plans (SLAIP) describing how the national plan would be delivered locally - the Lincolnshire plan was approved by the ICB Board on 27th November 2023, noting that the plan would be developed further over time.

Empowering patients

People can refer themselves into a range of community services in Lincolnshire and don't need to ask their GP practice to refer them: this includes podiatry, weight loss services, community equipment services and falls services. Work on self-referrals has progressed well over the year with an initial focus on making sure data is available to understand how many people are self-referring and to what services. Another area for development has been exploring self-referral for community physiotherapy services. There is ongoing improvement and an overall increase in the number of self-referrals for priority self-referral pathways. The next focus is on improving awareness of self-referral amongst the public and health and care services.

The Pharmacy First service launched on 31 January 2024 – this means people can receive treatment for a range of common conditions without the need for the patient to see a GP e.g. shingles, acute ear ache and sore throats. This aims to improve access to care for patients and to help GP practices reduce demand for conditions where treatment can be provided by a pharmacy. There has been good progress with pharmacy engagement in Lincolnshire with nearly all pharmacies currently signed up to deliver the service. Work is underway with GP practices and pharmacies to put systems in place and support referral pathways and communication between pharmacies and GP practices. The ICB is working with GP practices and pharmacies to promote the service using national communication resources and developing local ones.

An area for further improvement is making records accessible to patients, and the ICB continues to work with GP practices and NHS England to support this to happen and to increase the number of patients who can access their care record if they wish to.

Implementing Modern GP practice access

GP practices and Primary Care Networks have continued to work incredibly hard to improve access for patients – around 5.3 million GP appointments were provided in Lincolnshire in the 12 months up to January 2024, an increase of 9% from July 2022 – the highest in the Midlands region.

There has been good progress on supporting GP practices to move to digital telephone systems. All GP practices in Lincolnshire will be moving to a digital telephone system by April 2024. In addition, there will also be support for practices to move towards a digital system by April 2024 alongside supporting practices who already have digital phone systems to have access to the full range of functionality e.g. call-back, which means patients calling can request to be called back by the practices and don't need to wait on the phone.

Online consultation systems are available to all GP practices in Lincolnshire and mean patients can communicate with their practice online e.g. contacting their practices, booking appointments or ordering repeat prescriptions – the ICB is supporting practices to make best use of these systems with training and support on system optimisation available. The ICB is also working with Lincolnshire County Council on digital inclusion to support patients using online opportunities, e.g., working with Patient Participation Groups to support and assist other patients to learn about using online tools such as askmyGP.

The ICB Primary Care and Quality Teams are supporting GP practices to review how they can improve access and services using the national Support Level Framework (SLF) diagnostic tool – this uses a questionnaire with follow-up conversations to identify areas of good practice and areas to be developed. Practice visits to underpin the approach began in January, the plan is on track for 25% of practices to complete the SLF in 2023/24 and the remainder in 2024/25. Funding is available for practices to move to modern GP access approaches – around £680,000 of access transformation funding has been agreed by the ICB to support practices so far with further funding available into 2024/25.

Building capacity

Staff numbers in GP practices are increasing – there are 18% more full time equivalent posts in GP practices now when compared to 2019. The main increases in staff numbers relate to Primary Care Network additional roles e.g. clinical pharmacists, physiotherapists, mental health practitioners and social prescribers. There has been a reduction in the number of GP partners, but this is offset by more trainee and salaried GP posts.

Work with Primary Care Networks (PCN) to make use of Additional Roles funding to expand the primary care workforce has progressed over 2023/24. Lincolnshire had a target of having 329.50 WTE Additional Roles Reimbursement Scheme (ARRS) staff in post by March 2023. This has been exceeded as there are now 503.82 WTE staff in post. Lincolnshire has had particular success with the recruitment of General Practice Assistants which has been supported through close working with the Lincolnshire Training Hub to create an apprenticeship scheme that has already had two cohorts of staff enrol. Lincolnshire has the highest number of ARRS Trainee Nurse Associates and Nurse Associates in the Midlands region. Again, this is in part due to successful collaboration with the Lincolnshire Training Hub. Work is ongoing with the PCN Alliance to support PCNs to make best use of the additional roles funding available to them into 2024/25.

Cutting bureaucracy

The key work for the ICB is improving the interface between primary and secondary care services. Meetings have been organised by the ICB's Care and Clinical Directorate to identify and address quality and operational interface issues and involve clinical leaders from across the Lincolnshire system. Work is ongoing to develop a behavioural concordat setting out how organisations can best work together alongside work on improving processes for patients to receive fit notes where required. Dr Colin Farquharson, Medical Director at ULHT is one of two clinical representatives for the Midlands region at the national NHS England interface forum.

Primary Care People Group

The Primary Care People Group (PCPG) was established in February 2022 to bring together key stakeholders from across the county to agree a strategic Primary Care People Plan which emulates the national priorities set out in the NHS Long Term Workforce Plan 2023 – Train, Retain & Reform.

Now in its second year, the Primary Care People Plan has been refreshed to reflect contemporary people issues across all four pillars of primary care (GP, Community Pharmacy, Dental and Primary Opthalmic Services) and an additional priority added following improved engagement – 'to invest in primary care, demonstrating the value of our people and the service they deliver'. The plan also demonstrates Year-1 achievements by working collaboratively e.g. Additional Roles Reimbursement Scheme (ARRS) increased funding utilisation; expansion of GP Fellowships and champion roles; increased communication & engagement activities; and co-ordinated recruitment and training of new roles e.g. General Practice Assistants. By developing a Primary Care People Plan we better understand our challenges and how we can work collectively as primary care providers within the wider health & care system to 'Build Capability & Capacity for today and the future'.

Primary Care Estates

The ICB has an established Primary Care Estates Group which supports the routine governance arrangements for reimbursed general practice estate.

The Group supports the resilience and development of primary care estate, including oversight and governance in relation to the NHS General Medical Services - Premises Costs Directions. The Group has supported the development of a number of business cases, including the approval and opening of a new branch site for Beechfield Medical Centre in Spalding during 2023/24 and they are continuing to progress the planned relocation of Glebe Park Surgery in Lincoln and Spilsby Surgery.

The team is working together with colleagues to develop a proposal to build a new, purpose-built Integrated Health and Care Centre (IHCC) in Boston town centre. This is being developed in the form of an outline business case. The project team in the ICB is working in collaboration with Boston Borough Council (BBC) and others. The key aim is to provide a well-designed multi-service facility, primarily focusing on primary and community placed based, proactive, preventative care; whilst recognising the health needs of local people and addressing inequalities.

The Group also has oversight of plans for use of Section 106 funding within general practice. Section 106 of the Town and Country Planning Act 1990 allows local authorities to enter into a legal arrangement with a developer to ensure that appropriate funding is available to mitigate any impacts arising from housing development on health infrastructure. The ICB applies for funding on behalf of general practice and works with practices to ensure they utilise funds when they become available. The ICB continues to support a number of practices across the county to develop plans to improve and expand their sites with the available funding.

The ICB also successfully applied for NHS England capital funding to support improvement works for seven practices in the county, with funding being utilised in 2022/23 and 2023/24 to support improvements to the GP premises to expand clinical capacity.

As part of the Lincolnshire System Infrastructure Investment Group, Primary Care estate is a key part of the Infrastructure Framework that has been under development. This links to the Primary Care Network Estates Strategies that are currently under development. Lincolnshire ICS has developed a strategic framework which articulates the high-level programme case for the significant investment that is needed and without which our clinical vision and strategies will not be delivered.

It is an iterative framework that will enable each Trust and PCN to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs across Lincolnshire.

The framework takes account of the need to transform and integrate services, and ensuring that we have a population, place-based needs approach aligning to our digital strategies and the rural and coastal challenges that we have.

Primary Care Delegation

With effect from 1st April 2023, NHS Lincolnshire ICB took on delegated responsibility from NHS England for the commissioning of Primary Care Pharmaceutical Services, Primary Ophthalmic Services and Primary and Community Dental Services. This is in addition to GP services which are already delegated to the ICB.

This means that all primary care commissioning is now the responsibility of the ICB. This is a key enabler to our ambitions to better support integrated care and improved population health by joining up care pathways in order to plan and deliver better health and care for local populations.

Dental Services

As referred to on the previous page, from the 1st April 2023 the ICB took over delegated responsibility for commissioning dental services from NHSE, whilst responsibility for oral health improvement remains with local authorities. To support this transition, a dental strategy for Lincolnshire was created to provide a framework for the ICB and its partners to support action over the next three years, aimed at improving oral health and dental services through a 'whole system' approach.

Stakeholders involved in the development of this strategy agreed on a bold vision of creating oral health and dental services which promote the prevention of dental diseases and meet the needs of the people of Lincolnshire now and in the future. Through a series of workshops, four key themes for the strategy were agreed:

- Developing the Dental Workforce
- Improving Access to Dental Services
- Increasing the Focus on Prevention
- Strengthening the Integration of Oral Health into Wider Health and Care Services

Three cross-cutting themes were also agreed:

- the need to address health inequalities as the golden thread running across all pillars of our strategy, drawing on the CORE20PLUS5 inequalities framework for adults, and children and young people
- maximising the use of evidence, data, and intelligence to improve oral health
- enhancing leadership and creating an environment that fosters developing the culture of pride and accomplishment within and across all members of dental teams across Lincolnshire.

All of this sits under one overarching principle, that patients and the Lincolnshire public are at the heart of everything we do.

Community Pharmacy

Building on the dental strategy, the ICB will now progress the development of a community pharmacy strategy, in partnership with the local authority and Community Pharmacy Lincolnshire, to develop community pharmacy within Lincolnshire. This will endeavour to support resilience, improve access for patients and to improve integration with general practice.

Community pharmacy services have seen significant development during 2023/24, with the Pharmacy First service launched nationally on 31 January 2024, which adds to the existing pharmacy consultation service and enables community pharmacies to complete episodes of care for seven common conditions following defined clinical pathways. This supports additional access for patients, enabling patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply. In May 2023, NHS England and the Department of Health and Social Care announced a two-year delivery plan for recovering access to primary care. Part of the plan includes enabling patients to get certain prescription medications directly from a pharmacy, without a GP appointment.

Frailty Strategy

System partners from across primary care, health, social care and third sector came together with patients, families and members of the public to co-produce the Lincolnshire Older Person's Strategy, with a view to transforming the care delivered to patients with Frailty and those at risk of becoming Frail. The ambitions contained within the five-year strategy are based upon both local experiences and best practice from elsewhere.

Advances in health care have led to people living for longer than before. However, this does not always result in extra years in good health. Older people can develop multiple age-related, long-term conditions that can impact on their well-being and independence as they age. Frailty is a long-term condition where a person has reduced overall resilience and physiological reserves. This means even a minor illness can result in a rapid decline in function and health. Nationally, around 5 – 10% of people attending Accident and Emergency Departments are older and living with frailty, leading to more than 4,000 admissions daily. When they are admitted to hospital, they are at risk of a longer length of stay and the associated risks of harm, including increasing immobility, declining function and reducing independence. Frailty is not an inevitable part of aging and can be identified early.

The Lincolnshire strategy commits partner agencies to work together to integrate services for older people with a view to improving outcomes and experience. The delivery model focuses upon the following key areas:

Proactive care supporting all older people to access advice, guidance and a personalised range of services which will enhance their ability to live well, age well and remain as emotional and physically healthy as possible.

Primary care is the corner stone of proactive identification of frailty. Care will be delivered by integrated community and primary care multidisciplinary teams using evidence-based tools and assessments including the Comprehensive Geriatric Assessment. People with frailty will have access to a staff member skilled in case coordination who will manage their personalised care plan including advanced care plans. Where our population health needs and inequalities indicate it is required, such as in care homes, in some geographical locations and for specific population segments, additional support will be made available.

People living with frailty who are becoming more unwell benefit from a coordinated specialist review and assessment. Evidence shows they are less likely to be admitted to hospital or a care home for six months after having one. Assessment will be accessed through a clinically navigated **single point of access**, available 24/7. The team will ensure the referring clinician is not required to make multiple calls to gain support for a frail patient.

Specialist care for people living with frailty will be delivered by an **integrated workforce** who work across organisations, as a single team with a shared vision and values, working to an agreed set of professional standards and competencies.

Delivery of the strategy has begun in earnest, supported by the implementation of system wide governance arrangements, co-designed delivery plans and system wide communication and engagement with relevant teams. To date four Primary Care Networks have successfully applied to become early adopters and to pilot the agreed primary care interventions, 25 Frailty virtual ward beds have opened, and Frailty Same Day Assessment Centres are open five days a week at Lincoln County Hospital and Boston Hospital Pilgrim. Plans are in place to create community hubs across the county enabling all older people to access comprehensive, specialist, integrated and timely care closer to their home.

Long Term Conditions

Our Long Term Conditions programme has prioritised CVD, Diabetes and Respiratory transformation aligned to the Major Conditions Framework.

As part of our Cardiovascular programme we have continued to deliver our new model of integrated care in heart failure extending the access to specialist multi-displinary team reviews based in primary care out to our coastal community as part of a programme targeting health inequalities. The team won the Clinical Improvement: Long Term Conditions award at the General Practice awards (for vMDT pathway and implementation in Heart Failure). Our plan is to build on the success of the last year to extend access to MDTs. This will be enabled by further developing the virtual platform to provide a wider model for general long-term condition management. We have established an integrated lipid management service to support ULHT to reduce the waiting lists for patients and support primary care through education, risk stratification and active case load management.

There has been a significant focus on prevention in diabetes with the implementation of the Type 2 day service targeting patients under 40, the type 2 remission service from April 24 and the procurement of the diabetes prevention programme. We have also developed plans of new technologies such as hybrid closed loop and have held two transformational workshops, the work of which will continue through 2024 with the same aims of the respiratory pathways which is to build integrated models of care.

Palliative and end of life care

Since we published our new Palliative and End of Life service operating model and transformation plan in July 2022, we have continued to work collaboratively to implement change. Notably strengthening our 24/7 response arrangement with the expansion of a palliative Single Point of Access (SPA) and consolidating and integrating our night care through Marie Curie Rapid Response. In addition, we have improved access to Homecare (fast track CHC) packages of care with providers in place to cover different areas of the county. Plans are ongoing to fully implement the Lincolnshire-wide Palliative and End of Life integrated care model. Aligned to this, the Children and Young People (CYP) Team are strengthening the pathways for babies, children and young people who require palliative and end of life care and we have developed really really strong working relationships with children's hospices (Rainbows in Loughborough and Andy's in Grimsby) and helping to enhance the links between hospices and our local services.

Environmental Matters

Greener NHS Plan

With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play.

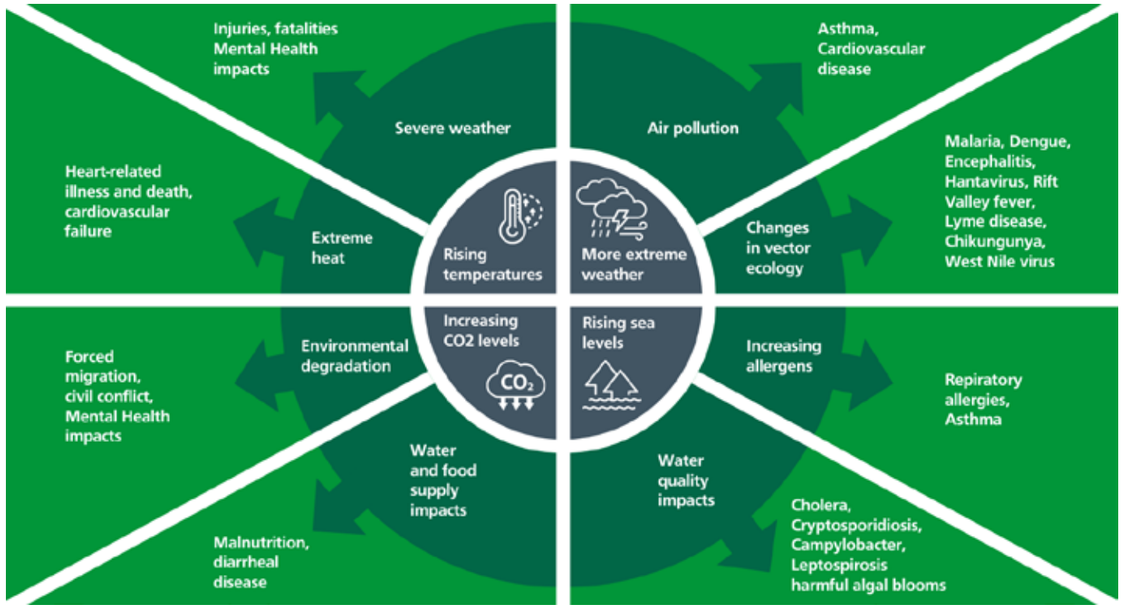
Two clear and feasible targets are outlined in the Delivering a 'Net Zero' National Health Service report:

- The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

Laid out in the NHS Long Term Plan, these extended sustainability commitments range from reducing single-use plastics and water consumption, through to improving air quality.

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

The UKHSA published its Health Effects of Climate Change report, State of Readiness report in 2023 with the apt acronym of HECC. It is an important overview of exactly how climate change is affecting health, and the extent to which it will do so in the future. Climate change affects most health determinants directly or indirectly by influencing the weather conditions we experience on a day-to-day basis. Climate change can increase risks to health directly through greater severity and frequency of extreme weather events such as flooding, drought, heatwaves or wildfires



Lincolnshire has suffered flooding events during a number of storms this year which has impacted on the delivery of services. This is a live example of climate change which was managed through the EPRR Team (as referenced earlier in this report).

The NHS net zero supplier roadmap , was published in October 2023. It sets out the steps suppliers must take to align with the NHS net zero ambition through to 2030. The purpose of this guidance is to provide further details on the implementation of the following milestones in the roadmap ('CRP and Net Zero Commitment Policy'):

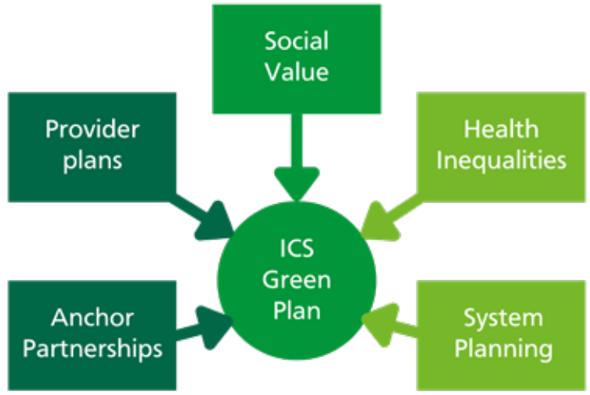
From April 2023: For all new contracts above £5 million per annum, the NHS requires suppliers to publish a Carbon Reduction Plan for their UK Scope 1 and 2 emissions and a subset of scope 3 emissions as a minimum (aligning with PPN 06/21).

From April 2024: The NHS will proportionately extend the Carbon Reduction Plan requirements to cover all new procurements.

The NHS Net Zero Building Standard, published on 22nd February 2023, provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future. Developed together with healthcare, industry, and sustainability partners, the Standard will support the NHS to get ready for and align with UK Government building requirements, as well as meet its commitments to deliver a net zero health service by 2045. This guidance is being followed in the development of business cases such as the Integrated Health and Care Centre in Boston.

The Lincolnshire system has established a Greener NHS Plan which outlines how we will reduce our environmental impact whilst improving health outcomes across Lincolnshire. The system is best-placed to achieve this, as the wellbeing of the populations that we serve is tied to the existence of our anchor organisations. This plan can achieve this twofold task, as many of the actions needed to reduce our carbon footprint have additional benefits for health. For example, the reduction of air pollution can decrease incidence of COPD. By reducing our system carbon footprint, we can improve the environment at the regional scale and therefore extend these additional health benefits across Lincolnshire.

The Lincolnshire approach is as follows:



Delivery of the Green Plan is overseen by the ICB, and monitored through the System Greener NHS Group, which includes representatives from across the ICB, and the provider Trusts and is reviewed internally on an annual basis. Links are maintained with local county council and district council colleagues.

The Lincolnshire SIRO is Mrs Sarah Connery, Chief Executive, LPFT who sits on the ICB Board. Mrs Connery is supported by Mrs Jacqui Bunce, Programme Director – Strategic Partnerships, Planning & Estate

The Lincolnshire System Greener Plan can be found on the ICB website. Areas of work are highlighted in the table below:

	• Work to deliver the NHSE Travel and Transport Strategy recognising the challenges in a rural and coastal county • NHS England Net Zero Travel and Transport Strategy • Working with District and County Council colleagues on EV charging
CO_2	• We have reduced the proportion of desflurane anaesthesia gas used in surgery to less than 5% of overall volatile anaesthetic gasses with the aim to eradicate this completely. • Reducing the emissions associated with nitrous oxide waste in line with the Standard Contract • Reducing the CO2e impact of inhalers - this is part of the Primary Care Green Plan
	• Ensure plans are in place to phase out fuel oil as a primary heat source (in NHS Secondary Care sites). • Ensure all new builds and retrofits over £15m are compliant with the Net Zero Hospital Buildings Standards. • ULHT and LPFT have bid for Public Sector Decarbonisation Scheme (PSDS) funding to improve the estate and reduce the trusts' carbon footprints.
	• Ensuring that the Green Agenda is incorporated into all staff inductions across the system. • Work towards all staff complete the ESR training. • As the system leadership changes are embedded and the Group Model established, agree the Board leadership for the Green Agenda and appropriate awareness and training for Boards.
	• All new NHS procurements include a minimum 10% net zero and social value weighting as per the PPN06/20 and PPN06/21 Greener NHS - Applying Net Zero and Social Value in the Procurement of NHS Goods and Services (england.nhs.uk) • Achieve a 50% reduction in use of office paper by 2025 compare to baseline, and ensuring ICSs and NHS trusts only purchase 100% recycled content paper for all office and non-office based functions by 2025.

A Primary Care Green Plan has been developed and shared. It is based on a Ten Point plan:

1. Declare a Practice Climate and Nature Crisis
2. Optimise inhalers
3. Calculate the Practice's carbon footprint
4. Monitor and reduce your practice's energy
5. Consider switching your business banking provider to a green bank
6. Environmental prescribing and treatment
7. Engage, educate, and empower patients to take individual action on the climate crisis for the benefit of their health
8. Promote active transport for both staff and patients
9. Embed the '3 Rs' into Practice culture
10. Use the Green Impact for Health Toolkit

Key achievements to report:

- The ICB moved out of Cross O'Cliff Court, Lincoln in July 2023, which reduced its carbon-footprint
- The system is reassessing its carbon footprint to understand the progress that has been made
- ICB Staff can now lease Electric Vehicles and Ultra Low Electric Vehicles through the Lease Car Scheme

The agile working policy supports the reduction in ICB travel mileage along the continued use of digital platforms for meetings where appropriate.

Information on the ICB's use of energy and water is in the table opposite for the period 1 April 2023 to 31st March 2024.

	Bridge House, Sleaford	Cross O'Cliff, Lincoln
	£	£
Utilities - Gas	N/A	26,454
Utilities - Electricity	11,576	19,203
Water	1,624	438
Total spend	13,200	46,095

Improvements in Quality

Quality Governance

The ICB has a duty under Section 14Z34 of the Health and Social Care Act 2022 to improve the quality of services and to ensure patient safety and positive patient experience. The National Quality Board also published in 2021 a revised Shared Commitment to Quality which also emphasises the requirement for Integrated Care Systems to deliver safe, effective, positive experience care together with services that are well led, sustainably resourced and equitable.

To aid achievement of these duties the Integrated Care Board has established the System Quality and Patient Experience Committee (SQPEC) which maintains oversight of the quality functions and responsibilities of the ICB.

The Committee meets bi-monthly, is Chaired by, the ICB Non-Executive Director with responsibility for Quality, and is attended by the ICB Medical Director and the ICB Director of Nursing, three Non-Executives who lead on quality from the ICB's main provider organisations in Lincolnshire, along with their respective quality leads and also representatives from Public Health and Healthwatch.

Supporting SQPEC is the Integrated Care System Quality Group (SQG) which establishes the escalated areas of system partner concern pertaining to Quality and the actions being taken to address identified concerns with subsequent escalation to the ICB QPEC for awareness and to provide assurance on the mitigating actions. The main purpose of the SQG is to ensure this quality concern escalation and to ensure quality improvement support is given from relevant system partners as needed and also for assurance to all the organisation Quality Leads represented, that required improvement actions are being addressed effectively either by individual organisations or collaboratively where necessary.

In support of SQPEC and SQG the ICB has established two quality oversight groups for all providers - one for Primary Care providers , and one for all other provider types. In addition, ICB Quality Team staff members who support the Quality functions of the ICB are aligned with all providers across primary and secondary care. These officers also attend provider local quality committees or meet regularly with their allocated providers so are aware of and able to support with any areas of quality concern.

The work of the ICB Quality Team members is aided by intelligence gathered about quality from wide-ranging and established processes, for example, via incident and serious incident reporting from providers; quality dashboards; complaints received; information provided by Healthwatch and other patient voice avenues; from regulators and health and care education and through many other sources.

Some of our providers are under an enhanced level of surveillance and support from the ICB and other partners because of previous regulator and/or ICB performance and quality concerns. For these providers the ICB Quality Leads attend dedicated Quality Review Meetings with the provider at a frequency indicated by the level of concern. The leads also undertake where relevant quality visits to seek assurance on actions or any other quality/safety concerns. Direct support is given to the organisation where required to facilitate quality improvement.

Quality Priorities

The System Quality Group has identified several theme areas which have required ongoing system focus for quality improvement in 2023/2024:

- Right place, right care, right time for care within Urgent and Emergency Care (UEC) with a need to maintain focus on patient access to services, care closer to home, reducing unnecessary hospital attendance and admission and long lengths of stay in hospital post-admission.
- Reducing care treatment delays within both unplanned and planned care pathways within tertiary, secondary and community care services for both adults and children. Where necessary ensuring robust harm review processes for patients waiting a long time for treatment
- Palliative and end of life care (PEOL) including continued work to improve advanced care planning plus Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) discussions and documentation.
- Health Protection – with a continued focus on infection prevention and control in light of Covid-19 and an increased prevalence of other infections/ viruses e.g. measles
- Ongoing work to reduce the incidence of pressure ulcers through a system improvement group established to collectively progress this work.
- Ongoing work to improve Falls prevention and response through the leadership of the system Falls Steering Group
- Continued workforce challenges across many services, requiring a constant focus on staff health and wellbeing, plus recruitment and retention initiatives.

Further information on these theme areas is highlighted in this report.

Tissue Viability

Pressure damage is the highest reported Serious Incident theme in Lincolnshire, often affecting patients and people in receipt of care in a variety of settings including hospitals, care homes and domiciliary care. Over the last year a number of pieces of national guidance have been published including the National Woundcare Strategy Programme Pressure Ulcer Recommendations and Clinical Pathway (Oct, 2023) and the Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern guidance (DHSC, March 2024).

The Lincolnshire ICS Tissue Viability and Pressure Ulcer Prevention Quality Improvement programme has been established to deliver a programme of work that will focus on reducing the incidence of pressure damage occurring, reduce variations in practice, promote effective and efficient use of resources, and improve outcomes for patients. The programme of work, which is sponsored by the ICS Quality Group and due to run over the next four years is also responsible for delivering the Lincolnshire Safeguarding Adult Board 2022-2025 prevention priority 'preventing and or limiting the impact of pressure sores (across NHS and independent sector providers)'.

The programme has six main workstreams, each led by representatives from across the ICS partner organisations. Co-production with patients and their carers is fundamental to the programme and stakeholder (staff) and public surveys undertaken in 2023/24 have identified a number of individuals who are willing to work with the programme.

The data and intelligence workstream will be developing ways of measuring the impact of the programme, in particular improvement in outcomes for patients.

Maternity and Neonatal Services

The Lincolnshire Local Maternity and Neonatal Service network (LMNS) is well established and continues to proactively work with system partners to drive forward improvements for Lincolnshire families. LMNS has a robust governance structure to ensure oversight and assurance of the quality, safety and transformation of local maternity and neonatal provision within Lincolnshire Integrated Care Board.

Some of the key work and successes this year are described below:

- In June 2023 there was a very positive Ockenden Insight Assurance visit to to ULHT facilitated by the LMNS to review implementation of two important National Review Recommendations i.e. the Ockenden Review 15 improvement Essential Actions and the East Kent Review recommendations
- The Three Year Delivery Plan for Maternity and Neonatal Services issued in March 2023 is underway and the ICB and Trust are working collaboratively to ensure that ambitions are planned and met. This is inclusive of the local Maternity & Neonatal Voices Partnership.
- Following the publication of the CNST Year 5 (Clinical Negligence Scheme for Trusts – where there are 10 Safety Actions to adhere to and show evidence for) and Saving Babies Lives Version Three, there has been an enormous amount of work by ULHT and ICB colleagues dedicated to reaching compliance for both in 2023/24.
- ULHT has now been successful in procurement of a new maternity digital system – 'Badgernet'. The roll out and full implementation will take place during 2024/25 with plans now in place with regard to staff training and additional digital midwives to support this process.
- An Equity and Equality Strategy has been created post several local engagement events to reduce health inequalities and improve outcomes for families within Lincolnshire. This is aided by an action plan developed to support delivery of the ambitions linked with the 3 Year Delivery Plan.
- A military project is successfully implemented in Lincolnshire with positive outcomes for military families before during and after pregnancy. This military project initiated in Lincolnshire has been showcased nationally, received national awards this year and is set to expand further across England.

Patient Safety

There has been continued commitment by the ICB, and providers of healthcare to Lincolnshire patients, to work as an ICS to review adverse incidents and serious incidents focusing on identifying and sharing learning, with a view to implementing sustained improvement in the care we commission and deliver. This work has provided the foundation for the implementation of the Patient Safety Incident Response Framework (PSIRF) published by NHS England in August 2022.

PSIRF defines the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents, for the purpose of learning and improving patient safety; and represents significant transformational change.

Within Lincolnshire a collaborative approach has been taken to the implementation of PSIRF. The ICB developed a Lincolnshire-wide PSIRF Implementation Group with active engagement from key healthcare providers who are headquartered within the NHS Lincolnshire ICB footprint. Membership is also extended to key stakeholders including (but not limited to) the Local Maternity and Neonatal System (LMNS); Coroners and Healthwatch.

The meeting provides support to those organisations, within the NHS Lincolnshire boundary, who are implementing PSRIF; to identify areas of good practice/learning and potential joint working and to identify any system risks associated with the delivery of PSIRF. Representatives from the ICB are also actively engaged with and attending the healthcare provider organisational PSIRF meetings.

Through the involvement in the above, the ICB has been able to work with providers in the development and sign off of the Provider Patient Safety Incident Response Policies and Plans, oversee and support effectiveness of systems to achieve improvement following patient safety incidents, support co-ordination of cross system learning responses and share insights and information across organisation/services to improve patient safety.

Learning from Patient Safety Events

The past year has also seen the implementation of the national mandated Learning from Patient Safety Events across the ICB footprint. This electronic system enables providers of healthcare to share information on learning events at an organisational, ICB and national level to further enhance patient safety.

Larger healthcare organisations are able to link their in-house patient safety and risk management systems to the national electronic system thereby enabling a seamless transfer of this important information in real time.

The system went live in December 2023 and is being further developed over the coming year by the national patient safety team to increase its functionality, the ICB is very keen to utilise this increased capability.

All Age Continuing Care

The ICB All Age Continuing Care Service has continued to maintain good performance on Continuing Healthcare (CHC) eligibility decisions being made within 28 days. There is also robust performance on Discharge to Assess for patients requiring CHC on hospital discharge, with the team joining daily discharge meetings now as business as usual, to ensure any CHC service blocks are addressed for patients. There have been continued workforce challenges in the team due to illness and vacancies, which has required the team to restructure and work differently. An ongoing consequence of this has been a backlog position with annual reviews. To address this there has been ongoing utilisation of an external provider to address priority reviews and thereby ensure for the CHC team an acceptable trajectory for clearance of any outstanding reviews and workload management. The service has also achieved annual NHS targets set for numbers of Personal Health Budgets in place.

Care Homes

Through the Enhanced Health in Care Homes programme the ICB continued to work with the Local Authority, Lincolnshire Care Association (LINCA), Primary Care Networks (PCN) and all other relevant system partners to ensure a network of support is available for care homes and domiciliary care providers. ICB Safeguarding Leads also continue with their regular input to the Care Home & Domiciliary Service Quality Review meeting led by the Local Authority with partner agencies, which considers in detail any specific provider concerns for follow up, to ensure appropriate support and improvement occurs. An additional Care Home and Home Care Quality Forum also provides an opportunity for health and care colleagues to share any concerns and initiatives relating to care homes and home care.

As part of Ageing Well work, 80 care homes, with high falls incidence were able to be issued with Raiser Lifting equipment this year and given training in their use. This initiative should ensure less potential for care home residents to suffer long lie falls. Falls response provision has also been extended in the overnight period through the LIVES Falls Response Service and through Age UK provision, again to limit the incidence of long lie falls in all areas in the community.

Primary Care Quality

The quality of general practice provision has continued to be assured through the work of ICB Locality Primary Care Quality Assurance Groups and constituent ICB locality linked staff. There is then escalation reporting of any areas of concern to the Primary Care Quality Oversight Group and ultimately to the Primary Care Commissioning Committee. At these groups there is careful consideration for each practice of wide ranging quality indicators including any incidents, complaints, Healthwatch and regulator feedback.

Any concerns are followed up directly with the Practice for improvement action as needed. Increasingly this follow up is in conjunction with the associated Primary Care Network (as Primary Care Networks develop, they will gradually take greater staged responsibility for the quality of care delivery in their local area).

Patient feedback through Healthwatch has continued to raise some access concerns for some practices. Where several concerns are raised, these are followed up directly with the practice to ensure any improvements required. Regular communication is also being shared with the public regarding the different routes for service access, including virtual contact and virtual consultations being undertaken routinely now by general practice when it is appropriate to do so.

Three of our practices have had more intensive support from the ICB, Local Medical Committee and system partners this year due to quality concerns and significantly adverse CQC ratings.

Caskgate Practice, Gainsborough currently has an inadequate overall rating with the CQC and is in special measures with the CQC, following an inspection visit in May 2023. Since that time, the practice has worked conscientiously to address the required improvement actions with the support of the ICB, LMC and other partners. Re-inspection of the practice has been delayed due to changes within the CQC including inspection processes and infrastructure. However Caskgate practice and the ICB are confident that the practice will be able to achieve improved ratings once the re-inspection does occur.

Richmond Practice, North Hykeham also received an overall inadequate rating from the CQC when inspected in May 2023, and is working hard to make the improvements required. Re-inspection by the CQC occurred from October to December 2023 and the practice has now moved to an overall Requires Improvement rating. The practice does remain in special measures with the CQC as it was felt the practice required more time to demonstrate the quality improvements made had been embedded. The ICB team and partners will continue to support with the practice's improvement journey as required.

Sidings Practice, Boston was also inspected by the CQC in October 2023 and have received an overall inadequate rating from the CQC. The ICB team and other partners have been working closely with this practice throughout 2023/2024, to support with quality improvement actions and will continue to do so over the coming months.

This year has also seen the ICB take on delegated responsibility for the wider Primary Care Services of Pharmacy, Optometry and Dentistry. From a quality perspective the ICB Nursing & Quality Team have worked with other East Midlands ICBs to develop a shared Quality Forum where quality for these services can be assured. Operational daily quality assurance of these services is provided through a dedicated commissioning and clinical advisor team, hosted by Nottinghamshire ICB, but working on behalf of all East Midlands ICBs. This team reports any quality concerns through to the dedicated Quality Forum described.

ICB support to workforce development and additional roles within primary care and general practice has continued to ensure continued workforce sustainability, given the challenges previously outlined and to maintain good quality multi-disciplinary care provision.

Particularly of note here is the work of the Lincolnshire-wide General Practice Nurse Reference Group, established in 2018 and supported by ICB Nursing

and Quality Team members . Attendees of the group include nurses working in practice, Health Education England, Lincolnshire Training Hub, the Local Medical Committee and relevant higher education institutions.

Some of the highlights of the work progressed by this group are described below:

- Launching a Career Start programme for nurses who are newly qualified or new to general practice.
- Establishing a Trainee Nurse Associate programme in general practice which has achieved comparable numbers to our local NHS Trusts.
- Developing a successful Return to Practice Programme for general practice.
- Organising an annual GPN conference and GPN awards.
- Establishing a process for allocating workforce development funding across practices based on a training needs analysis and commissioning well-evaluated training programmes.
- Launching a mentorship programme for those on Career Start, including Nurse Associates.
- Promoting general practice as a place to work at universities, colleges and schools.

The work of the group has ensured general practice nurses in Lincolnshire now have a collective voice and professional leadership. This has ensured general practice nursing can be on an equal footing with our NHS Trusts when it comes to applying for workforce development funding and having a voice on the ICB's People Board. Regionally and nationally, the Lincolnshire General Practice Nurse Reference Group has gained a reputation as a safe pair of hands for delivering on programmes of work, allowing Lincolnshire to attract funding for specific pilots, such as the General Practice Nurse Speciality Training Programme.

Children and Young People Transformation Programme

The Children and Young People (CYP) programme is an integrated programme of work bringing together key partners in Children and Young People's health and wellbeing.

NHS Lincolnshire Integrated Care Board works collaboratively with Lincolnshire County Council, NHS Trusts, Public Health, primary care and the voluntary sector. The work of the programme is overseen by the CYP Integrated Transformation Board which has a mission statement: 'Everyone working together to maximise the health and wellbeing of all children and young people, ensuring the voice of children and families is heard throughout our work.' Whilst there is also significant system transformation work happening in mental health, learning disability and autism, it is a separate programme of work although with clear links.

The CYP programme incorporates the NHS England CYP Transformation Programme alongside local priorities which have been informed by the intelligence we gather from the local population we serve, the communities they live in, our stakeholder partners and the staff who deliver the services.

The programme continues to be driven by data and intelligence, including an evolving use of population health management information, to ensure work being undertaken understands and addresses health inequalities within our CYP population in Lincolnshire. The voice of children and young people is integral to the work we do and we are looking at ways for us to further engage and co-produce with the people that use our services.

We recognise that demand on children's healthcare services has hugely increased since the Covid-19 pandemic which is a national picture and not just a challenge in Lincolnshire. This has given the programme some urgency as we

recognise the huge impact there can be on children and young people and families having to wait due to the increased pressure on services.

The national CYP CORE20PLUS5 programme outlines the key priorities from a health inequalities perspective. The five clinical priorities for CYP are, Asthma, Diabetes, Epilepsy, Oral Health, and Mental Health. The CYP programme directly aligns to these priorities (oral health and mental health are managed in their own separate programmes).

Transition from children's services into adult's services will be an integral part of consideration for all our projects. We know that when young people move into adulthood it can be a very challenging time for them and their families with services delivered in different ways and the care may even need to move to a different organisation. The CYP programme will look to develop some key principles for transition that will address the issues of continuity and in some cases gaps in service.

Whilst this sits within the CYP programme, it is important to emphasise that the biggest changes will need to happen within adult services and often in the way adult services are commissioned or delivered with differences in criteria causing challenges for patients and families as they transition into adult services.

The CYP programme is relatively immature and most of the initial work has been focused on building relationships, scoping and service redesign but this is a five-year programme from 2023-2028 and as a team we are excited about the potential to make a very real difference to children, young people and their families when they access healthcare in Lincolnshire.

Special Educational Needs and Disabilities (SEND)

In the ICB, our vision for children with Special Educational Needs and Disabilities (SEND) is that they are supported, feel safe physically and emotionally, are included and accepted within their community and lead happy and fulfilled lives. We are proud to place the individual care needs of children and young people at the very heart of what we do.

Lincolnshire reflects the national picture of growing demand on services, with increasing numbers of requests for support, particularly following Covid-19. Despite a challenging national picture, we are proud of the commitment and dedication of our teams across the NHS to provide excellent care, and we celebrate our strong relationships and collaborative working with our partner organisations and families to improve the lives of young people with SEND in the county.

This report is intended to be provide assurance that the Designated Clinical Officer (DCO) for Children and Young People (CYP) with SEND team is ensuring that the Integrated Care Board is meeting its statutory responsibilities with respect to SEND. The post is hosted by the ICB and supported by the Director of Nursing and Quality / Executive Lead for CYP and SEND, NHS Lincolnshire ICB. The DCO and Associate Designated Clinical Officer (ADCO) for SEND in Lincolnshire have achieved several key actions in 2023/24 this activity supports the continued areas of work that focus on the delivery of the ICB's statutory duties described in the SEND Legislation (SEND Code of Practice 2015) which states that the DCO team must:

- Work with the local authority to contribute to the Local Offer. This is a directory of services available online and designed to support CYP, families and professionals navigate the SEND landscape.
- Commission services jointly for CYP (up to age 25) with SEND, including those with Education Health and Care Plans (EHCPs).
- Have mechanisms in place to ensure practitioners and clinicians will support the integrated EHC needs assessment process and tribunal process.

Non-Statutory activity update includes:

- Development of Clinicians SEND Education Programme
- Development of the online Sensory Processing Difficulties Programme
- Co-development of the Special Schools Programme Health Strategy and supporting the implementation of Clinical Interventions in educational settings programme.
- Lincolnshire Young Voices is a group of young people with Special Educational Needs and/or Disability who are Experts by Experience. This group, co led by the DCO for SEND and Practice Supervisor in the Local Authority, has been developed for CYP with SEND to share their voice and is part of the widening participation strategy. This year saw LYVs winning the National Association for SEND (NASEN) award for its creation of an accessible and impactful e-learning resource called 'A Rough Guide – A Guide to Not Putting Your Foot in It.
- Maturity Matrix and ICB Readiness - Throughout the period 2022 - 2024, the DCO team has submitted or been interviewed around a series of seven comprehensive self-assessment tools for the Integrated Care System's transition from CCG with a particular focus on governance and infrastructure around SEND. As an ICB, the Lincolnshire system was rated as 'Green' and as such we are the only system in the East of England and East and West Midlands to do so.

The DCO team continues to work with our system partners in supporting improvements to service provision, however, the the focus of SEND in the ICB is to continue to improve the Annual Review process, the development of a SEND Performance Data Dashboard, the implementation of the LICB SEND Quality Assurance Framework and the development of 'SEND HELP!' project with LIAISE and LPCF.

Safeguarding

ICBs have a statutory responsibility, set out in primary legislation and statutory guidance, to safeguard adults, children, young people, and Looked After Children. NHS Lincolnshire ICB is committed to promoting the safety of all at risk of abuse or neglect, employing a safeguarding team which comprises of specialist safeguarding practitioners and designated professionals, including medical, nursing, and administrative staff to support this function. The team works proactively to support local, regional, and national safeguarding priorities and responding to the ever-evolving safeguarding landscape.

Safeguarding is a collective responsibility, whilst individuals and organisations have distinct roles, the system cannot operate effectively unless individuals and organisations work together. Oversight of local partnership safeguarding arrangements is provided by the Lincolnshire Safeguarding Adults Board (LSAB), the Safer Lincolnshire Partnership (SLP), the Lincolnshire Domestic Abuse Partnership (LDAP), and the Lincolnshire Safeguarding Children Partnership (LSCP). NHS Lincolnshire ICB is represented at all levels of work within these, providing leadership for safeguarding through attendance to the strategic boards, and sharing specialist knowledge and expertise through the active participation of the ICB safeguarding team in sub-groups, audit processes, statutory reviews (Child Safeguarding Practice Reviews, Serious Adult Reviews and Domestic Homicide

Reviews), and specific task and finish groups.

The ICB's Safeguarding Team attend regional and national NHSE meetings and forums, disseminating learning, and considering the implications of findings for the Lincolnshire system. Work currently being undertaken includes identifying how health can most effectively share information at multi-agency meetings, which commenced in response to national reports published into the murders of Arthur Labinjo-Hughes and Star Hobson in 2022. The health safeguarding system has worked closely as this work progresses, implementing interim measures to ensure health representation and contribution to risk assessment and decision-making processes.

The ICB Safeguarding Team provides level three safeguarding training to primary care staff, facilitates GP forums, and produces a bi-monthly safeguarding newsletter which is shared with all GP practices in the county. The newsletter enables current safeguarding information to be shared, the forums provide an opportunity for peer supervision and professional challenge.

Partners continued to work proactively in 2023/24 towards safeguarding priorities. Examples of work relevant to Lincolnshire are provided below, this list is not exhaustive but evidences the broad spectrum of work undertaken to protect children and young people at risk of harm and abuse:

The ICB's safeguarding team has been leading on the implementation of ICON (which stands for I – Infant crying is normal; C – Comforting methods can help; O – It is OK to walk away; N – Never, ever shake a baby) across Lincolnshire since October 2021. ICON is an evidence-based programme aimed at preventing abusive head trauma (AHT) in babies. The team continues to work closely with health and wider partners on its successful implementation. Work includes an eight-week media promotion programme of the ICON message via local radio stations in early 2024, with the aim of increasing awareness and reducing the incidence of AHT in infants.

The Designated Doctor chairs the LSCP Child Death Overview Panel (CDOP) which reviews the circumstances surrounding the deaths of children and young people under the age of 18 years. In 2022, following an increase in deaths of young people in Lincolnshire suspected to be suicides, CDOP completed a thematic review to recognise any themes which could help inform policymakers, commissioners, and those providing services to children and young people. All the recommendations in the review were accepted and work to progress these commenced with an anticipated completion date of March 2025. Most of the recommendations, however, were completed by the end of 2023.

Research provides extensive evidence of the poorer health outcomes experienced by Looked After Children and Care Leavers when compared to their non-care experienced peers. NHS Lincolnshire ICB continues to work in partnership with the local health system, the Local Authority and Barnardo's to support and improve services for this cohort of vulnerable children and young people. An initiative progressed by the safeguarding team, which aims to address the poorer health outcomes and financial inequality experienced by care experienced young people, was the funding of pre-payment prescription certificates for Care Leavers aged 18 – 25 years who are not entitled to free prescriptions under current exemptions. NHS Lincolnshire ICB agreed to fund this initiative which was rolled-out in August 2023.

In 2023 Lincolnshire County Council was chosen by the government to be a wave one Local Authority (LA) Families First for Children (FFC) Pathfinder site (the other sites are Wolverhampton and Dorset). The FFC Pathfinder sites are part of the government's Children's Social Care implementation strategy, Stable Homes, Built on Love. There are four key reform strands to the Pathfinder that will be delivered as a whole system transformation: overarching system-level reform, including multi-agency safeguarding arrangements; family help; child protection; and family networks. The Department for Education has developed key lines of enquiry to help build knowledge from Pathfinders with an emphasis on co-design with local statutory partners, local authority, ICB and Police, to lead and deliver these reforms.

The ICB safeguarding team has been, and will continue to be, actively involved in the progression of the Pathfinder work which is an exciting opportunity for Lincolnshire.

Working Together to Safeguarding Children (revised guidance published December 2023: Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)) sets out how the three safeguarding partners will work together with other agencies to safeguard and promote the welfare of children. As one of these safeguarding partners, NHS Lincolnshire ICB works in partnership with the police and the Local Authority to co-ordinate their safeguarding services: acting as a strategic leadership group in supporting and engaging others and implementing local and national learning including from serious child safeguarding incidents.

To demonstrate how the NHS has performed against this duty, and to see the LSCP priorities, please see link below to LSCP Annual Report 2023, LSCP Constitution 2022/23 and the LSCP Business Plan 2022 – 2025.

https://www.lincolnshirescp.org.uk/

The Safeguarding Accountability and Assurance Framework (SAAF) (B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf (england.nhs.uk)) identifies core duties across the lifespan of safeguarding for individuals working in providers of NHS-funded care settings and NHS commissioning organisations.

Responsibilities for safeguarding form part of the statutory functions for each organisation and its executive board must ensure effective discharge of this. NHS Lincolnshire ICB has contractual requirements and assurance processes for safeguarding with all its providers, the safeguarding team are continually looking at ways to improve the quality of assurance methods to support providers, reduce replication and ensure the focus is on positive outcomes for patients and communities.

NHS Lincolnshire ICB can confirm compliance to the statutory functions and assurance processes set out in the SAAF - legislation and mandatory reporting duties, roles and responsibilities of staff, and commissioning and assurance of NHS services.

Health Protection

Infection Prevention and Control with safe environments of care for patients and staff continued as a vital focus in 2023/24, due to the continued prevalence of Covid-19, seasonal influenza and a National rise in cases of Measles. The ICB assisted with this through the work of our Health Protection Team.

The ICB Health Protection Team (HPT) works on behalf of the ICB to ensure good health protection systems and processes are in place for NHS commissioned providers, member General Practices and to support the wider public health of the population. The work of this team covers three work streams, Infection Prevention and Control (IPC), Communicable Disease Control, and Vaccinations and Immunisation and therefore during this year the work of this team has continued to be of paramount importance.

2023/24 saw a return to "business as usual" and a renewed focus on proactive, rather than reactive Health Protection work. The Health Protection Team undertook assurance reporting and supportive visits with our providers, which had been suspended necessarily during the height of the Covid-19 pandemic.

Each trust receives at least a quarterly visit from the team and for all other providers, the aim is to visit most practices annually, although, with additional visits for IPC advice during renovation work and accreditation of Primary Care Surgical Scheme premises, 18 months is a more realistic timeframe. The outcomes of visits were positive with generally good compliance to IPC standards. Where issues were identified the team has worked with the relevant provider to advise and support mitigating actions. Engagement from most providers has improved since Covid-19, and there is more of a demand for supportive IPC visits by the team.

The HPT has supported the system to keep local guidance on living with respiratory illness up to date and relevant, with Flu and Covid planning an item on the System IPC Group Agenda.

The team continues to support the Influenza and Covid-19 vaccination campaigns and has been working closely with the newly formed ICB Vaccination and Immunisation Team.

The HPT attend regular briefings and webinars to ensure that the Lincolnshire processes are clear and in line with national and regional guidance. The Lincolnshire pathways that have been produced for MPox, Diphtheria and Measles were highlighted by NHSE and UKHSA as being a good example of Integrated, system working and have been shared with other ICBs in the region. The team coordinates the Lincolnshire Primary Care IPC Link Practitioner network and hold quarterly update and teaching sessions via video call and, more recently, face to face training sessions. Attendance has been increasing throughout the year.

The team has attended several conferences and other training events relevant to health protection, to ensure that the staff are qualified and competent to provide up to date advice and guidance to system partners.

The team has increased resource to manage both the expected demand and the unexpected remit of the Health Protection function i.e. communicable disease outbreaks. Support from the Vaccination Team has been crucial in being able to provide a rapid response to care home Influenza outbreaks, with all notifications being managed within 24 hours and antivirals issued to those who were eligible. Earlier in the year, the team coordinated a TB screening event at a factory, where contacts of a known case had been identified as being at risk and, therefore, eligible for screening. This provided an opportunity for a multi-agency approach to Health Promotion. A three day screening event took place with support from other agencies (e.g. smoking cessation, healthy lifestyles) where eligible workers were screened and

health information was made available to all staff.

The UK experienced a Measles outbreak, predominantly affecting Birmingham and London, and the Health Protection Team led on a Measles working group to produce a system wide Measles strategy to increase MMR vaccine uptake and prepare a system pathway for managing suspected and confirmed cases. This work involved a wide range of system partners and looked at immediate interventions as well as longer term plans to raise awareness and engage with partners and the public.

ICB Healthcare Associated Infections

The data for 2023/24 shows the system to be above trajectory for C.difficile by 29 cases to year end. For Gram negative organisms subject to mandatory reporting, E. coli are over trajectory (by 75 cases); P. aeruginosa is under by eight and Klebsiella species is over trajectory by 30 cases. There have been 11 MRSA bacteraemia cases during the 12-month period of reporting.

The Health Protection Team are reviewing all MRSA cases (currently undertaking an MRSA deep dive) and a sample of Gram negative organisms that have occurred over the year to identify themes to share across the system. A system IPC subgroup has been established to co-ordinate a collaborative approach towards reducing Gram negative infections.

Alert Organisms													
C.Difficile	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Monthly Total	7	19	13	18	8	22	13	16	15	13	16	16	176
Cumulative total - All	7	26	39	57	65	87	100	116	131	144	160	176	176
Cumulative trajectory	12	24	36	48	60	72	84	96	108	121	134	147	147
Performance against trajectory	-5	2	3	9	5	15	16	20	23	23	26	29	29
COHA	0	1	1	1	0	3	3	1	2	2	3	4	21
COCA	2	5	3	4	0	4	0	2	2	1	1	0	24
COIA	0	0	0	1	3	2	1	1	0	0	1	0	9
E.Coli	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Monthly Total	49	50	39	52	45	59	39	43	43	37	50	51	557
Cumulative total - All	49	99	138	190	235	294	333	376	419	456	506	557	557
Cumulative trajectory	40	80	120	160	200	240	280	320	360	400	440	482	482
Performance against trajectory	9	11	12	30	35	54	53	56	59	56	66	75	75
COHA	6	7	2	5	3	4	4	3	5	3	8	7	57
COCA	31	32	29	40	31	46	28	31	30	26	32	30	386
COIA													0
P. aeruginosa	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Monthly Total	8	1	3	5	4	8	6	2	3	4	8	2	54
Cumulative total All	8	9	12	17	21	29	35	37	40	44	52	54	54
Cumulative trajectory	5	10	15	20	25	30	35	40	45	50	56	62	62
Performance against trajectory	3	-1	-3	-3	4	-1	0	-3	-5	-6	-4	-8	-8
COHA	0	1	1	2	1	1	5	1	0	0	2	1	
COCA	4	0	1	2	2	3	0	1	2	3	2	1	
COIA													
Klebsiella spp.	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Monthly Total	19	12	14	19	8	16	14	9	15	20	13	17	176
Cumulative total - All	19	31	45	64	72	88	102	111	126	146	159	176	176
Cumulative trajectory	12	24	36	48	60	72	84	96	108	120	133	146	146
Performance against trajectory	7	7	9	16	12	16	18	15	18	26	26	30	30
COHA	7	3	4	2	0	1	3	1	0	1	2	3	27
COCA	9	6	7	12	5	8	4	4	7	15	5	12	94
COIA													
MRSA	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Monthly Total	1	0	2	1	0	3	1	0	1	1	1	0	11
Cumulative total	1	1	3	4	4	7	8	8	9	10	11	11	11
COHA	0	0	0	0	0	0	0	0	0	0	0	0	0
COCA	0	0	1	1	0	1	1	0	0	1	0	0	5
MSSA	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Monthly Total	17	20	16	13	13	16	12	9	19	18	14	11	178
Cumulative total	17	37	53	66	79	95	107	116	135	153	167	178	178
COHA	4	2	5	0	1	2	0	0	1	2	1	1	19
COCA	8	10	8	7	7	8	5	5	14	13	10	7	102

HOHA (Hospital Onset Healthcare Associated)– A case is deemed to be HOHA if the following rules are met:

- The location where the specimen was taken is given as 'Acute Trust' or is not known;
- The patient was either an 'In-patient', 'Day-patient', in 'Emergency assessment' or is not known;
- Patient's specimen date is on, or after, the third day of the admission (or admission date is null), where the day of admission is day 1.

COHA (Community Onset Healthcare Associated) – A case is deemed to be COHA when the patient was not HOHA but had been an inpatient at the same acute Trust in the four weeks prior to the date that their positive specimen was collected.

COCA (Community Onset Community Associated) - A case is deemed to be COCA when the patient has not been an inpatient at the same acute Trust in the 12 weeks prior to the date that their positive specimen was collected.

COIA (Community Onset Indeterminate Association) - A case is deemed to be COIA when the patient was not HOHA or COHA, but had been an inpatient at the same acute Trust in the 12 weeks prior to the date that their positive specimen was collected (i.e. between four and 12 weeks prior to their positive specimen).

The ICB Health Protection Team's focus for the year ahead (in addition to assurance reporting against the 10 Criteria of the Health and Social Care Act, Code of Practice (2008, updated 2015):

- Integrated approach to IPC within the system, including the development of system-wide protocols.
- Vaccination and Immunisation projects in conjunction with the Vaccination and Immunisation team, specifically Flu and Covid-19 programmes/ planning and proactive MMR uptake improvement.
- Education for Primary Care GP Link Practitioners.
- Re-introduction of Primary Care Housekeeper training and Link network.
- Supporting programmes identified in the System IPC Group, including an AMS working group and Seasonal Vaccination working group.
- Timely response to communicable disease incidents and outbreaks.
- Working with the Local Authority Health Protection Team to identify proactive, targeted work, including attendance at events (University Freshers Week) to raise awareness of Health Protection issues.

Working with People and Communities

This section provides a brief overview of our involvement activities – further details are available in the Lincolnshire ICB's People and Communities Involvement Annual Report 2023-24 on our website.

All of our involvement work is underpinned by our ten principles in the Lincolnshire ICB People and Communities Strategy.

Our commitment

The ICB is fully committed to involving patients, the public, partners and key stakeholders in the development of services and ensuring they are at the heart of everything we do. We understand that partnership working is key to empowering patients to have more choice and control over their own health. Through these partnerships, we can better understand the health needs of our population, resulting in improved health outcomes. The Health and Care Act 2022 mobilised partners within Integrated Care Systems (ICSs) to work together to improve physical and mental health outcomes, ensuring they are informed by the needs, experiences and aspirations of the people and communities they serve. It also required the Lincolnshire Integrated Care Partnership (ICP) to develop an Integrated Care Strategy to support the people of Lincolnshire to enjoy the highest quality health and wellbeing for themselves, their families and their communities, and as part of the ICP we are dedicated to working together to achieve this. Community engagement and involvement is one of the five key priority enablers in the strategy, demonstrating our commitment to developing 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.

Legal Duty for Involvement

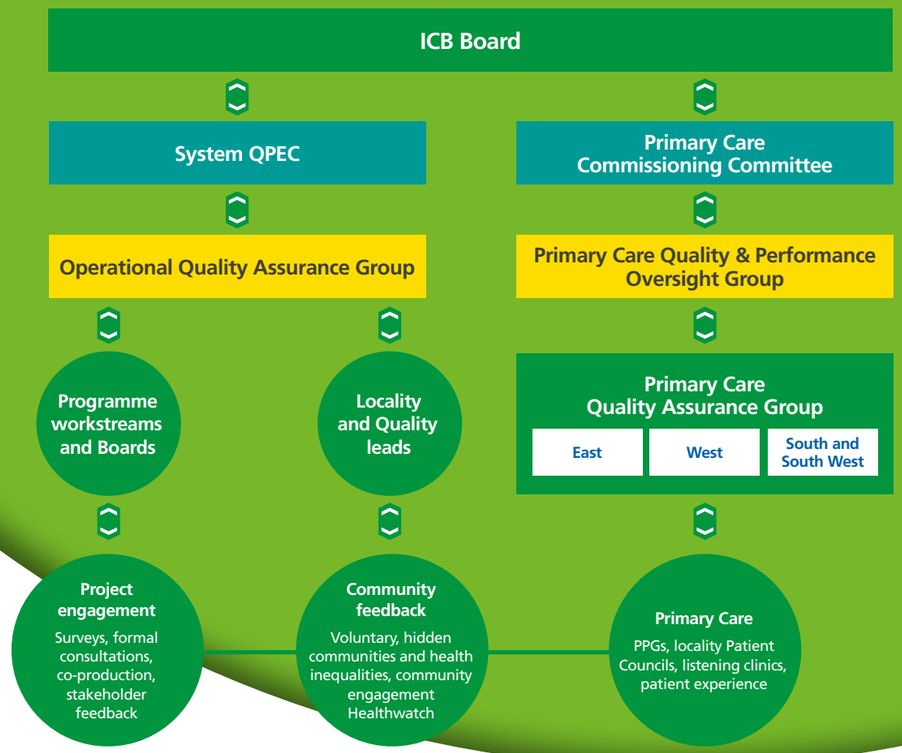
As outlined in section 14Z45 of the NHS Act 2006 and amended by The Health and Care Act 2022, the ICB has discharged its public involvement duty by having in place provisions for involving the public in the planning of commissioned services; and the development and consideration of proposals for changes in the commissioning arrangements which would have an impact on service delivery and decisions which would have an impact on services. By listening to local people and co-producing with those who represent them, we can improve the decisions we make and ensure we are considering the health needs of Lincolnshire residents. The ICB wants to continuously improve and develop how we can involve our communities. It is important to us that the public sees how their feedback has helped to shape local services and how much we value all feedback and engagement. How we do this is set out in our values which are outlined in our Constitution and the principles set out in our People and Communities Strategy which explain how we will work with people and communities and continue to develop and strengthen this with our partner organisations and patient representatives.

Governance and assurance information

Timely and meaningful involvement is a priority for us, and a strong framework, with clear structures and assurance processes, plays a key role in making sure that patients and communities are central to our decision-making.

- Our ICB Constitution clearly states our guiding principles about public involvement and is available to view on our website.
- Our involvement function is part of the ICB's Strategic Planning, Integration and Partnerships team, ensuring patients and our communities are at the heart of service development, improvement, and transformation. Strong links are maintained with the ICB Nursing and Quality Team to align patient experience and involvement with quality and safety.
- Full analysis and reports of our involvement activities including any differences in equality or health inequality group are shared with project and programme leads to help inform, shape and steer their programmes of work so those changing and improving services are hearing feedback from people and communities directly.
- Details of our involvement and outcomes of this are reported to the ICB Operational Quality Assurance Group Meeting with escalation as required to the System Quality Committee or to our Primary Care Commissioning Committee (PCCC) if it is regarding a primary care service.
- Reports of our involvement and feedback are also regularly shared with partners via our System Quality and Patient Experience Committee, who also review our People and Communities Involvement Annual Report and monitor our delivery plan for our People and Communities Strategy.
- Feedback from our engagements and consultations is also reported into our Board meetings to inform decision making on large projects.

The ICB's Continuous Listening Model demonstrates how all feedback is reported into the governance structures and evidences the difference it makes.



ICB Working with People and Communities Strategy in practice

Our strategy outlines our commitment to involving people and communities throughout Lincolnshire, highlighting the variety of ways we involve people and communities on an individual, group and community basis. We will ensure that our methods and approaches are inclusive and tailored to all the Lincolnshire population and stakeholders so they can have their say. To do this it is important that we recognise and understand who our stakeholders are and the most effective way to communicate and engage with them individually. This is supported by undertaking Equality and Health Inequality Impact Assessments to ensure that all voices in our community have an opportunity to be heard.

Lincolnshire ICB has adopted the ten principles set out by NHS England in the ICS design framework – these have been developed from work with systems across the country and, when embedded effectively, will create a golden thread running throughout the ICS, whether involvement takes place within neighbourhoods, in places or across the whole of Lincolnshire. Delivering our principles will demonstrate and evidence our commitment to the constitution. Our full Lincolnshire ICB's People and Communities Involvement Annual Report 2023-24 details the work we have undertaken towards achieving these principles.

Our System Quality and Patient Experience Committee were overwhelmingly supportive of the strategy and agreed for an annual delivery plan of involvement and engagement to be presented and agreed by SQPEC as part of the operational planning process as well as receiving regular reporting of feedback and outcomes.

Using insight and data to inform our work

We recognise the differences in our communities from their health needs, ability to access services (both digitally and in person), and the ways they want to get involved. All of our commissioning and involvement activities are built on a solid understanding of our population, service users, their experiences and the people that support them. We utilise the knowledge, relationships, networks and strong links our partner organisations already have with our communities to ensure a fully holistic, system approach to involvement. We use existing and tested opportunities to engage and communicate and seek to identify the best partner with the best relationship to lead the conversation.

Working as partners strengthens our collective messages and involvement activities. As well as joining up care, we are joining up our engagement and experience work to capture and improve the patient journey and use this to empower joined up system working.

We support our programme teams to make these links and ensure Equality Impact Assessments, Quality Impact Assessments and Health Inequality Impact Assessments (HEAT) are undertaken to fully understand the people and communities we serve who may be impacted by any changes. The insights and diverse thinking of people and communities are essential to enabling Lincolnshire ICB to tackle health inequalities and the other challenges faced by health and care systems.

Our Insight Database pulls together findings from involvement activities across the NHS and partner organisations to provide a solid base of intelligence and experiences which are shared to inform programmes of work, involvement planning and decision making.

How we reach diverse, potentially excluded and disadvantaged groups

Our ICB Involvement Team has recruited a dedicated team member to support tackling health inequalities, embedding consistent, best practice activities and empowering Lincolnshire's people and communities to be involved in all aspects of our work. This approach of putting people and communities at the heart of tackling our health inequalities will be replicated across all priorities and programmes. We have reviewed and updated our survey equalities and health inequalities monitoring questions to ensure we know who is getting involved with us and so we can proactively reach out to those who do not.

Especially important is to continue to use the learning from the Covid-19 Pandemic and the strengthened relationships with our partner organisations, reduction of duplication, collective responsibility to reach out to the people and communities we share using the best methods and links available regardless of organisational boundaries.

To help us involve people digitally we continue to strengthen our database of over 11,000 people, groups and communities who we can reach out to directly and invite to get involved in our programmes of work. This allows us to identify and target all demographics including those less likely to get involved such as people with caring responsibilities, in fulltime employment and living in rural locations as well as reach out to those potentially experiencing health inequalities or in particular geographical areas.

Reaching those who are unable or unwilling to get involved with us digitally is equally important and we make sure that we go to them – we attend local events and community groups such as fun days, college fresher fayres and local networking events, reaching a wide range of people and potentially hidden communities. We hold events in specific areas to proactively engage with those communities experiencing inequalities and incentivise their involvement to maximise participation. We share a range of materials with people at events and via our social media, enabling them to get directly involved in activities with the ICB or partners. This highlights the different ways they could get involved and are translated into the main languages if required.

We also recognise the reach into communities other programmes of work are developing and are working with LVET to increase diversity in participation in research as well as our Primary Care Network Alliance to increase public participation in primary care.

How we work with partner organisations

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. The ICB recognises the importance of working with our partners, to enable a collaborative approach to involving our communities and benefiting from the trusted and established relationships they have with the people of Lincolnshire. By working together, we reach different people in different ways and have the conversations with them that are important to them with trusted individuals. Our strong relationships with Voluntary, Community, and Social Enterprise organisations enables us to commission them to undertake some work on behalf of the ICB.

- The ICB is committed to delivering engagement at all levels from working with community leaders at a neighbourhood level or through partnership working such as Lincolnshire's Integrated Care Partnership - Better Lives Lincolnshire
- Healthwatch is a key partner and and act as a critical friend, as well as representing an independent view of the patient and public voice. Healthwatch is an integral member of the ICB Board as well as sit on various Committees.
- A representative of the Voluntary and Community Sector is also an integral member of the ICB Board, an associate member on the ICP Board, as well as sitting on various Committees
- Public Health and Local Authority representatives are regular participants at the ICB Board meetings.
- Our provider and primary care colleagues are part of our extended team and therefore are integral to the development and delivery of our shared strategic priorities
- We will engage with our Health Overview and Scrutiny Committee on potential service changes, enabling them to consider whether it is a substantial and significant service change requiring consultation process. We will work to assure them that healthcare is planned and delivered in ways that reflects the needs and aspirations of local communities, plans for substantial service changes are reasonable and everyone has equal access to services.
- Our day-to-day processes and systems have been established to work across involvement and participation teams within the ICB and NHS Provider Trusts across Lincolnshire. Joint working enables us to collaborate and reduce duplication, leveraging the links we all have with their patient groups and memberships while supporting each other

On a local level we continue to build strong relationships with our community groups and support organisations to help us reach individuals and communities. We work closely with groups and venues providing warm spaces, foodbanks, and services to our communities as well as individuals such as Islamic leaders and social prescribers and community connectors to draw on their wealth of experience and links to people we might not otherwise be able to reach. Our work with local and countywide partners is explained in more detail in our additional Lincolnshire ICB's People and Communities Involvement Annual Report 2023-24.

Seeing the impact of participation

It is essential that our extensive involvement work is meaningful and impactful and that the public can see that their involvement is making a real difference. Some examples of our involvement activities over the last year include:

- A robust, three phased engagement approach to develop the Joint Forward Plan, overseen by a Steering Group with patient representation
- Extensive engagement with targeted areas of deprivation to increase uptake of bowel cancer screening tests
- Engagement to understand views of those experiencing pressure ulcers and tissue viability services to improve the quality of services
- Initial co-production to develop health and wellbeing services for older people.
- Engagement with families of children and Younger People to review and develop Asthma, Diabetes and Epilepsy services.
- Co-production in the initial stages of wide ranging engagement to develop Women's Health Hubs.
- Listening Clinics in some of our GP practices as well as undertaken engagement and consultations on various changes to primary care services.
- Co-production of primary care digital solutions with our practice participation group representatives.
- Development and increase of our stakeholder database contacts and strengthened groups and meetings such as Patient Council, Locality PPG groups and other community groups and networks.
- Continued growth of our social media presence including NextDoor as well as getting out and about in our local communities through a series of events and roadshows.
- Continued ongoing engagement on General Experiences of Care, asking for anyone who has recently used NHS services to share their experiences with us.

How we enable and support those who want to get involved

The ICB has a number of ways to encourage involvement and our teams embedded within the ICB and ICS are supported by a strong network of people and community groups who initiate and contribute to our work. Our **Involvement Champions** support our programmes of work as patient representatives on steering groups and working groups and are advocates for the groups and communities they represent. They will work with us to support our involvement with local people and communities by sharing messages and gathering feedback to create a two-way communication process between the ICB and their communities. Our **Citizen Panel** aims to be reflective of people and communities in Lincolnshire, taking part in surveys about planning and improving local health and care services. **Patient Participation Groups** - (PPGs) are designed to give patients and practice staff the opportunity to meet and discuss issues and opportunities and supporting their wider practice population to get involved and increase understanding in their healthcare services. PPG representatives come together as a Lincolnshire Patient Council where they feed the views of their practice patients into the ICB and are involved in programmes and projects. NHS Provider Organisations support **Patient Panels** and **Patient Experts** to regularly influence and shape the work of the system service developments and many of our programmes are embedding **co-production groups** of those with lived experience to put the patient at the heart of our services.

All opportunities are promoted on our social media and website as well as circulated in our Involvement Bulletin. The Bulletin was developed to reduce engagement fatigue and to focus information in one place which is then sent fortnightly to our stakeholder and patient group database. This has gone from strength to strength and is now widely distributed, has increased participation in ICB engagement and shares information and involvement opportunities from across our provider Trusts and other partner and community organisations.

Our involvement activities are supported by strong social media promotion and the development of the NextDoor platform as a key vehicle to share our events and opportunities to get involved. In addition, we have produced specially designed leaflets and pull up display banners with our email address and QR codes to provide further opportunities at all events we attend for people to sign up to get involved in Lincolnshire ICB.

Social Media and engaging with the local population

Digital engagement with our local communities

The ICB strongly supports the use of social media as a positive communication channel, to provide members of the public, partners and other stakeholders with information about what we do and the services we commission.

We use social media to provide opportunities for genuine, open, honest and transparent engagement with stakeholders; giving them a chance to participate and influence decision making. Social media is a fantastic opportunity for us to listen and have conversations with a wide and diverse range of people, especially with hard to reach groups. It not only allows us to make announcements, e.g. health news, service information, upcoming events, it allows people to respond to whatever we post and encourage two-way conversation and feedback to improve the ongoing development of our services and to inform, engage, educate and inspire our local communities.

One of our key communication tools, which is often a first port of call for the public, is the ICB website. We are continuingly reviewing and developing our online presence to ensure that people can easily access information about the ICB, our system partners and programmes, latest news, events, engagement opportunities and the services available to them.

Between the 1st July 2023 and 31st March 2024 we had 101K users/ visitors and 355.7K page views. The most popular entrance to our site was via our homepage and our most popular pages were those with information about our vaccination programme in Lincolnshire and our community walk-in vaccination sessions. The ICB social media channels saw an increase in reach, engagement, and new followers in this period. The ICB gained 1,553 new followers across our social platforms.

By using organic and paid promotions, the ICB's channels have seen a significant increase in reach, impressions and engagements such as shares, likes, link clicks, and inbound messages and comments from followers and members of local communities.

Our most engaging social media posts are those that are people - centred, stories and spotlights on our amazing teams working together to improve Lincolnshire's health and wellbeing. As part of our ongoing social media strategy, we will work on more people-centred content and grow our audience with the help of key stakeholders and influencers.

We are now working better together as a system across our local NHS, working to inform, engage and involve our local community.

Improving Health, Reducing Health Inequalities and Prevention

This section explains how the ICB discharged its duty outlined in section 14Z35 of the NHS Act 2006 as amended by The Health and Care Act 2022.

Reducing Health Inequalities

The Lincolnshire Integrated Care Board (ICB) has a legal duty under Section 14Z35 of the Health and Care Act (2022) to reduce inequalities between persons with respect to their ability to access health services; and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. The Act also places duties on the ICB to:

- have regard to the wider effects of decisions on inequalities.
- promote integration which requires consideration of securing integrated provision across health, health-related and social services where this would reduce inequalities in access to services or outcomes achieved.

The ICB is also required to collect, analyse and publish information relating to health inequalities in line with NHS England's Statement on Information on Health Inequalities .

To do this effectively, the ICB works with its partner organisations to reduce health inequalities and embeds this requirement into its commissioning strategies and policies. Lincolnshire is deeply engaged in addressing health inequalities, through the local authority, NHS trusts and wider sector partners already being represented on both the Integrated Care Board (ICB) Board and the Integrated Care Partnership (ICP), with inequalities prominently identified as one of the key challenges for the health and care system and the population.

We have a shared Joint Health and Wellbeing Strategy in place informed by Lincolnshire Joint Strategic Needs assessment (JSNA) and Global Burden of Disease.

Our ambition for the Better Lives Lincolnshire, by 2030 is 'for the people of Lincolnshire to have the best possible start in life, and be supported to live, age and die well'

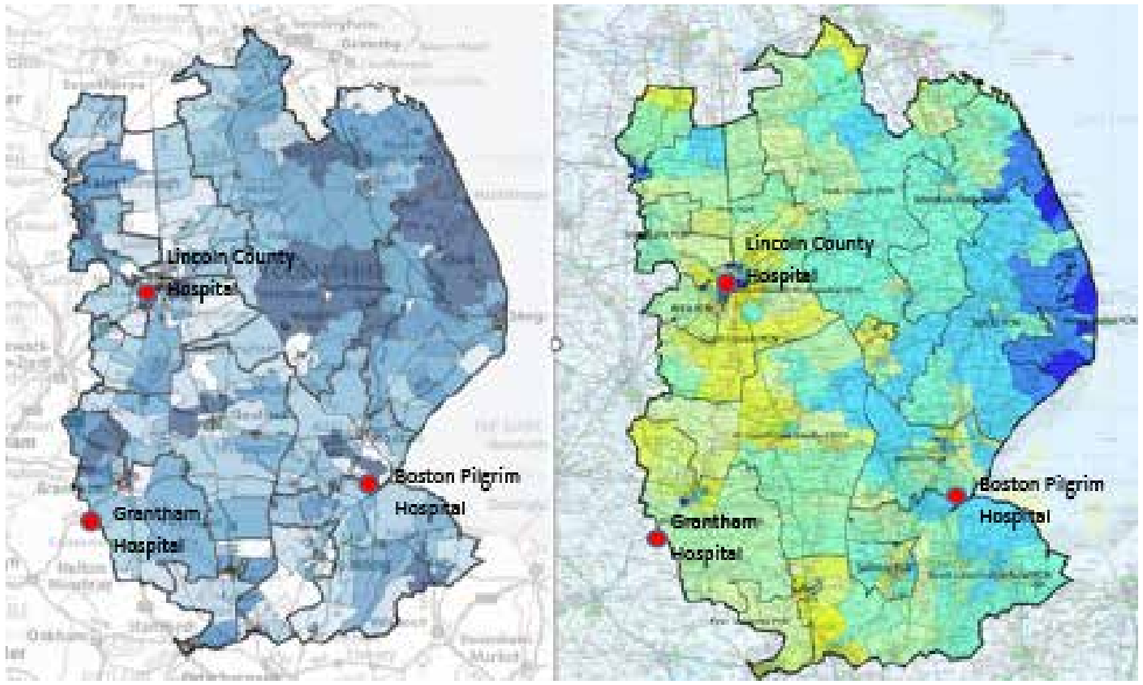
Lincolnshire has a challenging combination of rurality, coastal and urban deprivation, an ageing population, and a low-wage economy. This combination defines the difficulty of the mission to improve its population health.

While most of our population enjoys good health and have better health outcomes compared with the rest of the country, we know that significant health inequalities exist and some of our residents are dying from illnesses such as circulatory diseases, cancer and respiratory diseases at a younger age than we would expect.

There is a stark 20-year difference in healthy life expectancy between the highest and lowest socio-economic deciles of the population – based on Index of Multiple Deprivation (IMD) quintiles.

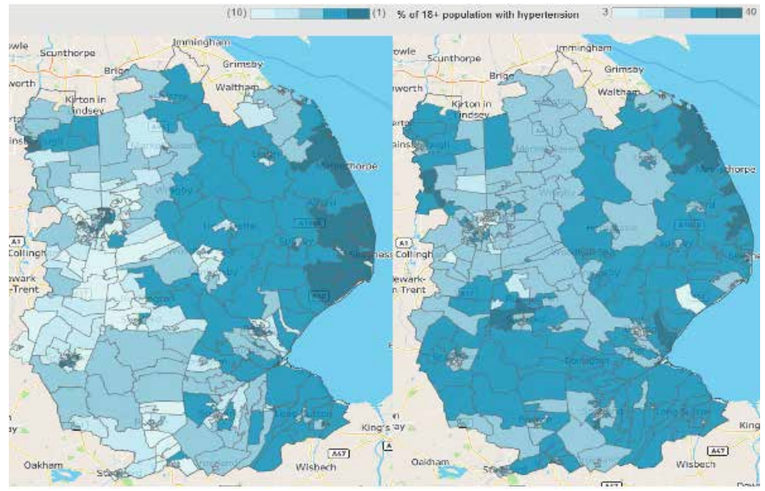
- The Chief Medical Officer's annual report 2021: Health in Coastal Communities, elucidates these challenges and specifically references the east coast, for example, communities in Skegness and Mablethorpe. According to 'The Centre for Towns' measures these conurbations rank: 1st (Mablethorpe) & 4th (Skegness) in the 20 most deprived places in England and Wales (Combines economic and social isolation). Mablethorpe is 5th in the top 20 places for social isolation. It is already known that residents of such communities find access to healthcare problematic, face a declining bus network and experience poor broadband relative to the major cities/ urban areas.

The maps below show the concentration of older adults in the Eastern parts of the county along with the large areas of socio-economic deprivation in the urban areas, in rural Eastern areas and along the coastal strip (right). This is a specific problem in Lincolnshire of two of its three major secondary care facilities (marked in red on the map) are located well away from the coast.



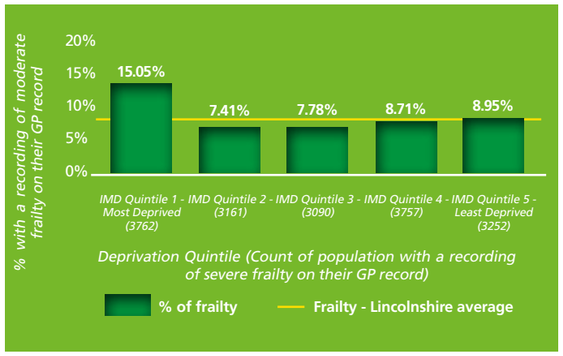
We have many areas in Lincolnshire that have different pockets of social deprivation due to its demographics (as shown in the maps to the right).

- We have areas with significant above average disease prevalence – resulting in premature mortality. The maps below shows Index of Multiple Deprivation Deciles in Lincolnshire (left) and the percentage of those in Lincolnshire that are aged 18+ with hypertension (right). There is some overlap with those living in more deprived and a higher prevalence rate of Hypertension, particularly in the Mablethorpe area.

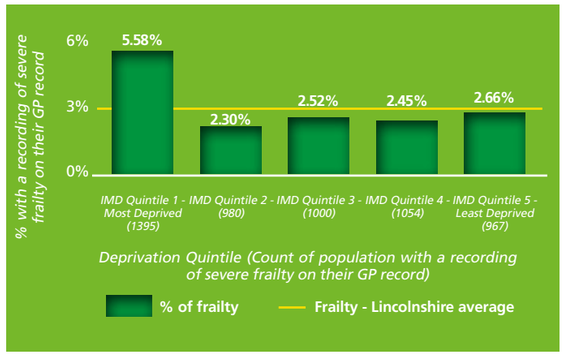


- An ageing population - It is predicted that the elderly population in Lincolnshire will increase by 3.4% in the next ten years, and the rate of increase in people aged over 85 is particularly pronounced with an expected increase of 52.4%.
- The charts below show that moderate and severe frailty are more prevalent in the most deprived quintiles.

Moderate Frailty Prevalence in Lincolnshire for 65 years and older, by Deprivation Quintile

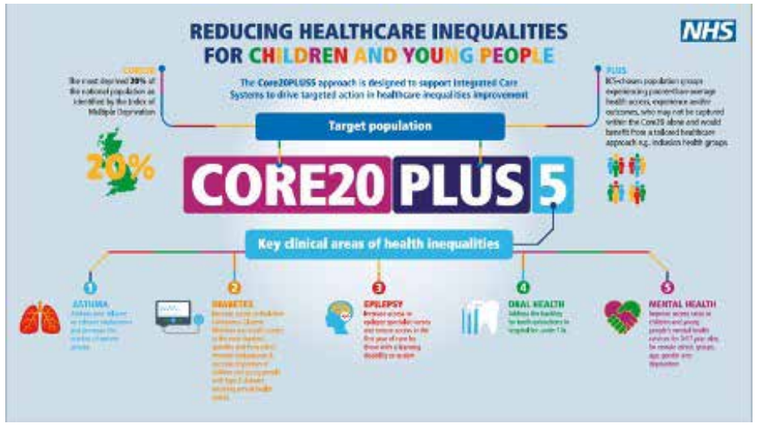


Severe Frailty Prevalence in Lincolnshire for 65 years and older, by Deprivation Quintile



Lincolnshire Joint Strategic Needs Assessment (JSNA) provides additional intelligence on health inequalities across many of the diseases causing the greatest burden for example, Diabetes, Cardiovascular Disease (CVD) and COPD, as well as on the main risk factors, for example, smoking and physical inactivity.

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



National

Nationally, NHS England has outlined an approach to support the reduction of health inequalities at both national and system level. Providing exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes. The approach described below – 'CORE20PLUS5' defines a target population cohort and identifies '5' focus clinical areas for accelerated improvement. This approach has been embedded within our Health Inequalities and Prevention Programme.

Within Lincolnshire our 'CORE20PLUS5' population are:

- The 20% most deprived communities as identified by the Index of Multiple Deprivation (IMD) – 121,000 patients (14.8% of Lincolnshire patients)
- Plus – People from ethnic minority backgrounds (151k patients, 15.6% of Lincolnshire patients), with the largest ethnic minority group being "any other white background" (8.5%) - a significant proportion of this group is people from an Eastern European background.
- ICS locally determined population groups (evidence and insight based) experiencing poorer-than-average health access, experience, and/or outcomes who may not be captured within the CORE20 alone and would benefit from a tailored health care approach:
  - o Adult key groups identified for Lincolnshire include Gypsy, Roma and Traveller groups, people experiencing homelessness, rural and coastal communities, farming, military families and carers.
  - o For children and young people this also includes children in care, care leavers, those in the justice system, those not in education, children with special educational needs and disabilities. Adults and children and young people with mental health conditions, learning disabilities and autism are also more likely to experience health inequalities.

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

- Priority 1: Restore NHS services inclusively.
  - o By understanding waiting lists, Did Not Attends (DNAs) and cancellations (all broken down by ethnicity and IMD quintiles).
- Priority 2: Mitigate against digital exclusion.
  - o Ensuring providers offer face to face care to patients who cannot use remote services and assessment of the impact of digital consultation channels on patient access.
- Priority 3: Ensure datasets are completed and timely.
  - o by prioritising improved recording and collection of ethnicity data across all settings of clinical data.
- Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes.
  - o through increased uptake of Covid-19 and flu vaccinations, ongoing management of long-term conditions and Annual health checks for people with learning disabilities.
- Priority 5: Strengthen leadership and accountability.
  - o Systems and Providers should have a named executive for tackling health inequalities.

The effectiveness of our response depends on a system approach, recognising the need for action by all partners across the whole range of factors that influence and determine inequalities. It will also depend on our ability to become increasingly sophisticated and systematic in the way that we use data and insight to build our understanding of our population's health and wellbeing needs – with a view to understanding how need varies between groups and at different levels of our system, as well as what groups and communities are impacted most by inequalities. With this in mind, we have in place a system-wide Prevention and Health Inequalities Executive Group between Lincolnshire's NHS and Local Authority with wider partners to reduce the avoidable inequity in people's health across the county.

Actions to address Health Inequalities

Our Health Inequalities approach promotes primary and secondary preventative services and addresses the inequalities in access and uptake, alongside work led through the ICP which targets the wider determinants of health. CORE20PLUS5 is embedded in our work.

Reducing health inequalities and improving health equity is everyone's business and will be a "golden thread" through all our work and at all levels from all partners. Changing the way we think about health inequalities and shifting to equality of outcomes for all by connecting the dots between the wider determinants of health and the population's health outcomes e.g. impact of jobs or housing on people's health.

Vision:

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

Approach:

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

Ambition:

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

This is achieved through action to address at three levels to have an influence on health outcomes:

- **Wider determinants:** Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and best start initiatives.
- **Prevention**: Actions to reduce the causes, such as improving healthy lifestyles – for example stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity.
- **Access to effective Treatment, Care and Support:** Actions to improve the provision of and access to healthcare and the types of interventions planned for all – for example ensuring there are health inequalities impact assessments for all commissioned services.

Working with partners to tackle Health Inequalities

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

Some examples of our key areas of work in 2023/24 include:

Embedding a system approach to health inequalities (HI)

- Working in partnership with the Primary Care Programme a Primary Care Network (PCN) Health Inequalities Leads Network was established in 2023. It meets bi-monthly, and the HI leads share their successes and learning of HI focussed work, raise HI questions for peer discussion and are given useful and relevant HI local/national updates.
- Three CORE20PLUS5 Ambassadors were accepted on NHSE Cohort 2. These Ambassadors will form local, regional and national networks and promote the importance of reducing HI and ensuring equitable access, excellent experience and optimal outcomes for all – particularly CORE20PLUS populations.
- Business Partners from the Health Inequalities team were established for key Programmes across the system. They work closely with Programme leads to embed Health Inequalities and identify opportunities to reduce HI.
- A Health Inequalities Voluntary, Community and Social Enterprise (VCSE) Grant Fund has been passported to Lincolnshire Voluntary Engagement Team (LVET) to run phase 2. Phase 1 has been successful in implementing 10 community projects to support reducing health inequalities across Lincolnshire.
- Plans in 2024/25 include providing programmes of Health Inequalities Training and Development including the Health Equity Assessment Tool (HEAT).

Demonstrating due regard in decision making (Section 14Z43 of the Health and Care Act 2022)

An Equality Impact Analysis (EIA) and Health Impact Assessment (HIA) is completed on all ICB commissioning decisions and policies to ensure access and inclusion for protected and marginalised groups and communities.

All service re-designs, business cases and project initiation documents (PIDs), new services and procurement exercises undergo a process of EIA.

The use of Health Equity Assessment Template (HEAT) has been embedded within the ICS planning processes, investment decisions and ICS governance arrangements in 2023/24.

HI performance and intelligence

- The most recent output in 2023/24 is the preliminary draft of the Health Inequalities Legal Duties performance report mandated by NHS England. This report consists of a variety of indicators across nine domains (domains include elective care, cardiovascular disease, and mental health, amongst others). It will provide data driven insights to reduce inequalities in health outcomes in these domains.
- Ongoing plans for 2024/25 include continuation of developing intelligence and insights to support understanding of health inequalities and prevention priorities; developing system HI metrics, KPIs & dashboards, improving data collection, utilising PHM approaches to address HI and work with system BI colleagues to develop HI elements of the joined data set reporting suite and creating a HI Hub.

HI in clinical areas and cross cutting themes

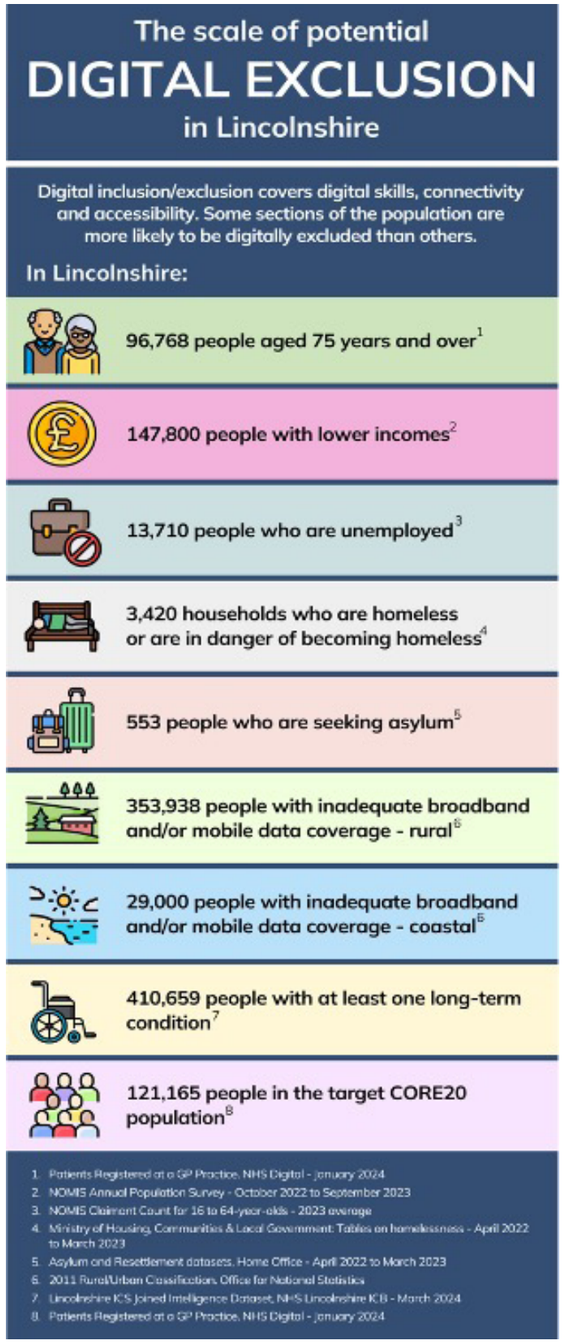
- We have worked with programmes to deliver against five national HI priorities and 5 clinical priority areas within CORE20PLUS5 for Adults and Children & Young People. The HI Bowel Cancer Screening Project is an example of this. We used data in the first instance to establish the correlation between deprivation and bowel screening uptake and have since focussed on understanding the key barriers and challenges that prevent people from completing their bowel screening in the seven most deprived GP Practices in Lincolnshire. In 2024/25 the project group, which is multiagency, will coproduce solutions with people from the selected GP Practices to increase the uptake of bowel screening and support reducing health inequalities.

Communication and engagement

- Insight from engagement with people and communities and a co-production approach is central to our work.
- The ICB has been successful and selected to form part of the CORE20PLUS5 Connectors Programme in 2023/24. Voluntary Centre Services (VCS) is the delivery partner, and the focus is on Children and Young People with Diabetes. This project will help understand what is driving the inequity of access identified and how to break down barriers across the county for access, experiences and outcomes.
- The Health Inequalities Bulletin was launched in 2023 and is distributed bi-monthly system wide and provides relevant local and national updates, training opportunities, useful statistics and case studies highlighting work being done in Lincolnshire to address health inequalities. At present, there is a distribution list of over 350+ staff and the reach is wider.
- The Lincolnshire Health Inequalities Community of Practice was refreshed in 2023/24 and is an information repository available to all health and care staff with resources to understand health inequalities, local & national data, tools & templates and a discussion forum to ask any questions to members of the workspace.

Prevention

- In November 2023, East Lindsey Primary Care Network (PCN) focused on the rural workforce, and identified that farming and agricultural workers often find it difficult to seek health checks and advice, such as blood pressure (BP) testing, due to the demands of their jobs. Pop up blood pressure clinics were provided including advice and support from One You Lincolnshire and Social Prescribing Link Workers. The PCN plans to come back to the factory to host more pop-up clinics to help employees on different work shifts, including those working outside of regular office hours. The company liked the clinic and how it fits with their efforts to improve employee health and wellbeing, even thinking about making it a yearly event.
- The Health Inequalities Programme funded the High Intensity Use project which launched in August 2023 in Trent PCN. Due to its success it plans to roll out across other PCNs over the next 18 months. High Intensity Use is defined as vulnerable individuals who use healthcare more than expected. The British Red Cross "Nowhere Else To Turn" report found a clear link between high intensity use of A&E and wider health inequalities, with frequent attendance in the most deprived parts of the country. The link workers try and understand the real or underlying reasons for these people attending A&E more frequently. The model is non-clinical and seeks to offer a strength and assets-based personalised conversation, being solution-focused and opening up the opportunity to understand what is important to people, and in turn, how people can be supported differently. It is still too early to measure the impact that the service has had, however, initial feedback from people who have been supported is positive.



Digital Inclusion

In 2023/24, we established a Digital Inclusion Strategy Group made up of system partners. We have established who is most at risk from digital exclusion in Lincolnshire and are working through the Digital Inclusion Framework which will support the development of a Digital Inclusion Strategy for Lincolnshire in 2024/25.

Inclusion Health

In 2023/24 we developed an 18-month series of Health Inclusion Workshops which aim to educate the Lincolnshire workforce on the health inequalities they face and provide an insight into how the experience, access and outcomes may differ to the rest of the population. The workshops have all been co-produced and are co-facilitated with people with lived experience and subject matter experts. A total of 176 staff from across the system have attended the workshops.

To date we have run the following Health Inclusion workshops;

- Gypsy, Roma, and Traveller
- Learning Disabilities
- Autism and Neurodiversity
- Military personnel, their families, and veterans
- People from Eastern European Backgrounds

What has become apparent from developing the workshops is the absence of data we have for some Health Inclusion groups which hides the health inequalities experienced by them. Utilising the NHSE Health Inclusion Framework we will develop a Health Inclusion Strategy for Lincolnshire in 2024/25. The need for accurate coding will be form part of this and help us to understand the Health Inequalities experienced by our Health Inclusion groups.

System Approach to Prevention

Working with system partners, Lincolnshire ICBs' 'life-style approach' to prevention continues to move forward at pace. Prioritising prevention in Lincolnshire is important as it supports people to live longer, healthier lives. Through helping individuals to make healthier lifestyle choices, we not only save lives by reducing premature mortality, but also contribute to the sustainability of the healthcare system by reducing avoidable illness and admissions.

The NHS Long Term Plan (LTP) provides funding for evidence-based NHS prevention programmes that include reducing smoking, obesity, and alcohol intake. In collaboration with the Local Authority commissioned integrated lifestyle service, 'One You Lincolnshire,', behavioural support is available across Lincolnshire to address the root causes of poor health, rather than to merely treat symptoms.

These services which are designed to help people stop smoking, maintain a healthy weight and make sure their alcohol intake is within a healthy limit; continue to grow and ensure equity of access for both NHS inpatients and the general population.

With support from system partners, Lincolnshire has expert programmes available as detailed on the next page.

Tobacco Dependency Services

Since January 2023, Mental Health patients at Lincolnshire Partnership NHS Foundation Trust (LPFT) and pregnant patients under United Lincolnshire Hospitals NHS Trust (ULHT) have been able to access 'in-house' Tobacco Dependency Services.

- Maternity: Implementing the NHS Long Term Plan, alongside the Saving Babies' Lives care bundle element, the Maternity Team has developed and implemented a new model of enhanced support for all expectant mothers, to become smokefree. From a variety of locations across Lincolnshire, patients identified as a smoker receive both behavioural support and Nicotine Replacement Therapy (NRT) from the STAAR (Stop Smoking Team – Act Advise Refer) Team for the duration of their pregnancy.
- Mental Health: Originally rolled-out in Rehabilitation Units, the QUIT Team now provides behavioural support and NRT to all Mental Health Inpatient smokers across Lincoln, Boston and Sleaford.
- Acute and Community Inpatients: Both services commenced in March 2024, with the acute service to initially be provided at Lincoln County Hospital before being rolled out further. The Community Inpatient services will begin within John Coupland Hospital (Gainsborough) with additional locations added upon successful recruitment of additional Tobacco Dependency Advisors.

As part of the full patient pathway, onward referral to One You Lincolnshire is provided for any patient that requests this upon discharge from NHS services. Therefore, ensuring ongoing support to aid long-term quit success.

Weight Management Services

Nationally there are four tiers of weight management for both Adult and Children each covering a different activity which plays a crucial role in providing a comprehensive approach to preventing and treating obesity.

Specifically for the population of Lincolnshire, Tiers 1 and 2 are provided within the county (NHS and County Council commissioned services), whilst Tier 3 and 4 services are currently provided in Derbyshire by University Hospital of Derby and Burton (UHDB).

The programme is establishing an NHS Weight Management Steering Group to provide oversight and assurance of this NHS Long Term Plan prevention priority. The first meeting of the group will be held in Quarter One 2024.

Alongside this we are working closely with all GP practices to raise awareness of and increase eligible referrals to the (Tier 2) NHS Digital Weight Management Programme (DWMP) which supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health.

Diabetes Prevention Programme

Referenced within weight management services, diabetes is another fundamental programme within prevention, as type 2 diabetes is largely preventable through lifestyle changes. The 'Healthier You' NHS Diabetes Prevention Programme (NDPP), also known as the Healthier You programme, is provided across Lincolnshire by Xyla Health and Wellbeing, and identifies people at risk of developing type 2 diabetes.

Whilst continuing to increase referrals to Tier 2 weight management services to help achieve remission in diabetes, we are working closely with Xyla Health and Wellbeing to ensure all GP practices are routinely referring eligible patients to the NDPP, and where necessary we are collaboratively liaising with practices to understand any barriers to referrals and/or uptake.

In utilising the approach of Making Every Contact Count (MECC); plans are underway to enlist the support of the specialist vaccination service team to also increase uptake in the Diabetes Prevention Programme.

This targeted focus on prevention will see the team undertake a dual role of providing both Covid-19 vaccinations during the booster programmes with the addition of a 'reach out service' around health promotion initiatives and holistic support. This work will be in conjunction with the two identified PCNs to target individuals on the diabetes register.

Working together with a specific population group, the aim will be to understand the barriers, challenges/ reasons leading to low referrals and uptake. Work will then commence to co-produce solutions with people with lived experience and key stakeholders to encourage, support and increase uptake.

In response to the NHS Long Term Plan, the ICB, along with system partners, set out plans last year to take a systematic population health approach to reducing health inequalities and addressing unwarranted variation in care.

Population Health Management (PHM)

Population Health Management defines the approach to supporting implementation of more preventative and personalised care models driven through the best use of data and intelligence and the application of high quality decision making at all levels of our system and organisation. This includes: 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.

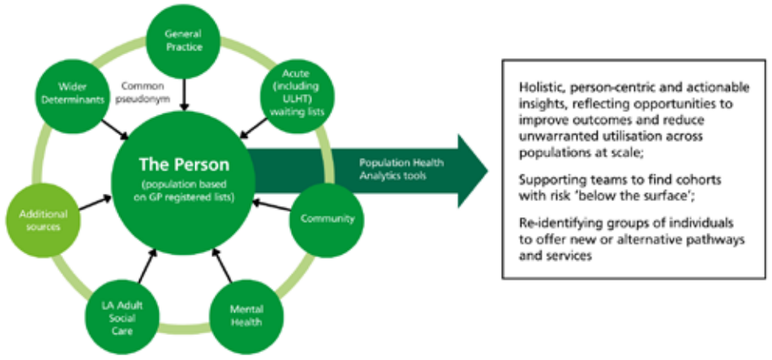
The ICB is committed to positioning PHM approaches at the heart of our system transformation and improvement initiatives; utilising the novel insights PHM provides to shape our system to meet the needs of our local people, ensure best use of our collective resources and to achieve better outcomes for the local population. PHM is recognised as best practice to enable gold standard decision making across the local system. Our ICS has a mature Population Health Management Programme which has been in operation since early 2020.

Our local PHM Programme seeks to create a Coalition of Interest and Intent with advocates of the methodology in all partner organisations across the system. Our approach to transformation aligns three key programmes which describe how we design and deliver effect change – PHM, Reducing Health Inequalities and Personalisation.

Our Intelligence Infrastructure

Enabled by a collaborative approach to Information Governance, the Lincolnshire Joined Intelligence Dataset (LJID) has been created and is available for use by colleagues across all statutory organisations and general practice. This dataset includes linked data from primary care, secondary care (acute and mental health), community services and adult social care for 100% of the Lincolnshire population. This dataset is considered to be one of the most comprehensive in the country.

Using linked data for PHM analytics



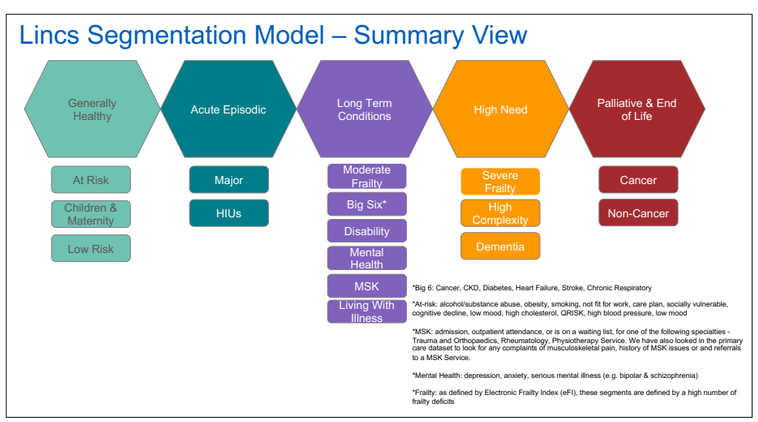
A robust workstream has been developed of Data Infrastructure and IG professionals to support and deliver on the ambitions for the linked dataset.

Analysts from across the ICB, Commissioning Support Unit, provider Trusts, Local Authority & general practice have access to the linked dataset to support their work.

The linked dataset is surfaced in the PHM Reporting Suite which enables analysts to interrogate the data and create new intelligence products and population insights for stakeholders across the system. It provides a single platform for advanced data and analytical techniques, such as population segmentation, risk stratification and financial risk modelling.

Population Segmentation

The PHM programme has led the design of the Strategic Segmentation Model for the local population. This defines a segmentation framework which allows the ICS to understand the population at the highest level, define the strategic outcomes for each segment of the population and agree how to measure our impact on the people within each segment.



This model will provide a touchstone to understand population health outcomes and serve as a common language around which the system can shape itself to better meet the needs of our people.

Workforce Training and Development

The Lincolnshire system has a well-established Analyst Network which includes over 100 colleagues from across partner organisations. This network provides a forum for training, peer support and open discussion about intelligence generation and use of the linked dataset.

The PHM programme will continue to deliver training, mentoring and buddying opportunities to non-analyst colleagues across Lincolnshire to build capability and capacity to utilise PHM methods at all levels of the system. This work focusses on three key outcomes:

- Collaborative working with analysts to effectively interpret available intelligence and generate insight
- Effective utilisation of intelligence in high quality decision-making, planning and intervention design
- Application of the full PHM cycle to drive transformation and improvement

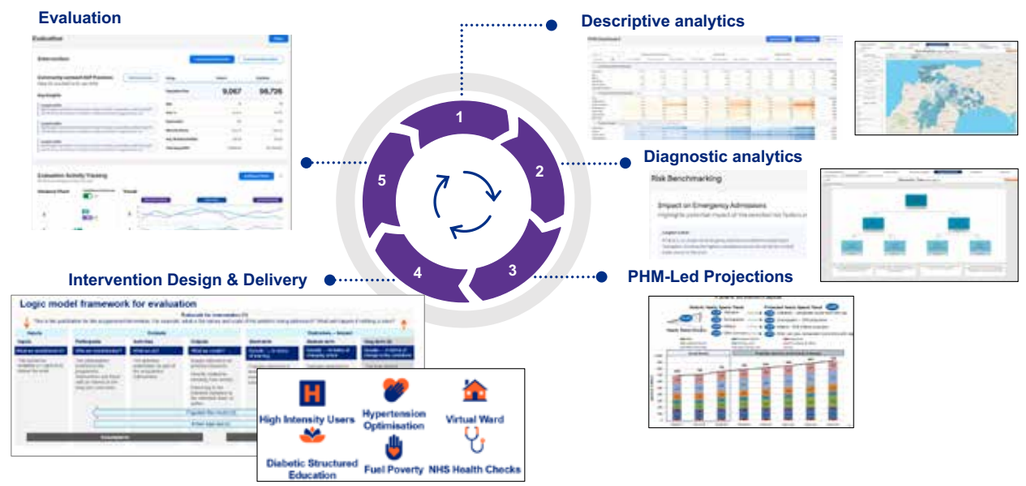
Innovation, Intervention and Implementation

Our local approach to PHM centres around creating space for collaboration, learning, and understanding our population, with diverse teams drawn from a variety of partners to enable effective working across organisational boundaries.

Following the PHM Cycle, teams are supported to understand a cohort of people, the challenges they face and the things we can improve to deliver better outcomes and health gain.

The PHM cycle embeds accurate impact modelling and evaluation into any new intervention designed and ensures evidence based decisions can be made about refining, upscaling or stopping new interventions or service with confidence.

The PHM cycle — insight, to action, to impact assessment



Equality, Inclusion and Human Rights (EHIR)

This report highlights key areas of Equality, Diversity and Inclusion (EDI) work achieved during April 2023 to March 2024. The information demonstrates Lincolnshire Integrated Care Board (LICB) compliance to the **Equality Act 2010, Public Sector Equality Duty (PSED) 2011** and how the ICB has, through the exercise of all its functions, given due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Key work achievements in 2023:

1. Workforce Race Equality Standard (WRES):

The WRES report 2023 and action plan 2023-2026 has been finalised, approved at the Senior Managers Operational Delivery Group (SMODG) meeting of 28th September 2023, and published on the ICB website at beginning of October (before the deadline of 31st October 2023).

Our focus for the next couple of years is to ensure improvements in the following areas:

WRES indicator 3: Limited data available to calculate ratio of White and BME staff entering the formal disciplinary process.

WRES indicator 5: Black, Asian and Minority Ethnic (BME) staff experiencing harassment, bullying or abuse, from patients' relatives and public in the last 12 months is 22.2% (11.9% above the national average of 10.3%) and White 9% (1.3% below the national average of 10.3%)

WRES indicator 6: BME staff experiencing harassment, bullying and abuse from other staff in the last 12 months is 16.7% (5.5% above the national average of 11.2%) and White staff 10.9% (0.4% below national average of 11.2%).

WRES indicator 7: BME staff believing that LICB provides equal opportunities for career progression or promotion is 25% (13.3 % below the national average of 38.3%) and White staff 45.5 (13.8% below the national average 59.3%)

A WRES action plan sets objectives and actions for the above areas and links to the high impact areas of the NHSE EDI Workforce Improvement Plan including:

- High Impact area 2: Overhaul recruitment processes and embed talent management processes.
- High Impact area 6: Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

2. Equality Delivery System ((EDS)

The ICB, as required by NHSE, commenced full implementation of EDS in 2023/24. This was the first time that the ICB worked on all three domains. With limited examples of previous work, it has been a process of ongoing learning, familiarisation and developing working relationships around the whole EDS framework. The following was achieved:

Domain One – Commissioned or Provider Services

The ICB chose to work with LCHS and agreed to focus on two service areas: Assess to Discharge and Stroke team. A task and finish group was set up to collect EDI evidence/information about the services which focused mainly on the following areas: -

- Service policies/practices for staff and patients
- Equality Impact Assessments as part of review/development of service practices
- Monitoring and analysis of staff/ patient data
- Consideration of accessibility issues

Main findings focused on lack of available workforce, patient and public equality data to assess disparities amongst different protected characteristics and socially excluded groups. A further finding was to promote the use of the Accessible Information Standard (AIS) to support patient communication accessibility requirements. A domain 1 action plan was produced to work on these areas.

Domain Two – Workforce Health and Wellbeing

Up to date workforce data/evidence relating to the EDS domain 2 outcomes was collected/analysed and a revised action plan for 2024-25 was developed. Data sources included ESR, annual staff survey and WRES data. Main findings of the report related to the need to have more effective communication of information including raising the awareness of managers and staff around bullying and harassment, health and wellbeing, raising confidence of managers to have caring conversations and encouraging the use of freedom to speak guardians, lack of sufficient workforce data - encouraging staff to fill in equality monitoring forms to self-classify so that ongoing monitoring can take place and gaps in practice can be identified and addressed.

An action plan was developed for domain 2 to support work around these areas.

Domain Three – Inclusive Leadership: Evidence for the 3 EDS outcomes was collected as below:

Outcome 3A: A letter and online form was developed. This was sent to all leaders Band 8a and above and those with line management responsibilities (mainly bands 6+). The responses have been analysed to form the evidence for this outcome.

Outcome 3B: Through the Head of Corporate Governance. A random sample of substantive Board or prime Committee papers from the last year, March 2022 to April 2023 was collected. The percentage of papers that identified equality-related impacts, through analyses or other assessments was defined, and how negative impacts were mitigated, monitored, and managed.

Outcome 3C: A template was provided, and information was gathered on the levers that are in place to manage performance and monitor progress with staff and service user.

In summary, the main findings showed that in all three outcomes ICB leaders were positively working towards ensuring EDI and health inequalities was on the agenda of various papers and committees. Improvements in the following areas were identified:

- Papers: Review of current templates that embed EDI and update as required.
- Attendance at cultural, religious or EDI events: To improve capacity to attend such events and networks or delegate to team to ensure visibility of ICB leaders.
- Improve scheduling of EDI issues/ monitoring on SMODG and Executive meeting agendas.
- Regular attendance at SMODG to support implementation and monitoring of WRES, EDS and future work around Workforce Disability Equality standard (WDES) and Gender Pay Gap (GPG) reporting.
- Consider the setting up of a data collection and analysis group to enable quarterly reports to be produced, to compare data and identify gaps – this would support ongoing review of WRES, EDS implementation and ICB EDI workforce objectives.
- Requirement for a task and finish group to work on EDS Domain Two and WRES action plans.

Regular updates of the whole EDS process and findings were shared with different stakeholder groups and through peer review meetings and benchmarked with other ICBs in the midlands.

Final EDS Scoring: Total scoring for EDS = 23.5 which just takes the ICBs into the 'achieving' level (those who score between 22 and 30, adding all outcome scores in all domains, are rated Achieving). All EDS domain reports including the final full report can be found here Documents Library - Lincolnshire ICB

Next steps for EDS work

- Implementation of action plans for all three domains.
- Task and finish group has been set up to support the implementation of domain 2 and WRES action plans.
- board Development Session took place on the 27th February 2024 to further develop/agree domain 3 objectives/ actions (see section 3).
- EDI Objectives/actions developed for 2024-2027, to meet the PSED, will be taken from some of the objectives/ actions of the EDS 1,2 and 3 action plans.
- Ongoing review of action plan outcomes will be undertaken and shared with SMODG and executive members on a quarterly basis.
- An EDS Assurance Group will be created to meet each quarter to monitor progress.

3. Board Development Session

This took place in February 2024 and provided a good opportunity for members to gain an update of EDI activities and compliance. It also enabled them to have discussions around objective setting and how they can support the delivery of EDI and produce a culture shift in EDI thinking within the ICB and wider system. EDI objectives have been drafted (see below) as a result of the session and, once approved, will form the basis of the EDI strategy for 2024-2027, work on which will commence from April 2024 onwards.

4. ICB EDI Objectives for 2024-2027

1. Leaders to drive the EDI agenda and create a sense of belonging through the delivery of measurable objectives on EDI for Chairs, Chief Executives and Board members, which align to the recently published EDI improvement plan high impact area 1.

a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

2. Strive to create a compassionate, diverse and inclusive culture by fostering an ethos across the ICS of wellbeing, inclusion and belonging.
3. Proactively address health inequalities in Lincolnshire using EDI and Health inequalities information as an integral part of the organisation and the Board decision making processes.

a. Joint work with population health and health inequalities team to regularly collect and analyse data to monitor health access and health outcomes with the aim to reduce health inequalities amongst different protected characteristics and health inclusion groups.

b. Undertake systemwide targeted health campaigns to improve access and outcomes for patients and public from different protected characteristics and health inclusion groups.

4. Comply with our EDI responsibilities and ensure that there are mechanisms in place to monitor the impact and cultural shift in the way we fulfil our ICB duties.

a. Monitor outcomes of results from WRES action plans setting further specific and measurable targets to address disparities within certain WRES indicators.

b. Implementation of WDES, Gender pay gap and Ethnicity pay gap, action planning and monitoring outcomes through appropriate governance processes.

c. Ongoing implementation of the three domains of EDS and monitoring of outcomes of action plans to sustain 'achieving' level and set processes in place towards reaching 'excelling' level.

For more information about our EIHR work please visit the equality webpage of the LICB Website: Commitment to Equality, Inclusion and Human Rights - Lincolnshire ICB

Compliments, Concerns and Complaints

Valuing Patient Experience

The ICB values the opportunity to hear what people think about the services we commission, and we use feedback to support decisions about services. We analyse complaints and monitor the themes and trends to promote learning. This information is reviewed in conjunction with other quality metrics to drive quality improvement and is used to further support the schedule of quality assurance visits which improves patient experience and patient outcomes.

Breakdown of Formal Complaints	
Quarter 1	16
Quarter 2	74
Quarter 3	63
Quarter 4	51
Total	**204**

From 1st July 2023, the ICB holds statutory responsibility for complaints handling for primary care services; this includes GPs, dentists, pharmacists and opticians, and was previously the responsibility of NHS England.

Whilst these formal complaints will be managed by the East Midlands hub, hosted by Nottingham & Nottinghamshire ICB, who will carry out complaint investigations on behalf of ICB, the The ICB will also hold overall responsibility for the complaint with sign off by the Chief Executive or delegated signatory. The ICB will also hold responsibility for managing informal concerns.

The change from 1st July 2023 is reflected in the increase of figures, within the breakdown of formal complaints, from Quarter 2 onwards.

During April 2023 to March 2024, we received 204 formal complaints, both directly from patients or their family, the public, and from Members of Parliament on behalf of their constituents.

LICB views compliments, concerns, and complaints as a valuable source of information and we use this as part of our ongoing monitoring for services we commission.

We ensure that we acknowledge all feedback received, making sure that any concern or complaint response is dealt with compassionately, effectively and in a timely manner.

To prevent informal concerns escalating to formal complaints, we endeavour to resolve concerns by either providing the information needed or signposting the complainant to the appropriate department or organisation to enable direct contact and response.

Our responses to concerns and complaints are administered in line with the Local Authority Social Services and National Health Service (England) Regulations 2009.

By the end of the reporting period 1st April 2023 to 31st March 2024, of these 204 formal complaints, 17 were upheld, 21 were partially upheld, 48 were not upheld, 17 were closed as not pursued, which leaves a total of 101 being carried forward.

Principles for Remedy

The ICB continues to use the Principles for Remedy for NHS Complaints, as set out by the Parliamentary and Health Service Ombudsman (https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy).

This identifies good practice with regards to providing remedies for patients wishing to make a complaint and these are supported by the ICB:

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

The ICB has adopted all six principles of remedy in the development of our complaints handing procedure and they form a core part of LICB's Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments.

The Policy clearly sets out the organisations process for handling complaints in order for the ICB to meet statutory requirements and how the ICB takes responsibility, acknowledges failures, provides an apology, and uses the learning from any complaint investigation to improve their services.

Freedom of information

The Freedom of Information Act 2000 (FOI) gives people a general right to access information held by or on behalf of public authorities. It is intended to promote a culture of openness and accountability among public sector bodies and to facilitate a better public understanding of how they carry out their duties, why they make the decisions they do and how they spend public money. Exemptions deal with instances where a public authority may withhold information under the FOI Act or Environmental Information Regulations. Exemptions mainly apply where releasing the information would not be in the public interest, for example, where it would affect law enforcement or harm commercial interests.

Requests are handled in accordance with the terms of the FOI Act and in line with best practice guidelines from the Information Commissioner's Office and the Ministry of Justice. In line with the requirements of the FOI Act, the ICB has a comprehensive Publication Scheme to make information about the ICB readily available to the public without the need for specific written requests. However, from 1st April 2023 the ICB processed 417* requests covering the following work streams: Commissioning and Procurement, Continuing Healthcare, Corporate information, Estates, Finance, Workforce information, Communication and Technology, Individual Funding Requests, Medicines Management, Mental Health, Policies, Primary Care, Services/treatments and Statistical Information.

Financial Summary

The annual accounts of the ICB have been prepared in accordance with the National Health Service Act 2006 (as amended) Directions by the NHS Commissioning Board, in respect of Integrated Care Boards' annual accounts. The accounts have been prepared on a 'going concern' basis to show the long-term commitment to healthcare services.

This is described at note 1.1 to the accounts. The annual accounts are detailed in in full from page 100 in this report.

The level of accuracy used in financial reporting for the ICB is informed by the materiality concept. A transaction can be material by the impact it has on the financial duties of the ICB, but also the reputational and legal implications for the ICB and its internal and external stakeholders. Where judgements and estimates have been made in the preparation of the financial statements, the concept of materiality has been used. However, it should be noted that the concept of materiality has not been applied to disclosures required by law and accounting guidance, precise figures have been used for these disclosures.

ICBs are set a Revenue Resource Limit (RRL) by NHS England that represents the maximum that can be spent in the year. This is used to inform the financial plan for the year. The ICB agreed an initial plan with NHS England to deliver a £2.4m under-spend against its in-year RRL. The ICS moved the forecast position to that agreed with NHS England as part of the 2023/24 financial operational reset process. This revised plan expected the ICB to deliver a deficit of £14.8m for the financial year. The actual outcome for the year was an £14.9m deficit at 31st March 2024, which equates to £0.1m adverse variance against the revised H2 financial reset plan.

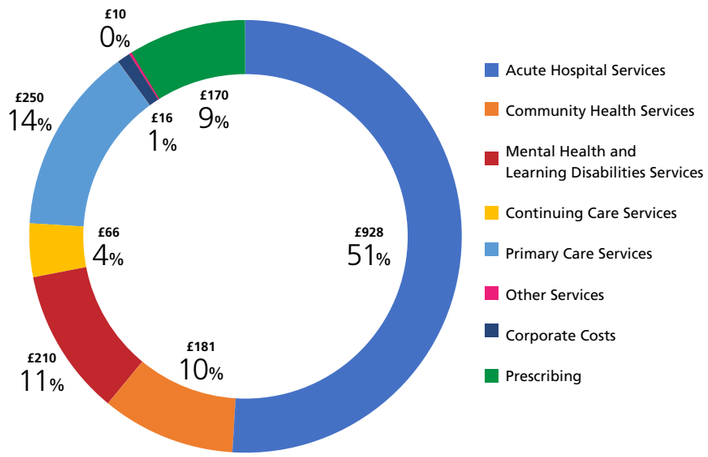
The ICB therefore failed to meet its financial breakeven duty in 2023/24. Under the National Health Services Act 2006 the ICB has not discharged its duties under sections 223GB to 223N (financial duties). The main drivers of the slightly adverse position were the effects of industrial action over the course of the year, and the impact of inflationary pressures, which were higher than plan at the start of the year.

The wider Lincolnshire NHS system (including the ICB and NHS providers) delivered a financial position that was in line with NHS England expectations, an impressive result given that the system as a whole absorbed significant costs associated with industrial action and inflation driven pricing pressures. The system as a whole exceeded its Financial Recovery Programme target with a £58.9m delivery against a plan of £55m. This achievement was fundamental for successful exit from NOF4.

The financial outlook for 2024/25 is challenging, and the Financial Recovery Plan will operate for a second year.

The ICB's plan for 2023/24 did not contain any planned capital resource use. The ICB had a capital allocation for Primary Care Services GP IT goods. Spend against this allocation is not recorded in the accounts of the ICB as all costs are reimbursed by NHS England and all assets are recorded in NHS England's accounts in line with their capital plan.

2023/24 Analysis of Net Expenditure (£m)



Summary Headline Financial Information

NHS Lincolnshire ICB's delivery of its financial targets for 2023/24 as follows:

	Financial Year Ended 31 March 2024		
	Commissioner Full Year for the period 1 April 2023 to 31 March 2024 £m	Lincolnshire Provider Full Year for the period 1 April 2023 to 31 March 2024 £m	Total Lincolnshire Care Services Full Year for the period 1 April 2023 to 31 March 2024 £m
Revenue Resource Limit	£1,814.8	£272.7	£2,087.4
Net Operating Expenditure	£1,829.6	£283.2	£2,112.9
Surplus/(Deficit)	-£14.9m	-£10.5	-£25.4

The ICB managed its administration functions within the allocated Running Costs Allowance of £16.2m.

Cash payments were also managed within the Maximum Cash Drawdown limit which was £1,861,708,947.21 as allocated by NHS England.

The ICB is an approved signatory to the Prompt Payment Code. This initiative was devised by the Government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses.

Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute. Approved signatories undertake to:

- Pay suppliers on time.
- Give clear guidance to suppliers and resolve disputes as quickly as possible.
- Encourage suppliers and customers to sign up to the code.

In the NHS, performance is measured by the Better Payment Practice Code which requires the ICB to pay at least 95% of valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The ICB is fully compliant with the code, with around 99% of non-NHS invoices paid within 30 days. Full details are given in Note 6 to the accounts.

The operating expenditure of the ICB can be split into two types:

- Programme – this is expenditure on the purchase of healthcare. The ICB overspent against its programme allocation. It spent 99.1% of its total resources on programme expenditure.
- Administration – costs that are not for the purchase of healthcare but relate to the direct running costs of the ICB. The ICB underspent on its Running Costs allocation. The ICB spent 0.8% of its total resources on administration expenditure.

Mental Health

The Mental Health Investment Standard (MHIS), set by NHS England, requires all ICBs in England to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year.

In Lincolnshire, we are committed to improving the mental health and wellbeing of our local people. 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 due to more efficient and effective services now being delivered in a more appropriate care setting. In 2023/24 NHS Lincolnshire spent £154.2m equating to 8.6% of its programme allocation on Mental Health Services which represented a 9.4% growth in expenditure spend on this service in Lincolnshire.

The Lincolnshire system therefore delivered against the against the MHIS target for the financial year.

Mental Health Spend (£m)	£154.2
ICB Programme Allocation (£m)	£1,798.6
Mental Health Spend as a proportion of ICB / CCG Programme Allocation	8.6%

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

The Accountability Report

Corporate Governance Report

Members' Report

The Members' Report has been prepared by ICB Board.

The Board is responsible for ensuring the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the ICB's principles of good governance.

The ICB Board consists of the ICB Chair, the Chief Executive, Director of Finance, Director of Nursing, Medical Director, six Non-Executive Directors, three Partner Members representing NHS and Foundation Trusts, Local Authority and Primary Medical Services, senior managerial support and representatives from Public Health, Healthwatch, Health and Wellbeing Board and Voluntary Sector.

Sir Andrew Cash was the Interim ICB Chair for the reporting period 1st April 2023 to 31st August 2023. Dr Gerry McSorley was the Acting ICB Chair from the 1st September 2023 to 31st March 2024. Mr John Turner has been the Chief Executive (Accountable Officer) for the reporting period 1st April 2023 to 31st March 2024.

The composition of the Board and the Audit and Risk Committee through the year and up to the signing of the Annual Report and Accounts (including advisory and Non-Executive Directors) is outlined in this section. Details of members of other committees and sub-committees are set out in the Annual Governance Statement (AGS).

The ICB Board is up to its full establishment of six Non-Executive Directors but one individual is acting up into the role of ICB Chair. The appointment of the substantive Chair is subject to Secretary of State approval.

Name	Role
Cllr Wendy Bowkett	Partner Member, Local Authority
Sir Andrew Cash	Interim ICB Chair (1st April 2023 to 31st August 2023)
Mrs Sarah Connery	Executive Board Mental Health Member
Ms Anita Day	Non-Executive Director (from 1st September 2023)
Mr Martin Fahy	Director of Nursing
Mrs Maz Fosh	Partner Member, NHS & Foundation Trusts (1st April 2023 to 31st July 2023)
Mr Matt Gaunt	Director of Finance
Dr Sunil Hindocha	Interim Medical Director
Mrs Dawn Kenson	Non-Executive Member, Chair of Service Delivery and Performance Committee and Acting Deputy ICB Chair (from 1st January 2024)
Dr Gerry McSorley	Acting ICB Chair (1st September 2023 to 31st March 2024) and Chair of the Primary Care and Delegated Functions Committee and Remuneration Committee (up to 30th August 2023)
Mr Andrew Morgan	Group Chief Executive and Partner Member, NHS & Foundation Trusts (from 1st August 2023)
Mrs Julie Pomeroy	Non-Executive Member, Chair of Finance and Resource Committee and Remuneration Committee (from 1st September 2023)
Mrs Margaret Pratt	Non-Executive Director and Chair of the Audit and Risk Committee (interim up to 30th June 2023 – substantive from 1st July 2023)
Mrs Clair Raybould	Director for System Delivery (Board Member from the 1st August 2023)
Mrs Sharon Robson	Non-Executive Director and Chair of the Quality and Patient Experience Committee (from 14th August 2023)
Dr Kevin Thomas	GP and Primary Medical Services Representative
Mr John Turner	Chief Executive
Professor Sir Jonathan Van-Tam	Non-Executive Member and Chair of System Quality and Patient Experience Committee (up to 22nd May 2023)

Regular Participants

Name	Role
Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
Mr Simon Evans	System Director of Clinical Integration and Leadership Development (up to 13th August 2023)
Mrs Sarah Fletcher	Healthwatch Representative (up to May 2023) – replaced by
Mrs Michele Jolly	Voluntary and Care Sector Representative
Mrs Sarah-Jane Mills	Director for Primary Care and Community and Social Values
Mrs Sandra Williamson	Director for Health Inequalities and Regional Collaboration
Professor Derek Ward	Director of Public Health
Cllr Sue Woolley	Chair of the Health and Wellbeing Board

Committees

In order to discharge its duties effectively, the Board has a number of formally constituted Committees as set out in the ICB Constitution and Corporate Governance Handbook, which includes the Scheme of Reservation and Delegation.

The ICB Board has two statutory Committees. They ensure the ICB is compliant with statutory responsibilities and functions.

- Audit and Risk Committee (ICB Committee)
- Remuneration Committee (ICB Committee)

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

- Primary Care Commissioning and Delegated Functions Committee (ICB Committee)

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

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

These Committees are ICB Joint Committees with the three provider partner organisations in Lincolnshire. They are Chaired by an ICB Non-Executive Director and include Non-Executive Director representation from each of the three provider organisations – Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust.

All Board Committees are accountable to the ICB Board and report to the Board on how they discharge their responsibilities.

A table detailing the ICB Non-Executive Director membership of the Board Committees is detailed below:

Committees and NEMs	Gerry McSorley (GM)	Dawn Kenson (DK)	Jonathan Van-Tam (JVT)	Julie Pomeroy (JP)	Margaret Pratt (MP)	Sharon Robson (SR)	Anita Day (AD)
Audit and Risk		X		X	X (Chair)		
Remuneration	X (Chair up to August 2023)	X	X (to May 2023)	X (Chair from September 2023)	x (in attendance only)	X	x (September 2023 onwards)
Primary Care Commissioning and Delegated Functions	X (Chair)		X (to May 2023)	X			
Service Delivery and Performance		X (Chair)					
Quality and Patient Experience			X (Chair) (to May 2023)			X (Chair) (August 2023 onwards)	
Finance and Resource Committee				X (Chair)			

Audit and Risk Committee – Interim Chair, Mrs Margaret Pratt (from 1st April 2023 through to 30th June 2023). Confirmed Chair from 1st July 2023.

The Audit and Risk Committee meets at least four times a year and is chaired by the Non-Executive Director with lead responsibility for governance. The Committee has met six times between 1st April 2023 to 31st March 2024 and has had 83% attendance from Non-Executive Directors. All meetings were quorate.

The Audit and Risk Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across all activities that support the ICB in achieving its objectives.

A key purpose of the Audit and Risk Committee is to monitor the integrity of the ICB's financial statements and assure itself that relevant risks, particularly financial, are appropriately identified and managed within a robust system of internal control. The Audit and Risk Committee is also responsible for seeking appropriate assurance on arrangements for counter-fraud and audit work programmes.

The Audit and Risk Committee has been attended by, and updates have been received from, the ICB's Internal and External auditors as well as its Counter Fraud Service at each meeting along with updates on Information Governance. The Audit and Risk Committee also receives regular updates on the development of risk management systems for the ICB including the development and establishment of the Board Assurance Framework in line with the ICB Strategic Risks.

During the period 1st April 2023 to 31st March 2024 the Committee has regularly provided reports to the ICB Board and has produced its Annual Report covering the period 1st April 2023 to 31st March 2024 and a Self-Assessment.

These documents were presented to the ICB Board at its private meeting held on the 28th May 2024.

The membership of the Audit and Risk Committee for the period 1st April 2023 to 31st March 2024 comprised:

Name	Role
Mrs Julie Pomeroy	Non-Executive Director
Mrs Margaret Pratt	Non-Executive Director – Acting Chair of the Audit and Risk Committee up to 30th June 2023. Confirmed Chair from the 1st July 2023.
Mrs Dawn Kenson	Non-Executive Director

The following people are also in attendance:

Mr Matt Gaunt,
Director of Finance

Emma Rhodes, Deputy Director of Finance

Mrs Julie Ellis-Fenwick,
ICB Board Secretary

Internal Audit representatives, PwC from 1st April 2023 to 30th June 2023 and then TIAA from 1st July 2023

External Audit representatives, Ernst and Young

Local Counter Fraud Specialist

Remuneration Committee – Chair, Dr Gerry McSorley (up to 31st August 2023). Mrs Julie Pomeroy, Chair (from 1st September 2023).

The Remuneration Committee meets as required throughout the year and is chaired by one of the ICB Non-Executive Directors.

The Remuneration Committee met five times between 1st April 2023 to 31st March 2024 and has had 100% attendance from Non-Executive Directors. All meetings were quorate.

The Committee's main role is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B of the NHS Act 2006, which in summary is to:

- Confirm the ICB Pay Policy including adoptions of any pay frameworks for all employees including senior managers/ directors (including Board Members) and Non-Executive Directors.

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

Further information on the membership and attendance by the Non-Executive Directors of the Remuneration Committee is detailed on page 85.

Primary Care Commissioning and Delegated Functions Committee – Chair, Dr Gerry McSorley

The Primary Care Commissioning Committee (PCCC) is Chaired by one of the ICB Non-Executive Directors. The Committee has met four times in public between 1st April 2023 to 31st March 2023 and has had 83% attendance from the Non-Executive Directors. All meetings were quorate.

The Primary Care Commissioning Committee has also held a number of development sessions during the period 1st April 2023 to 31st March 2024. Topics discussed are listed below:

- Primary Care Recovery Plan

- Update on the People Plan

- Digital Risk Assessment

- Frailty Strategy

- Foundation for further discussions on the PCCC's role for strategic commissioning of POD and the relationship with regional arrangements.

PCCC have increased awareness of regional POD arrangements covering:

- POD commissioning
- Risk and issue management
- Governance, funding and reporting
- Quality assurance.

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

Finance and Resource Committee – Chair, Mrs Julie Pomeroy

The Finance and Performance Committee is Chaired by one of the ICB Non-Executive Directors. The Committee has met 12 times between 1st April 2023 to 31st March 2024 and has had 69% attendance from Non-Executive Directors. All meetings were quorate.

The Committee was established to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- Financial performance of the ICB;
- Financial performance of NHS organisations within the ICB footprint.

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

System Quality and Patient Experience Committee – Chair, Professor Sir Jonathan Van-Tam (up to 22nd May 2023). Chair, Mrs Sharon Robson, Chair (from 14th August 2023)

The System Quality and Patient Experience Committee (QPEC) is chaired by one of the Non-Executive Directors.

The Committee has met seven times between 1st April 2023 to 31st March 2024 and has had 75% attendance from Non-Executive Directors. All meetings were quorate.

The Quality and Patient Experience Committee conducts its role in a number of ways including scrutinising the clinical effectiveness of commissioned health care providers both in and out of the county. This work involves crosschecking multiple sources of information that the ICB receives, such as complaints data, patient experience feedback, performance data, incidents, infection rates and staffing levels.

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

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

Service Delivery and Performance Committee – Chair, Mrs Dawn Kenson

The Service Delivery and Performance Committee is chaired by one of the Non-Executive Directors.

The Committee has met 12 times between 1st April 2023 to 31st March 2024 and has had 88% attendance from Non-Executive Directors. All meetings were quorate.

The Committee was 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 key focus of the Committee is on progress and delivery of the Lincolnshire NHS system strategic priorities and operational plan; this being a sub-set of the broader Integrated Care Strategy.

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

As referred to in the Annual Governance Statement, after each Board Committee meeting an assurance report is prepared and presented to the Board for consideration. This includes a summary of items discussed and any areas for escalation. The presentation of these reports ensures the Board receives timely information rather than waiting for the presentation of full minutes.

Each of the Board Committees also completed a Self-Assessment in December 2023 as part of the Board's review of its governance and functions. The outcome of the assessments was considered by the Board as part of its Development Session held on the 19th December 2023. Further information on the Board development work is detailed in the Annual Governance Statement.

Register of Interests

The ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure and be able to evidence that these decisions secure the best possible services for the population it serves, the ICB must demonstrate accountability to relevant stakeholders, particularly the public, and probity and transparency in the decision-making process.

As required by section 14Z30 of the NHS Act 2006, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

The ICB has established a Standards of Business Conduct and Conflicts of Interest Policy, which was approved by the ICB Board at its first meeting held on the 1st July 2022. This policy sets out clear procedures to deal with situations where an officer/member has a conflict of interest and is included in the ICB Governance Handbook available here: www.lincolnshire.icb.nhs.uk

In accordance with section 14Z30(2) of the NHS Act 2006 registers of interest are recorded in the ICB Registers of Interests which is published on the ICB website.

One of the requirements of the statutory requirements for an ICB is to identify a Conflicts of Interest Guardian. The ICB's Conflict of Interest Guardian is Mrs Julie Pomeroy, Non-Executive Director.

The Conflicts of Interest Guardian is responsible for:

- Being a safe point of contact for employees or workers of the ICB to raise any concerns in relation to the policy.
- Acting as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns regarding conflicts of interest.
- Providing support, independent advice and judgement on non-publication of conflicts and minimising risks.
- Providing advice on minimising the risk of conflicts of interest.

Personal data related incidents

There has been one serious incident as a result of a breakdown in business process in 2023/24 relating to ICB access to GP clinical data which was not reportable to the Information Commissioners Office (ICO) as there was no breach to personal data. Further details of the ICB's Information Governance arrangements can be found within the Annual Governance Statement.

Modern Slavery Act

The ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Lincolnshire Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed Mr John Turner to be the Accountable Officer of NHS Lincolnshire Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Lincolnshire Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Ernst and Young auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

Annual Governance Statement

1st April 2023 to 31st March 2024 Lincolnshire ICB

Introduction and context

NHS Lincolnshire Integrated Care Board is a body corporate established by NHS England on 1st July 2022 under the National Health Service Act 2006 (as amended).

The Integrated Care Board's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

Between the 1st April 2023 and 31st March 2024, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Lincolnshire Integrated Care Board's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Lincolnshire Integrated Care Board's Accountable Officer Appointment Letter.

I am responsible for ensuring that the Lincolnshire Integrated Care Board is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Integrated Care Board as set out in this governance statement.

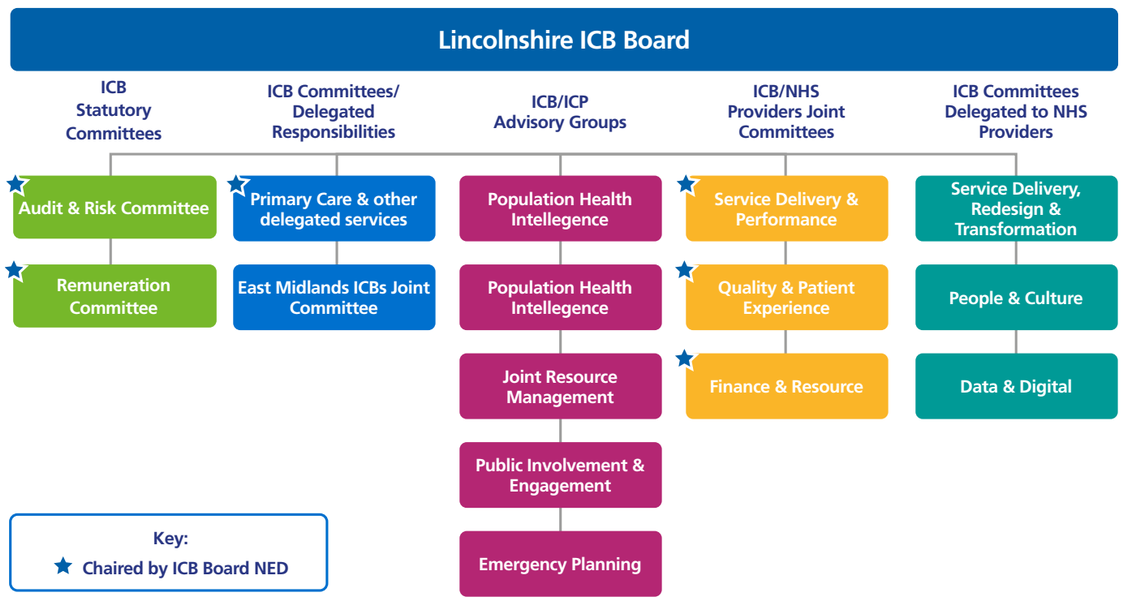
Governance arrangements and Effectiveness

The main function of the ICB Board is to ensure it has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The ICB is legally required to have a Constitution which sets out the statutory framework within which the ICB operates. The ICB Constitution was approved by NHS England in line with 'The Integrated Care Boards (Establishment) Order 2022. The Constitution was last amended in July 2023 to enable the ICB to participate in Joint Committee arrangements for the provision of certain services and also to reflect a change in the membership of the Board.

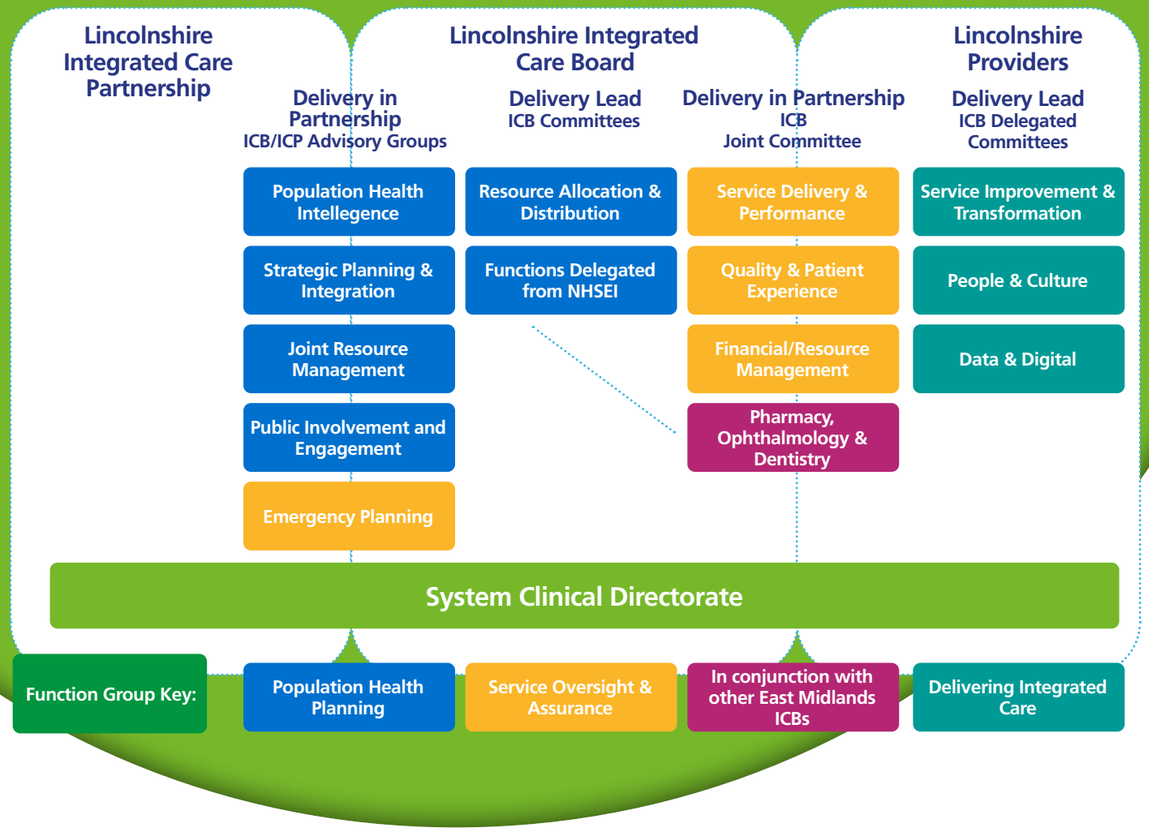
ICB Governance Structure

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



ICB Function Map

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



The Constitution is supported by documents which provide further detail on governance arrangements in the ICB. These include Standing Orders, Scheme of Reservation and Delegation and associated financial authority limits. These documents are reviewed regularly.

The ICB Governance Structure is supported by the ICB Functions and Decisions Map to facilitate transparent decision-making and foster the culture and behaviours that enable system working. It demonstrates which key decisions are delegated and taken by which part or parts of the system.

The ICB's Committee structure supports the ICB's governance processes and ensures that there is effective monitoring and accountability arrangements for the systems of internal control. The Terms of Reference for these Committees have been reviewed during the year to ensure robust governance and assurance arrangements are in place and that they remain appropriate for the ICB.

The ICB Board ensures that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it. The ICB Board sets the ICB's vision, values and strategic objectives, and formulating strategies, plans and policies. The ICB Board then holds the organisation to account for the delivery of these, ensures that the organisation operates with openness, transparency and candour, and seeks assurance that systems of control are robust and reliable and that statutory duties are being met. The Board is also responsible for creating a healthy culture within the organisation and the wider system through its interaction with system partners.

The Board met seven times between 1st April 2023 to 31st March 2024. The Board had 80% attendance from all Members. All meetings were quorate, and any decisions made were exercised in line with the ICB Constitution and Standing Orders.

There was one meeting in 2023 where the ability to exercise emergency powers was used in line with the ICB Standing Orders. This related to the ICB's submission to NHSE of the Financial Operating Reset Plan in response to the significant financial challenges created by industrial action in 2023. The exercise of such powers was reported to the next formal meeting of the ICB Board for formal ratification, and the Audit and Risk Committee for oversight.

The Board has performed effectively throughout the period 1st April 2023 to 31st March 2024 in ensuring good governance around the ICB's decision making processes and in setting up a robust Committee structure to manage areas of risk and priority for the ICB. In making this statement, my sources of evidence and assurance are demonstrated through having the right skill mix and experience of Board Members with clearly defined roles and responsibilities (both as individuals and as a unitary Board). There have been some changes to the Board Members in 2023, including the appointment of an Acting ICB Chair (following the departure of the ICB Interim Chair in August 2023), an Acting Deputy ICB Chair, two new Non-Executive Directors to replace two previous NEDs who left in 2023, and a sixth Non-Executive Director, which has strengthened the skill mix of the Board.

In accordance with good governance practice, Board matters are supported by a forward plan which is a key mechanism for enabling the Board meetings to function efficiently and prioritise key items of business.

The Board agendas and supporting cover sheet for reports are demonstrably aligned to the four core purposes of the ICB. During 2023 the Board reviewed and strengthened its front cover sheet to include an additional section to identify inclusion areas such as data protection, quality and equality impact assessments.

All reports to the Board and its Committees have mandatory sections on the assessment of health inequalities impact, equality and diversity impact and risk and assurance.

Board Performance and Development

The ICB Board is committed to being a strong dynamic and effective Board operating in line with best practice. As part of that commitment, in September 2023 it agreed to undertake an assessment of its governance and functions by commissioning expert independent facilitation to support its assessment and review process.

The Board held six Development Sessions in 2023/24 which considered a number of topics, which provided further assurance about the developing governance of the ICB.

In December 2023 the Board completed a Self-assessment exercise, the outcome of which was considered as part of a facilitated Board Development Session held on the 19th December. A further session was held in February 2024 which served as a reminder of work undertaken to date and Board aspirations and potential next steps. Five key themes were agreed at that meeting which will be progressed in 2024/25.

The Board also considered Equality Diversity and Inclusion (EDI) responsibilities in the ICB at the February 2024 session. Further information on the EDI and the Public Sector Equality Duty feature in the performance section of the Annual Report.

The Board will continue to have Development Sessions throughout 2024/25.

Annual assessment of Integrated Care Boards

The ICB is subject to external scrutiny by NHS England which has a statutory duty to conduct an annual retrospective performance assessment with respect to each financial year and publish a summary of these assessments. The ICB received formal feedback in July 2023 which recognised that overall the Lincolnshire system had delivered well against the Exit Criteria of the Recovery Support Programme. Operational Performance had also improved, and good progress had been made in relation to the on-going actins relating to provider landscape developments.

In February 2024, NHS England issued a communication setting out the key principles of the assessment and actions required to support the 2023/24 assessment, which set out a similar approach to 2022/23. NHS England will use the ICBs Annual Report as the key source of evidence for the 2023/24 assessment. In preparation for this, the ICB has facilitated appropriate tailoring of the Annual Report to the structure of the annual assessment.

Board Committees

Information on the Board Committees, including their key responsibilities, membership, attendance records and highlights of their work during the period 1st April 2023 to 31st March 2024 is detailed in the Members' report.

As Accountable Officer I rely on the effective operation of the Committees and gain assurance through the reports which are produced following each meeting and presented by the respective Non-Executive Director Committee Chairs. These reports detail items of particular note, areas of risk and points of escalation for consideration.

UK Corporate Governance Code

Whilst NHS Bodies are not required to comply with the UK Code of Corporate Governance, for the period 1st April 2023 to 31st March 2024, the ICB has considered the principles of the UK Code of Corporate Governance as relevant to the ICB including drawing on other best practice available. As Chief Executive I believe this is important context for my assessment of the governance of the ICB.

The Annual Governance Statement demonstrates how the ICB has regard to the principles set out in the Code considered appropriate for ICBs.

Discharge of Statutory Functions

The ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the Integrated Care Board is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the Integrated Care Board's statutory duties.

Further information can be found in the performance section of the Annual Report on how the ICB has discharged its general duties as per sections 14Z34 to 14Z45 and 14Z49 of the NHS Act 2006 (as amended).

Risk management arrangements and effectiveness

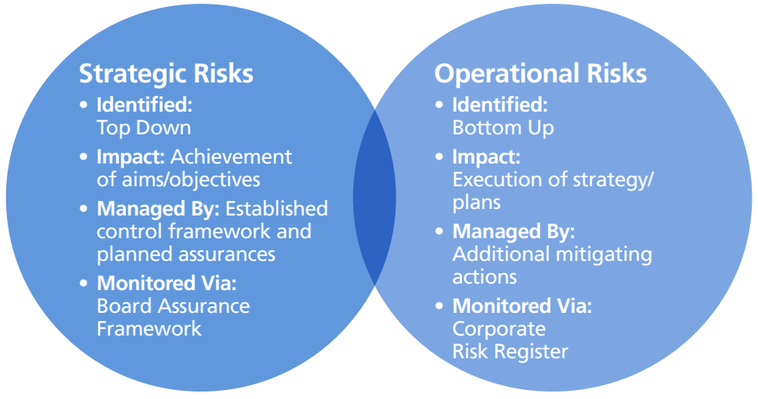
A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. Effective risk management ensures processes are in place to proactively identify, understand, monitor and address current and future risks; both operationally and strategically.

This integrated risk management system includes the Risk Management Framework, Strategy and Policy, which clearly sets out the processes in place to ensure the systematic identification, assessment, evaluation and control of risks, including arrangements for the Corporate Risk Register (CRR) and Board Assurance Framework (BAF).

It enables the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the ICB objectives.

The policy is in line with and has adopted the following principles of risk management as set out in guidance provided by ISO 31000: 2018 standard.

The organisation's strategic risks are outlined within the Board Assurance Framework, which provides the Board with confidence that the ICB has identified its strategic risks and has robust systems, policies and processes in place that are effective and driving the delivery of its strategic objectives.



All strategic risks are owned by an Executive Director of the ICB and are aligned to a specific Board Committee.

By contrast, the ICB Corporate Risk Register comprises operational risks, mainly identified by services themselves. It does not include all the organisation's operational risks – just the most significant ones.

Each Programme within the ICB has and maintains its own Risk Log with only those who have a score of 12 or more identified for escalation and inclusion on the Corporate Risk Register.

All risks are owned by members of the ICB's Senior Leadership Team and are regularly reviewed by the Risk Management Group and mitigations tracked for evidence of effectiveness and improvement.

As part of the year end audit process for the period 1st July 2022 to 31st March 2023 the ICB's external auditors observed as part of their Value for Money reporting that the formal process for the assessment of risk had not yet been finalised including population of the BAF. During 2023/24 a considerable of work has taken place on the development of the BAF. The Audit and Risk Committee has been briefed regularly on the progress and of robust risk management arrangements for the ICB, including the development of the ICB Board Assurance Framework (BAF), Corporate Risk Register and Risk Appetite. To support this on-going work the BAF and Risk Appetite has been a key part of the agendas for the Audit and Risk Committee and the Board Development Sessions.

The BAF is a live document and has been continuously updated during 2023/24.

TIAA, the ICB's internal auditors, carried out an audit review of the adequacy and effectiveness of the ICB's risk management arrangements including how it interfaces with the ICS wide risk management structures in 2023/24. This review also considered the extent to which risk management arrangements are linked to the ICS whilst ensuring accountability at the ICB. The outcome of the review identified some actions to be taken forward in the first quarter of 2024/25 in respect of the ICB's risk management arrangements and key documents, such as the CRR and BAF. Overall, the review indicated adequate and effective risk management arrangements provide the ICB Board with reasonable assurance that systems underpinning risk management are effective and can be relied upon to provide assurance that the main risks to the achievement of the ICB's key strategic objectives are effectively managed.

As Accountable Officer this provides me with assurance that the ICB has sound and effective risk management arrangements in place.

Stakeholder Involvement in managing risks

The ICB Board membership is inclusive to ensure diverse public stakeholders and other stakeholders' voices help inform ICB decision-making and assist in highlighting risks at ICB Board level. The ICB Board has a strong Non-Executive Director leadership for audit and governance; finance and performance; system delivery; workforce, digital and health inequalities; and quality and patient experience. The ICB Board also includes our Partner members from Trusts, Local Authority and Primary Medical Services; Chief Executive, Director of Finance, Director of Nursing, Medical Director and Director of System Delivery. The Director of Public Health, Chair of the Health and Wellbeing Board and representatives from Healthwatch and the Voluntary Sector and Care Sector also attend and are active participants in the Board meetings.

The Board has also strengthened its relationship with local NHS Trust provider organisations by inviting their respective Chairs to attend and participate in the Board Development Sessions. From April 2024 this has been extended to the Lincolnshire County Council's Director of Adult Social Care.

Further information about stakeholder involvement is detailed in the main body of the report, including the ICB's links with the University of Lincoln and the Medical School and specific information on research work and action to improve gaps in the NHS workforce in Lincolnshire that has been progressed in 2023/24 and plans going forward.

Risk Assessment

Risk identification, assessment and monitoring is a continuous structured process in ensuring that the ICB works within the legal and regulatory framework, identifying and assessing possible risks facing the organisation, and planning to prevent and respond to these.

The key forums for the management of risk in the ICB are outlined below:

Risk Management Group

- Has delegated duties as the 'gatekeeper' for escalation and de-escalation of any key risks.
- Has responsibility for the management of risk monitoring and action.
- Reports to the Senior Management Operational Delivery Group on a monthly basis.
- Reports to the Audit & Risk Committee on a quarterly basis.

Senior Management Operational Delivery Group

- Has oversight of the Risk Management Group
- Receives a monthly report.

Audit & Risk Committee

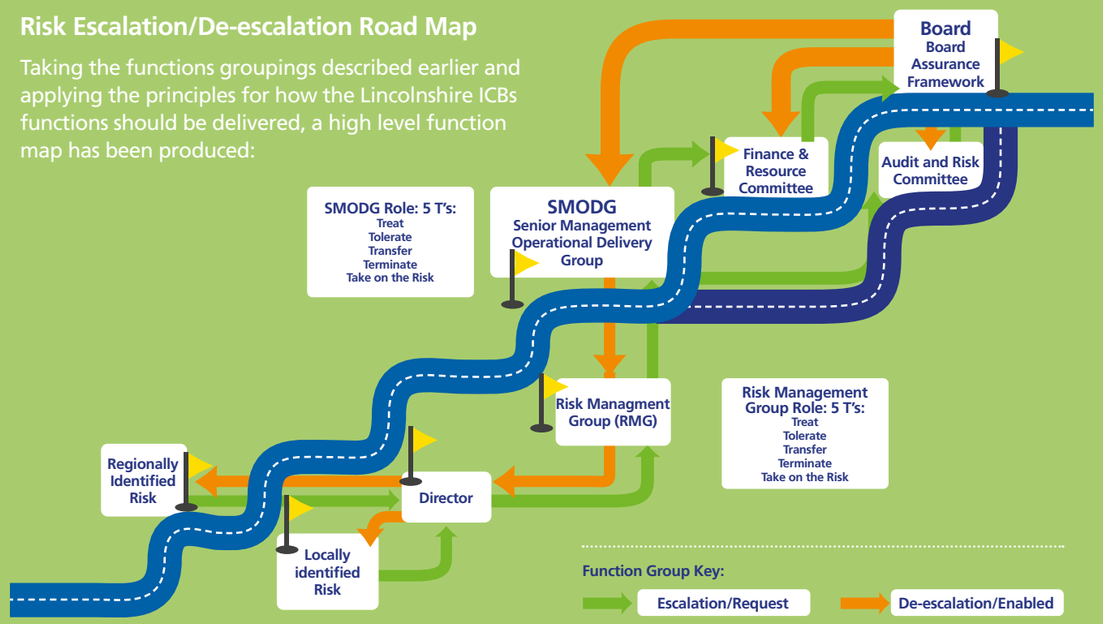
- Responsible for seeking assurance for the Board in order that the systems of internal control are managing risk is appropriate.
- Receives a report of risks from the Risk Management Group on a quarterly basis.

The ICB escalates risk for two reasons. Firstly, for information, and secondly when a risk requires action or resource/ authority to proceed from an authorised source.

In conclusion - NHS England (NHSE) has confirmed that there are no identified risks to compliance with the ICB licence.

Risk Escalation/De-escalation Road Map

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



Risk Register

Building on the work carried out thus far by the ICB, the Corporate Risk Register (CRR) has been further refined and the format refreshed and refined in the light of the duties and accountabilities of the ICB. All previous 'legacy risks' from the previous CCGs have been archived in line with internal risk management processes.

At the end of 2023/24, the ICB had two current risks on the Corporate Risk Register covering primary care/ GP resilience and ICS financial position, and two horizon scan risks for internal financial ledger system update and cyber security. Only one of those (cyber) is rated as high risk.

The ICB risk scoring matrix is detailed below:

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

Commissioning Support Unit

The ICB purchases the majority of its commissioning support services from Arden & GEM CSU.

This includes the following:

- Provider Management
- Business Intelligence
- Human Resources
- Information Governance
- Equality and Diversity
- Health and Safety
- Business Continuity
- Freedom of Information

The ICB keeps all contracts under review in order to ensure efficiency and value for money. The ICB also receives Service Auditor Reports which provide assurance about the operation of their internal controls, and which are detailed later in the Annual Governance Statement along with other sources of assurance, such as from Internal Audit.

Other sources of assurance

Internal Control Framework

A system of internal control is in place in the Integrated Care Board to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The ICB system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk, it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Audit and Risk Committee has specific responsibility for reviewing, managing and reporting risk to the Board. There are controls in place to comply with good practice and these are audited by internal and external auditors each year.

The internal audit programme covers key areas of the ICB business on a risk-assessed basis to review the ICB's compliance with agreed policies and procedures. In 2023/24 the Head of Internal Audits opinion on the efficacy of the operation of internal controls is that reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Where internal audit assess that controls require improvement; or where compliance with agreed controls needs to be strengthened, management agree the actions to be taken and are then held accountable for delivering the agreed improvements. The Audit and Risk Committee monitor the delivery of agreed improvements against the timescales agreed by management.

Data Quality

The data used by the Board is based on the NHS national data sets. All data is checked for accuracy and is automated to avoid errors and inconsistency. To ensure consistency, procedures are documented and regularly reviewed. There have been no data quality issues reported between the period 1st April 2023 to 31st March 2024.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information, and special category data.

This framework is supported by NHS Digital's Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the Integrated Care Board, other organisations and to individuals, that personal information is safeguarded securely and used properly in line with National Data Guardian requirements. The ICB is not required to submit its DPST until 30th June 2024.

There are processes in place for incident reporting and investigation of serious incidents. The ICB has not had any personal data related incidents in year that have met the criteria for external reporting to the Information Commissioner's Office. We have developed data protection impact assessments (DPIAs) and management procedures to embed an information risk culture throughout the organisation.

Business Critical Models

The ICB does not use any business critical models at this time and will continue to review any models that it uses in the future to ensure quality assurance of such models.

Third party assurances

The ICB receives assurance through reports from audits performed on other organisations that provide services to the ICB:

For the period 1st April 2023 to 31st March 2024 the ICB has received reports relating to:

- Arden and Greater East Midlands Commissioning Support Unit ((Finance and Accounting, Employment Services and Procurement)
- NHS Shared Business Services (SBS) Limited (Dental Payment Process system)
- Capita Business Services (Primary Care Support England)
- NHS Business Service authority-Electronic staff record.
- NHS Business Services Authority (Prescription Payments Process system)
- NHS England NHS England (Processing of General Practitioner Data Services)

In reviewing the above reports, I have noted that, with the exception of the Shared Business Service 2023/24 International Standard of Assurance Engagement 3402 audit (ISAE3402), which was undertaken by PwC the Internal Auditors of SBS, provided an unqualified audit across all core services (Finance and Accounting, Employment Services and Procurement). However, the reports findings identified that the opinions have been qualified on the basis of a relatively small number of exceptions. Overall, PwC's opinion was that "the control objectives stated were achieved and operated effectively throughout the period 1 April 2023 to 31 March 2024.

The majority of these exceptions have already been actioned or plans put in place to rectify these.

Overall, the ICB is satisfied with the management responses provided in relation to these exceptions and the actions being implemented to address them.

Control Issues

The ICB has implemented governance, risk management and internal control processes and subjected them to scrutiny through the various Committees of the Board.

In the Month Nine Governance Statement some control issues were highlighted in relation to the financial position and key quality and performance targets.

Oversight and management of these has been primarily through the Board, its Committees and supporting governance structure which includes representatives from partners across the ICS.

Information on the ICB year-end financial position and performance in relation to the key constitutional targets and standards are detailed under the Performance and Finance Sections of the Annual Report and include the actions taken to resolve or mitigate against these areas.

Review of economy, efficiency & effectiveness of the use of resources

The ICB set a Financial Plan towards the beginning of the year which was agreed by the ICB Board. The Plan is monitored on a monthly basis and reported to the Board.

The ICB also uses non-financial measures to manage its day-to-day business and to give a comprehensive and balanced view of performance. Details on key performance indicators are included earlier in this report under the section on Performance Analysis.

The 2024/25 NHS planning round concluded in May 2024 with a final national submission for all NHS Provider & ICB organisations of their NHS System Operational Plan 2024/25. At the May 2024 meeting the ICB Board approved its ICB budget for 2024/25.

In November 2023, NHS England issued a letter to all NHS organisations entitled 'Addressing the significant financial challenges created by industrial action in 2023/24'. All NHS Boards were required to sign off various financial and service performance commitments which ran through the winter period (which was referred to as the 'Half Two' financial position).

The ICB Board held an extraordinary meeting in late November 2023 to approve the draft submission. This followed a detailed review by the three Lincolnshire NHS Trust Boards along with the joint meeting of the System Finance and Resource and Service Delivery and Performance Committees.

In November 2023, the ICB received formal notice of transition to NHS Oversight Framework (NOF) Segment Three and exit from the Recovery Support Programme (NOF 4). This was excellent news for the ICB and system and signified a marker of Lincolnshire's improved long term financial sustainability.

Delegation of functions

The ICB received delegated authority for Primary Care Commissioning budgets when it was established on 1st July 2022. These consisted of GP contract budgets, and related areas of expenditure.

To assure itself of the effective use of resources for delegated budgets the ICB accesses monthly payment information, which is reviewed and challenged for understanding and further information if required.

A financial report is taken bi-monthly to the Primary Care Commissioning and Delegated Functions Committee of the ICB which allows review and challenge by Non-Executive Directors. There is a risk register covering primary care risks and emerging risks. This is reviewed by the Primary Care Commissioning and Delegated Functions Committee at each meeting.

Escalation reports from the Primary Care Commissioning and Delegated Functions Committee are reviewed at the Board, and the delegated budgets form part of the overall financial report of the ICB.

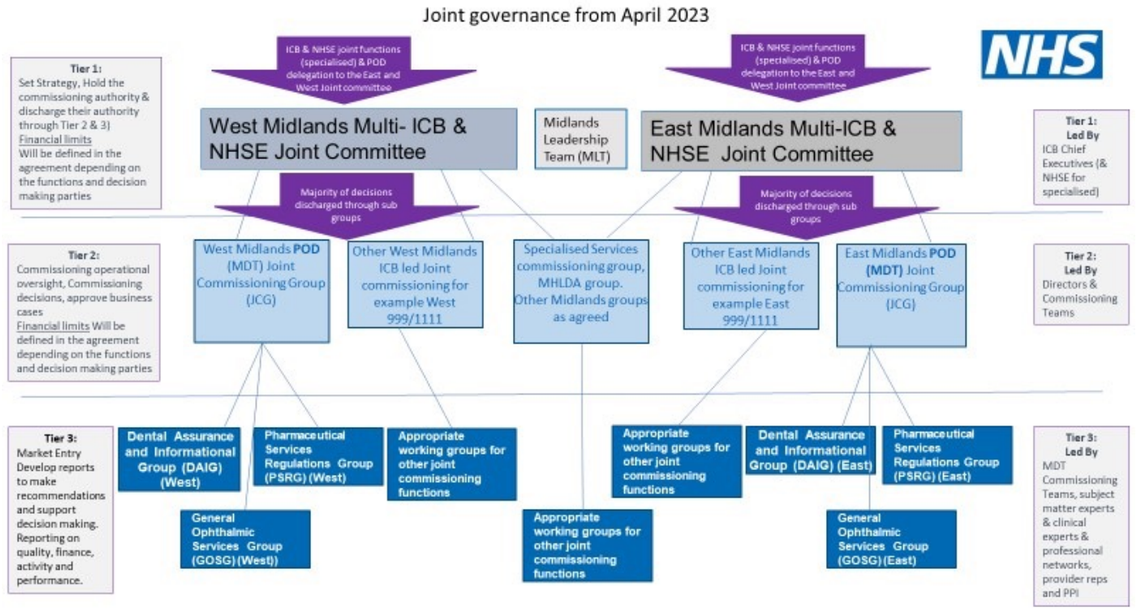
Internal audit also carry out a mandated audit review of primary care commissioning which provides me with a satisfactory level of assurance that the Committee is operating satisfactorily.

From 1st April 2023 the ICB received delegated authority from NHSE for Pharmacy, Optometry and Dentistry (PODs). The delegation of PODS is in accordance with NHSEs long-term policy ambition of giving systems responsibility for managing local population health needs, tackling inequalities, and addressing fragmented pathways of care.

The East Midland ICBs (Derby and Derbyshire, Leicester, Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottingham and Nottinghamshire) agreed in 2023 to collaborate in areas that are most effectively undertaken at scale. Working at scale adds value to common goals, whilst retaining local ICB population health sensitivity where appropriate.

NHSE and the East and West Midlands ICBs agreed to formalise collaborative working arrangements by entering into Joint Working Agreements, and in doing so committed to establishing a governance framework consisting of collaborative Joint Committees, groups, subgroups and hosted teams through which the work is undertaken, and delegated authorities discharged. Following this agreement, the ICB resolved in July 2023 to amend its Constitution to recognise formally the joint working arrangements.

The governance framework is illustrated below.



All decisions are through formal joint committees, ensuring equal and equitable decision making for each individual ICB with no one ICB having primacy over another.

As Accountable Officer I attend the meetings of the East Midlands Joint Committee along with the Acting ICB Chair. The Director for Health Inequalities, Prevention and Regional Collaboration is the ICB Executive Lead for both PODs and joint working across the East Midlands. Regular reports and updates are provided to the Board and as Accountable Officer I am satisfied that the governance framework is operating satisfactorily.

In December 2023 the NHS England Board approved plans to delegate 59 specialised services to the Midlands, North West and East regions. The ICB Board at its meeting held on the 26th March approved the progression to the formal delegation of the 59 specialised services.

Counter fraud arrangements

For the period 1st April 2023 to 30th June 2023 counter fraud work was provided by PricewaterhouseCoopers (PwC). From the 1st July 2023, the ICB has contracted with Audit Yorkshire (Yorkshire and Scarborough Teaching Hospitals NHS Trust) service to undertake counter fraud work. The Counter Fraud Service (CFS) works with the ICB to conduct a self-assessment of the position against the NHSCFA Counter Fraud Functional Standard Return (CFFSR) which is approved by the Audit and Risk Committee and submitted to NHS Counter Fraud Authority on an annual basis.

The executive lead role for Anti-Fraud and Anti-Bribery and Corruption sits with the Director of Finance (as a member of the ICB Board). The CFS attends the regular meetings of the Audit and Risk Committee, providing formal updates against an agreed annual programme of activities.

The 2023/24 Counter Fraud Functional Standard Return has identified that the ICB is green rated in the majority of areas, with only one area identified as amber in relation to Requirement 3: The LCFS is in the process of embedding the prescribed fraud risk assessment methodology as required by the NHSCFA. Any risks identified LCFS has accommodated within the Annual Counter Fraud Plan for 2024/25.

Head of Internal Audit Opinion

From the 1st April 2023, the ICB along with its NHS system partners in Lincolnshire have contracted with TIAA for internal audit services. Following completion of the planned audit work for the financial year for the Integrated Care Board the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Integrated Care Board's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

1. Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.
2. The basis for forming the opinion is as follows:
   i. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
   ii. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for NHS England/Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances. The Shared Business Service 2023/24 International Standard of Assurance Engagement 3402 audit (ISAE3402) undertaken by PwC the internal Auditors of SBS provided an unqualified audit across all the core services provided by the NHS SBS (Finance and Accounting, Employment Services and Procurement). PwC's opinion was that "the control objectives stated were achieved and operated effectively throughout the period 1st April 2023 to 31st March 2024. The ICB also receives assurance through reports from audits performed on other organisations that provide services to the ICB. For the period 1st April 2023 to 31st March 2024 the ICB has received reports relating to Arden and Greater East Midlands Commissioning Support Unit (finance and payroll), Capita Business Services (primary care support England), NHS Business Service Authority-Electronic staff record, NHS Business Services Authority (prescription payments to pharmacists and student bursaries) and NHS England (processing of General Practitioner Data Services).

We have noted that, with the exception of the audit of NHS Business Services Authority (student bursaries), qualified opinions have been provided by the service auditors. However, consideration of the reports' findings has identified that the opinions have been qualified on the basis of a relatively small number of exceptions when testing the operation of controls and these have no impact on the ICB's control environment. The majority of these exceptions have already been actioned or plans put in place to rectify these. Management responses have been provided in relation to these exceptions and the actions are being implemented to address them. The Audit and Risk Committee approved the Internal Audit plan 2023/24 that had been developed in conjunction with the ICB Executive Team.

During the period 1st April 2023 to 31st March 2024, Internal Audit issued the following audit reports:

TITLE	RATING
Financial Management	Reasonable Assurance
Workforce Planning/Running Costs Reduction	Reasonable Assurance
Key Financial Controls including review of Payroll controls	Reasonable Assurance
Implementation of Projects and Post Implementation Review	Reasonable Assurance
Risk Management and Board Assurance Framework	Reasonable Assurance
Primary Care Commissioning – Pharmacy, Ophthalmic and Dentistry	Reasonable Assurance
LDA Transforming Care (Adults) review	Limited Assurance
Data Security and Protection Toolkit (Part One)	Substantial Assurance

LDA Transforming Care (Adults) - There were two areas reviewed by internal audit where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited' assurance.' Recommendations were made to further strengthen the control environment in these areas and the management responses indicated that the seven recommendations have been accepted and specific timescales for completion agreed. Progress against these seven recommendations will be closely monitored by the Audit and Risk Committee in 2024/25.

The Audit and Risk Committee acknowledges the risks identified in the reports reports rated as reasonable and substantial and the associated recommendations, which will be closely reviewed and monitored by the Committee during 2024/25.

For the period 1st April 2023 to 31st March 2024 all audit actions were monitored. A report was provided to each meeting of the Audit and Risk Committee on the actions that remained outstanding, and the progress made to date. As at the 31st March 2024 no actions were outstanding in relation to relation to CCG legacy recommendations.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the Integrated Care Board who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Integrated Care Board achieving its principal objectives have been reviewed.

I have also been provided with assurance through the Executive Team meetings, Board and Board Development Sessions that the necessary plans and governance arrangements are in place for the satisfactory delegation of 59 specialised services to the ICB from the 1st April 2024.

A plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

During the year, the ICB has developed and strengthened its governance arrangements. The ICB will continue to use the Board Assurance Framework to assure the Board and others that the ICB's key controls to manage strategic risks are assessed and continuously improved.

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

Remuneration Report

As required by the Companies Act 2006 the ICB has prepared a Remuneration Report containing information about director's remuneration. This report is in respect of the senior managers of the ICB. Some of the information in the report is part of the annual audit of the accounts, and this is indicated when it applies in the title of each section.

The definition of "senior managers" is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Integrated Care Board. This means those who influence the decisions of the ICB as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.'

The tables on subsequent pages of this report summarise the remuneration (excluding National Insurance contributions) and pension status of the ICB's Board members and other senior managers for the period 1st April 2023 to 31st March 2024. Prior year comparators are for the period 1st July 2022 to 31st March 2023 as the ICB was only established on 1st July 2022.

The ICB's Remuneration Committee, which is a Committee of the Board, ensures that remuneration is both equitable and fair throughout the organisation. The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17-19 of Schedule 1B to the NHS Act 2006, i.e. to confirm the ICB Pay Policy, including adoption of any pay frameworks for all employees including senior managers/ directors (including Board Members) and Non-Executive Directors. It also ensures that the ICB's most senior managers are appropriately and fairly rewarded for their contributions, conforming to the ICB's probity and financial integrity as part of the corporate governance arrangements.

Remuneration Committee

The membership of the Remuneration Committee and their attendance at meetings throughout the period April 2023 to March 2024 was as follows:

Dr Gerry McSorley	Acting ICB Chair (from the 1st September 2023) and Chair of the Remuneration Committee (up to 31st August 2023)
Sir Andrew Cash	Interim ICB Chair (up to 31st August 2023)
Ms Anita Day	Non-Executive Director (from 1st September 2023)
Mrs Dawn Kenson	Non-Executive Director
Mrs Julie Pomeroy	Non-Executive Director and also Chair of the Remuneration Committee (from 1st September 2023)
Mrs Sharon Robson	Non-Executive Director (from 14th August 2023)
Professor Sir Jonathan Van Tam	Non-Executive Director (up to 22nd May 2023)

The Chair of the Audit and Risk Committee 'attends' the Remuneration Committee meetings as an observer. There were five meetings of the Remuneration Committee held between 1st April 2023 and 31st March 2024 and further information on attendance is included in the Annual Governance Statement.

Arden and GEM CSU are contracted by the ICB to provide professional Human Resources advice to the ICB. Arden & GEM advice was paid for as part of their overall contract; no fee or other payment was made to any individual employed by Arden and GEM.

Policy on the Remuneration of Senior Managers

The Remuneration Committee is responsible for determining the remuneration of all individuals who are non-employees and engaged under Contracts for Services. Remuneration for these positions is informed by local and national pay benchmarking. Their remuneration is reviewed periodically to ensure that it keeps pace with increasing demands on the time of the individuals in those positions.

Duties of the Remuneration Committee

For the Chief Executive, Directors, and other Very Senior Managers:

- determine all aspects of remuneration including but not limited to salary, pensions, and cars;
- determine arrangements for termination of employment and other contractual and non-contractual terms.

For all staff (including senior managers):

- determine the ICB pay policy (including adoption of pay frameworks such as Agenda for Change);
- oversee contractual arrangements;
- determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of national guidance.

To avoid any conflict of interest in respect of Non-Executive Directors who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by a Remuneration Panel – the details and membership of the Panel are set out in the ICB Governance Handbook. The Non-Executive Directors are not part of this process.

The notice period for executive directors is six months and the arrangements for compensation payments for early termination of contract will comply with NHS regulations. The remuneration for executive directors does not include any performance related bonuses and none of the executives receive personal pension contributions other than their entitlement under the NHS Pension Scheme.

Remuneration of Very Senior Managers

Employment terms for a Very Senior Manager (VSM) or member of the ICB's Executive Team are determined separately and where appropriate the principles of Agenda for Change are applied to these employees to ensure equity across the ICB. Remuneration for VSM employees is informed by the ICB Executive Pay Framework. When the VSM Pay Framework is published it will also be used, but until then there is a robust process in place within the ICB.

The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Non-Executive Directors from the Board and their decisions are informed by independent, local and national benchmarking to ensure the best use of public funds and to help with recruitment and retention. Their decisions also take into consideration using annual VSM pay review guidance from NHS England and annual Agenda for Change pay circulars to ensure parity where appropriate.

Use of prior year comparators in the Remuneration Report

Prior year comparators only cover the nine month period July 2022 to March 2023, in line with the Department Of Health Government Accounting Manual 2023/24 paragraph 4.802 shown on the next page. This situation arose because the ICB was created on 1st July 2022.

Salaries and Allowances [Audited]

Salaries and allowances for the senior managers of the ICB from July 2022 to March 2024 are shown in Tables 1a and 1b shown opposite. The notes describe principles which apply to both tables.

Pension related benefits shown in Table 1a are pro rata apportionments of the full year April 2022 to March 2023 in line with NHS Business Services Authority guidance. This is necessary as pensions data is only provided on an annual basis.

Salaries and Allowances Notes

1. Total remuneration includes salary and non-consolidated performance-related pay as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

2. None of the ICB's senior employees are entitled to performance related bonuses.

3. The Interim Medical Director was engaged through an off-payroll engagement with a GP practice.

4. There were no payments or awards made to past senior managers, payments made for loss of office during the periods shown or payments to anyone who is not a senior manager but has previously been a senior manager at any time.

5. All pension related benefits show the increase in 'lifetime' pension which have arisen in the relevant period. The sum reported reflects the amount by which the annual pension received on retirement age has increased in the year multiplied by 20 (the average number of years a pension is paid to members of the NHS pension scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.

6. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000, they would be shown in the salary band (£'000) 45-50.

7. Where an employee has been in post for part of the year, their pay and pension amount are time apportioned to reflect their time in post with the ICB. Any start and end dates are shown in the notes.

8. The calculation of pension related benefits includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial period.

Table 1a: Salaries and Allowances for the period 1st July 2022 to 31st March 2023

Name and title	July 2022 to March 2023					
	"Salary (bands of £5,000)"	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	"TOTAL (bands of £5,000)"
	£000	£	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	80 - 85	0	0	0	20 - 22.5	100 - 105
Mr Andrew Cash, Interim Chair	45 - 50	0	0	0	0	45 - 50
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	25 - 30	0	0	0	0	25 - 30
Mr Martin Fahy, Director of Nursing	100 - 105	0	0	0	85 - 87.5	185 - 190
Mr Matt Gaunt, Director of Finance	120 - 125	0	0	0	60 - 62.5	180 - 185
Dr Sunil Hindocha, Interim Medical Director	95 - 100	0	0	0	0	95 - 100
Mrs Dawn Kenson, Non-Executive Director	10 - 15	500	0	0	0	10 - 15
Mr Gerry McSorley, Non-Executive Director	10 - 15	0	0	0	0	10 - 15
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	80 - 85	0	0	0	22.5 - 25	105 - 110
Mr Peter Moore, Non-Executive Director	5-10	0	0	0	0	5-10
Professor Sir Jonathan Van-Tam, Non-Executive Director	10 - 15	0	0	0	0	10 - 15
Mrs Julie Pomeroy, Non-Executive Director	10 - 15	0	0	0	0	10 - 15
Mrs Margaret Pratt, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
Mrs Clair Raybould, Director for System Delivery	85 - 90	0	0	0	22.5 - 25	110 - 115
Mr John Turner, Chief Executive	135 - 140	0	0	0	0	135 - 140
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	80 - 85	0	0	0	22.5 - 25	105 - 110

Notes to Table 1a

The ICB was unable to appoint a permanent medical director until approval of the terms and conditions for the post were received from NHS England. The Business Case was declined by NHS England, so alternative arrangements for the post were agreed by the ICB Remuneration Committee, which came into effect on the 1st April 2024. Dr Sunil Hindocha has been working with the ICB on an interim basis in this role through an off-payroll engagement with the Heart of Lincoln GP practice. The value reflected in the above table was the amount paid or payable to the Heart of Lincoln GP practice between July 2022 and March 2023.

All postholders reported above were in post for the full year with exception to the following:
- Mr Peter Moore, Non-Executive Director – left the ICB on 31 January 2023.
- Mrs Margaret Pratt, Non-Executive Director – in post from 21 October 2022
- Mr Simon Evans, System Director for Clinical Integration and Leadership Development – in post from 3 January 2023.
- Dr Sunil Hindocha, Interim Medical Director - started working with the ICB on 1 July 2022.

The expenses shown relate to travel costs which were outside the normal limits for non-taxable refund.

Table 1b: Salaries and Allowances for the year ended 31st March 2024

Name and title	April 2023 to March 2024					
	"Salary (bands of £5,000)"	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	"TOTAL (bands of £5,000)"
	£000	£	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	120 - 125	0	0	0	10 - 12.5	130 - 135
Mr Andrew Cash, Interim Chair	25 - 30	0	0	0	0	25 - 30
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	45 - 50	0	0	0	0	45 - 50
Mr Martin Fahy, Director of Nursing	140 - 145	100	0	0	0	140 - 145
Mr Matt Gaunt, Director of Finance	170 - 175	0	0	0	72.5 - 75	245 - 250
Dr Sunil Hindocha, Interim Medical Director	170 - 175	0	0	0	0	170 - 175
Mrs Dawn Kenson, Non-Executive Director	15 - 20	800	0	0	0	15 - 20
Mr Gerry McSorley, Non-Executive Director and Acting ICB Chair from the 1st September 2023	50 - 55	700	0	0	0	50 - 55
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	120-125	0	0	0	0	120-125
Professor Sir Jonathan Van-Tam, Non-Executive Director	0 - 5	0	0	0	0	0 - 5
Mrs Julie Pomeroy, Non-Executive Director	10 - 15	0	0	0	0	10 - 15
Mrs Margaret Pratt, Non-Executive Director	10 - 15	0	0	0	0	10 - 15
Mrs Anita Day, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
Mrs Sharon Robson, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
Mrs Clair Raybould, Director for System Delivery	135 - 140	0	0	0	35 - 37.5	170 - 175
Mr John Turner, Chief Executive	185 - 190	0	0	0	0	185 - 190
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	120 - 125	0	0	0	0	120 - 125

Notes to Table 1b

The ICB was unable to appoint a permanent medical director until approval of the terms and conditions for the post were received from NHS England. The Business Case was declined by NHS England, so alternative arrangements for the post were agreed by the ICB Remuneration Committee, which came into effect on the 1st April 2024. Dr Sunil Hindocha has been working with the ICB on an interim basis in this role through an off-payroll engagement with the Heart of Lincoln GP practice. The value reflected in the above table was the amount paid or payable to the Heart of Lincoln GP practice from April 2023 to March 2024.

All postholders reported above were in post for the full year with exception to the following:
- Sir Andrew Cash, Interim Chair – left the ICB on 31 August 2023.
- Professor Sir Jonathan Van-Tam, Non-Executive Director – left the ICB on 22 May 2023.
- Mr Simon Evans, System Director for Clinical Integration and Leadership Development – left the ICB on 11 August 2023.
- Mrs Sharon Robson, Non-Executive Director - started working with the ICB on 14 August 2023.
- Mrs Anita Day, Non-Executive Director - started working with the ICB on 1 September 2023.

Note that £313 relates to work done by Mrs Robson for the Maternity team. This is outside of her normal Non-Executive role.

The expenses shown relate to travel costs which were outside the normal limits for non-taxable refund.

Non-cash remuneration: benefits in kind

Employees can receive non-cash benefits which must be reported to HMRC each year on a P11D form. These include discounted services or goods, vouchers (including childcare vouchers), living accommodation, travel allowances, company cars, vans, bikes or other vehicles available for private use, low-cost loans, private insurance, professional fees and subscriptions.

None of the senior managers received benefits in kind during the period July 2022 to March 2023, nor did they in the year April 2023 to March 2024.

Pensions benefits [Audited]

Most of the senior managers do not have pensionable pay, either because (for the medical staff) they are part of a GP pension scheme or because (for non-executive directors) their engagement does not qualify as pensionable pay. Figures for the remaining staff for July 2022 to March 2024 are shown in Tables 2a and 2b on the next page. The notes describe principles which apply to both tables.

Pension Benefit Notes

1. The below information is based on data provided by the NHS Pensions Agency.

2. The employer's contribution rate to pension benefits was 20.68% of pensionable pay from July 2022 to March 2023, and in the financial year from April 2023 to March 2024.

3. Pension figures included in the table on the next page, are for senior managers that have pensions paid directly by the ICB and include all of their NHS service, not just pension payments that related to the year in question.

4. Where an employee has been in post for part of the year their pension amount is time apportioned to reflect their time in post.

5. Staff are able to make additional voluntary contributions alongside their regular contributions.

6. The Department of Health and Social Care Group Accounting Manual confirms that where a senior manager has opted out of the pension arrangements for the whole of the year, no pension figures should be reported. This guidance has been applied to Tables 2a and 2b for Mr John Turner, who chose not to be covered by the pension arrangements during either reporting period.

7. The calculation of the real increase in Cash Equivalent Transfer Value includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial period.

8. The benefits and corresponding Cash Equivalent Transfer Value disclosed in Table 2 below does not allow for any potential adjustment in relation to the McCloud judgement.

9. Table 2a covers the period July 2022 to March 2023. Data provided by the NHS Pensions Agency for the full year 2022/23 has been apportioned to give the figures shown.

Table 2a: Pension Benefits for the period ended 31st March 2024

Name and title	July 2022 to March 2023							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2022	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	0 -2.5	0	35-40	0	409	13	442	0
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	0	0-2.5	25-30	50-55	375	0	388	0
Mr Martin Fahy, Director of Nursing	2.5-5	7.5-10	65.70	165-170	1,238	90	1,369	0
Mr Matt Gaunt, Director of Finance	2.5-5	0	35-40	0	474	50	552	0
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	0-2.5	0-2.5	50-55	110-115	1,043	33	1,111	0
Mrs Clair Raybould, Director for System Delivery	0-2.5	0-2.5	30-35	50-55	492	19	534	0
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	0-2.5	0-2.5	40-45	80-85	703	23	753	0

Pension information as at 1 July 2022 was not available from the NHS Pensions Agency and so had to be estimated from the full year figures. This was done by:

- starting with the opening figures as at 1 April 2022;
- uplifting the opening figures in line with the HM Treasury price increase tables (taking 25% of the annual uplift to estimate the increase from April to June);
- adding an estimate of the real increase in pensions from April to June by apportioning the annual increase across the year.

The same apportionment principles apply to the disclosures for Mr Simon Evans. He started with the ICB on 3rd January 2023. Increases to pension benefits are shown in proportion to his working time with the ICB, and the increase in Cash Equivalent Transfer Value was spread across the year to calculate the 1 July 2022 CETV.

Table 2b: Pension Benefits for the year ended 31st March 2024

Name and title	April 2023 to March 2024							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024	Lump sum at pension age related to accrued pension at 31 March 2024	Cash Equivalent Transfer Value at 1 April 2023	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	0 - 2.5	0	40 - 45	0	442	131	633	0
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	0	5 - 7.5	25 - 30	70 - 75	388	29	509	0
Mr Martin Fahy, Director of Nursing	0	17.5 - 20	70 - 75	200 - 205	1,369	183	1,708	0
Mr Matt Gaunt, Director of Finance	2.5 - 5	0	40 - 45	0	552	161	792	0
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	0	35 - 37.5	55 - 60	160 - 165	1,111	206	1,446	0
Mrs Clair Raybould, Director for System Delivery	0 - 2.5	37.5 - 40	35 - 40	95 - 100	534	198	805	0
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	0	35 - 37.5	45 - 50	125 - 130	753	191	1,036	0

Some staff are affected by the Public Service Pensions Remedy and their membership between 1st April 2015 and 31st March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero. This applies to Mr Simon Evans, Mr Martin Fahy, Mrs Sarah-Jane Mills and Mrs Sandra Williamson.

The following definitions are provided for the pension tables above.

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with 'SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008'.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

There have been no compensation payments for early retirement or for loss of office during the period April 2023 to March 2024 (and there were none in the period from July 2022 to March 2023).

Payments to past directors

There have been no payments to past directors.

Fair pay disclosures [Audited]

Percentage change in remuneration of highest paid director

Entities are required to disclose pay ratio information and detail concerning the percentage change in remuneration for the highest paid director. To support this comparison, figures from July 2022 to March 2023 have been extrapolated into full year figures.

Percentage changes from 2022-23 to 2023-24	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	2.7%	n/a
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.6%	n/a

No comparatives are available for the change in the previous year as the ICB was only created in July 2022, so this is the first year that a change can be measured.

There are no material transactions other than salaries and allowances.

The change in the salary for the highest paid director relates to the 2023/24 pay award; salaries for directors of the ICB have been set in advance in accordance with prevailing policies and guidance.

The pay award for most other staff followed Agenda for Change agreements.

Staff received the pay award for 2023/24, being a 5% increase in basic pay for all pay points, with the lowest paid staff seeing their pay brought up to the top of band 2 (a 10.4% pay increase).

This general increase of 5% was offset to some extent by staff turnover, meaning that experienced staff at the top of the pay scales can be replaced by new starters at the bottom of the pay scale.

The overall impact was an average increase of 3.6% in staff pay.

Pay ratio information

In 2023/24 no employees received remuneration in excess of the highest-paid director / member (and also none in the previous period July 2022 to March 2023).

As at 31 March 2024, remuneration ranged from £2,500 to £187,500 (March 2023: £2,500 to £182,500) using midpoints of the bands based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is normally further broken down to disclose the salary component (but for the ICB salary is the only component, so no further breakdown is presented). The banded remuneration of the highest paid director in the Integrated Care Board in the financial year 2023-24 was £185-£190,000 (July 2022 to March 2023, £180-£185,000) based upon gross earnings in March 2024. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022-23	25th percentile	Median	75th percentile
Total remuneration (£)	25,678	42,750	50,847
Salary component of total remuneration (£)	25,678	42,750	50,847
Pay ratio information	7.11	4.27	3.59
2023-24	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	27,596	43,200	50,952
Salary component of total remuneration (£)	27,596	43,200	50,952
Pay ratio information	6.79	4.37	3.68

There have been no significant changes in the ratios between years.

There has been a small increase in the ratio for the 75th percentile (higher paid staff) as the pay increase for the highest paid director is slightly higher than the pay increase for this staff group.

There has been a small decrease in the ratio for the 25th percentile as there are proportionately fewer lower paid staff in 2023/24.

The median pay ratio is about 4.3 for both years. This is consistent with the pay, reward and progression policies for the ICB's employees because:

- staff are paid in accordance with Agenda for Change regulations;
- the skill mix of staff to deliver ICB objectives requires a mix of professional, senior and administrative staff which is under regular review;
- the pay of the highest-paid director is set by the Remuneration Committee in line with national benchmarks.

Exit Packages for the year ended 31st March 2024 [Audited]

There were no exit packages agreed in the financial year 2023-24 (and there were none in the period July 2022 to March 2023).

Table 1: Exit Packages for the financial year April 2023 to March 2024

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
More than £200,000	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0

Table 2: Exit Packages for the period July 2022 to March 2023

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
More than £200,000	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0

Reporting of redundancy and other departure costs is in accordance with the provisions of the Agenda for Change redundancy policy. Exit costs in this note are accounted for in full in the year of departure. Where the ICB has agreed early retirements, the additional costs are met by the ICB and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Other Departures

There have been no other departures during 2023-24 (and there were none in the period July 2022 to March 2023).

Table 1: Other Agreed Departures for the year ended March 2024

	Agreements	Total Value of Agreements
	Number	£'s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total	**0**	**0**

Table 2: Other Agreed Departures for the period July 2022 to March 2023

	Agreements	Total Value of Agreements
	Number	£'s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total	**0**	**0**

As a single exit package can be made up of several components (each of which will be counted separately in this Note) the total number above will not necessarily match the total numbers in Note 4.4 Exit Packages which will be the number of individuals.

* Any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below.

**Includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.

There were no non-contractual payments (£0) made to individuals where the payment value was more than 12 months of their annual salary.

Staff Report

Staff Engagement

2023 heralded one full year for staff from our former constituent CCGs. We saw an exciting year of development for our teams within NHS Lincolnshire Integrated Care Board.

As we moved into a new financial year we have worked hard with our teams to ensure that they continue helping to shape our organisation. Our engagement with all teams continued right throughout 2023/24.

Our Staff Engagement Group (SEG) meets on a monthly basis and continued its development by welcoming new members to the group in order that there was wide representation across the ICB.

A new Chair of SEG was elected during the year from members of the group to help support engagement and support local charities. Christmas 2023 saw the group support the Sleaford and Lincoln Food Banks with donations from many staff across the ICB.

Under the guidance of the Director of Nursing, the ICB continues to develop initiatives based on best practice as set out in the seven areas of the NHS People Promise

The ICB was able to hold face to face staff events for the first time since before the pandemic. These events enabled staff to be updated on ICB, wider Lincolnshire and national issues, discuss and make suggestions concerning aspects of the 2022 staff survey and enabled further engagement by bringing together different teams from across the ICB to work on outcomes to help shape the organisation and make it an even better place to work. Feedback from the events was very positive with staff valuing the opportunity to meet face to face.

Following the events, a range of actions have been initiated. These include a review of induction, improvements to support on the intranet, development support for new/inexperienced managers and support staff as well as focused sessions on topics identified at the time. This work will support a number of elements of the NHS People Promise and the Lincolnshire People Plan which are essential for closer system working within our Integrated Care System in Lincolnshire

Our system work across Lincolnshire ICS continued with our partners and our One Workforce Lincolnshire brand. This work, coordinated at system level, focuses on developing innovative new ideas to support staff by improving the Health and Wellbeing of staff teams, addressing bullying and harassment through the continuation of our system wide allyship programme and undertaking recruitment and selection in line with our System wide Recruitment and Selection Toolkit. In addition development opportunities are also available from the system through One Workforce Lincolnshire on health and well-being.

To ensure that we continually improved as an organisation we continued to engage with staff on a weekly basis through our hosted Team Talk Live Event, where members of the executive team update staff on a wide range of topics including our regular business activities, staff development and employee wellbeing initiatives. Our regular guest speaker slot continues to be popular and this enables staff to meet colleagues virtually from other areas of the ICB, our Non-Executive team and individuals from across the wider Lincolnshire Integrated Care System.

Staff Survey

Of all 42 ICBs in England, the ICB was ranked second in the 'signature category' of the proportion of staff who would recommend it as a place to work. This is a major achievement for everyone working in the ICB with two thirds of employees recommending the ICB as a place to work and 87% stating that the ICB made positive adjustments to enable people to carry out their role.

We are also proud to report that in the National People Promise Benchmark Group which is a national commitment to work together to improve the experience of all staff working in the NHS, the ICB scored above average in most areas. This is a pleasing result and provides a firm foundation for us to build on.

We do also note that, like virtually every other ICB (all bar three whose score improvement was minimal) our score in this category was lower than last year. This obviously is something that we will be looking at carefully to understand all of the feedback and comments that we have received from staff and to act to improve wherever we can.

We truly value and appreciate everyone's input into completing the staff survey itself and thank all our staff for helping to make NHS Lincolnshire ICB a great place for people to work.

Staff Composition

We monitor a number of human resource indicators, including staff sickness rates, vacancy rates and staff turnover. This allows us to explore further management of such issues and to gain assurance around the proactive support offered to staff regarding their health and wellbeing.

We are pleased to report that our cumulative sickness absence has decreased from 4.52% for the period 1st April 2023 to 3.28% as at the end of March 2024. This downward trend is welcome and positive given that our staff have had to deal with some challenging workloads both pre and post COVID-19 pandemic. As an organisation we will continue to monitor absence and address any trends.

Staff Turnover

The cumulative turnover rate for the ICB staff in for the period 1st April 2023 to 31st March 2024 was an average of 16.36%. The ICB uses a variety of source documents including exit interview data and feedback from the NHS staff survey to identify what steps it needs to take to monitor this figure to reduce turnover.

The results of these surveys are analysed at regular intervals and any specific trends or concerns will be reviewed by the ICB's senior management team who will ensure that any recommendations are implemented accordingly.

Number of Senior Managers

	Female		Male		Total	
	Headcount	%of workforce	Headcount	% of workforce	Headcount	% of workforce
Board Members	1	0.26%	4	1.04%	5	1.30%
Senior Managers (Band 8c and above)	28	7.29%	12	3.13%	40	10.42%
Other members of staff	264	68.75%	75	19.53%	339	88.28%
Total	293	76.30%	91	23.70%	384	100.00%

Staff Composition Table

Payscale	Gender	WTE	Bank Staff
Apprentice Grade	Female	1.00	
	Male		
Band 2	Female	4.20	2
	Male	4.00	
Band 3	Female	30.30	
	Male	12.80	
Band 4	Female	33.99	
	Male	3.00	
Band 5	Female	24.92	
	Male	8.00	
Band 6	Female	33.85	
	Male	12.00	
Band 7	Female	51.91	
	Male	12.00	
Band 8a	Female	42.39	1
	Male	13.00	1
Band 8b	Female	16.53	
	Male	7.90	
Band 8c	Female	11.60	2
	Male	5.00	
Band 8d	Female	4.60	
	Male	4.00	
Band 9	Female	7.00	
	Male	1.00	1
Board Members	Female	1.00	
	Male	4.00	
GP/Clinical Leads	Female	0.30	
	Male	0.70	
VSM	Female	2.00	
	Male	1.00	
		353.98	7

An analysis of staff numbers and cost is provided at note 4.1 and 4.2 to the accounts. As they are part of the statutory annual accounts disclosures, these figures are subject to audit.

Sickness Absence Table	
	Apr 23 -Mar 2024
Total days lost	2637
Total Staff years	361
Average working days lost	7.30

Staff Policies

We have an established a set of policies for the ICB which are based on best practice. We will continue to develop further policies as the need arises. In addition, we have developed our intranet to make sure that staff have access to uptodate information and to help new starters quickly settle into the organisation. We have a comprehensive wellbeing offer to staff to make sure that they are supported in both their physical and mental health. We regularly review this offer with our partner organisations to make sure our support is aligned with the wider Lincolnshire System and the NHS People Plan.

We continue to support disabled people and we are a Disability Confident Employer. We are committed to:

- inclusive and accessible recruitment
- communicating vacancies
- offering an interview to disabled people
- providing reasonable adjustments
- supporting existing employees

Our equality information is available on our website. This information is part our public commitment to meeting the equality duties placed upon us.

NHS Lincolnshire is Mindful Employer and is a signatory to the Mindful Employer Charter.

We are proud to support the Armed Forces Covenant Defence, Employers Recognition Scheme (ERS) and in 2023 we were presented with the Silver Award recognising the contribution that our Armed Services make. The Silver Award means that the ICB has made a commitment to ensuring that all staff working in the Armed Forces have equal access to opportunities across the ICB and the wider NHS. We are pleased to be awarded this nationally recognised standard.

All of our staff are encouraged to meet with their line manager to have regular one-to-one.

Additionally, we have in place an annual appraisal where more in depth discussions can take place to enable managers and employees to discuss performance wellbeing and career development. The ICB recognises that in order for the NHS to meet its further workforce challenges it has to regularly review how it recruits and retains staff ensuring that it both meets the needs and desires of its workforce while meeting the operational needs of the service. We have an active apprenticeship scheme to ensure that we help nurture new talent in the organisation from all backgrounds and to ensure that we are providing opportunities for future progression within the organisation.

These apprenticeships focused on finance and mental health which have traditionally been difficult to fill areas. As part of this programme the ICB has developed degree apprenticeship pathways to support the upskilling of staff to help support resourcing in key areas of the business. This has been undertaken within an agreed financial envelope which is what the apprenticeship levy is there to support through levy payments that the ICB has a statutory obligation to make.

Additionally, throughout the year our Organisational Development Team have focused on the development of a wide range of initiatives to support our staff including coaching and mentoring as well as supporting our wider discussions with staff through our whole team staff events held during the year which included review of induction and development support for new/ inexperienced managers and support staff.

Lincolnshire ICB works with its partners across Lincolnshire and has an agreed Lincolnshire People Plan which supports the key pillars including, Looking after its People, New Ways of Delivering Care and Growing for the Future.

How well has the ICB looked after its people?

The ICB places significant emphasis on making sure that the wellbeing of its staff is placed at the heart of everything we do. In addition to our established occupational health and employee assistance programme, the ICB offers its staff a wide range of wellbeing support from the wider Lincolnshire ICS system for both physical and mental health (recent initiatives include the launch of the Shiny Mind and Champion Health apps as well as access to our more established Lincolnshire system services such as Steps to Change). We have also recently aligned our benefits offer to staff to ensure that the ICB remains an employer of choice within the Lincolnshire System.

Any new wellbeing initiatives are announced at our weekly briefing and further detail is provided on our wellbeing hub on our HR intranet page which is accessible to all staff. Further support to staff is available from our HR team and we encourage all our managers to have conversations with staff as part of their one to one and appraisal process.

Staff who have been absent through ill-health have a return-to-work interview with their manager to identify any concerns and ensure that any additional support that may be required is provided.

Throughout the period of this reporting year our Human Resources and Organisational Development teams have supported both managers and staff through face-to-face coaching and mentoring sessions with specific tailored support being provided to teams across the ICB. In addition, our HR Team have supported the delivery and engagement of staff events including the launch of the staff survey which has been articulated on page 95 of this report.

Our managers conduct return to work interviews with staff who have returned after a period of absence. This helps identify any particular issues and support packages that need to be put in place.

Since the Covid-19 the ICB has adopted a new, agile approach to office working which, where business reasons permit, gives staff the flexibility to work part of the week from home and part of the week in the office. This blended approach to working has been regularly reviewed since the start of the pandemic and has been adjusted to take account of Covid-19 restrictions in order to keep our staff and residents safe. The ICB has reviewed its flexible working policy to ensure that the right to request flexible working is a day one right which was an integral part of the 2020 NHS People Plan.

The ICB has recognised the need for staff to become multiskilled and where possible operates a matrix working model which recognises the diverse range of talents across the organisation. This has enabled us to provide opportunities for our staff to support essential work across the Lincolnshire system, and in particular, support the delivery of national NHS requirements including the launch of our System Control Centre in November 2023. This built on our work supporting our partner organisations with specific project around the delivery of key targets which are detailed under the Performance section of this report.

Off Payroll Engagements

Table 1: Length of all highly paid off-payroll engagements

For all highly paid off-payroll engagements as of 31 March 2024, greater than £245 per day:

	Number
Number of existing engagements as of 31 March 2024	2
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: New Off Payroll Engagements

For all off-payroll appointments engaged at any point between 1 April 2023 and 31 March 2024, greater than £245 per day.

	Number
The number of off-payroll workers engaged between 1 April 2023 and 31 March 2024	4
Of which:	
The number not subject to off-payroll legislation	0
The number subject to off-payroll legislation and determined as in-scope of IR35	1
The number subject to off-payroll legislation and determined as out-of-scope of IR35	3
The number of engagements reassessed for compliance or assurance purposes during the year	0
of which the number of engagements that saw a change to IR35 status following review.	0

"IR35:
A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes."

Table 3: Off Payroll board members/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024.

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year.	17

Freedom to Speak Up Guardian

Our Freedom to Speak up Guardian is Mr Martin Fahy, who is our Director of Nursing. He is supported by Mrs Vanessa Wort, who is the ICBs Freedom to Speak up Lead and our Associate Director of Nursing.

The ICB has adopted a Freedom to Speak Up Policy which is in line with national guidelines for Freedom to Speak Up. The ICB has also established four Freedom to Speak Up Champions and an area for Freedom to Speak Up information on our staff intranet. This enables our staff to know how and who to speak up to and what will happen when they do.

The ICB is committed to conducting its business with honesty and integrity. It expects all staff to maintain high standards in accordance with its Constitution and will continue to maintain and develop a culture of openness and accountability and a supportive environment, in which staff can raise any issues or concerns in a timely manner.

Trade Union Facility Time

The ICB does not have any designated trade union representatives and is reporting a nil return under the Trade Union (Facility time Publication's requirements) regulations 2017.

Expenditure on Consultancy

Consultancy spend from 1st April 2023 to 31st March 2024 was £586,166.

Consultancy spend for July 2022 to March 2023 was £587,042

Conclusion

This staff report provides a most appropriate space to give heartfelt thanks to our ICB staff who have consistently gone the 'extra mile', have adapted rapidly to changing circumstances and demands and have served Lincolnshire exceptionally well. In meeting these challenges ICB staff have worked closely with all of our partners across Lincolnshire and have together made great progress in system and partnership working, in improving care for patients, in how health inequalities are tackled, in improving health outcomes and to social justice. Their hard work, commitment and dedication is hugely important and valued and we would like to express our genuine thanks and appreciation.

Parliamentary Accountability and Audit report

The ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report starting from page 100. An audit certificate and report is also included in this Annual Report.

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

Financial Statement

Entity name:	NHS Lincolnshire Integrated Care Board
This year	2023-24
Last year	For the 9 month period ended 31 March 2023
This year ended *	31 March 2024
Last year ended	31-March-2023
This year commencing:	01-April-2023
Last year commencing:	01-July-2022

NHS Lincolnshire Integrated Care Board - Annual Accounts 2023-24

NHS Lincolnshire ICB (QJM)
Bridge House, The Point, 16 Lions Way, Sleaford, Lincolnshire NG34 8GG

CONTENTS **Notes**

Explanatory Foreword to the Accounts

NHS Lincolnshire Integrated Care Board (ICB) received an in-year Revenue Resource Limit (allocation) of £1,814,754,413 in 2023-24. The ICB however had a reduction to allocation of £16,827,000 representing the former Lincolnshire CCGs historic deficit brought forward. In total, the ICB received a funding allocation of £1,797,927,413 for 2023-24.

As set out in these accounts, the ICB incurred net expenditure of £1,829,636,490 during 2023-24 which was higher than the ICB's Revenue Resource Limit by £14,882,076 (as demonstrated in Note 41 to the accounts). When including the former CCG's historic deficit brought forward resulted in a cumulative revenue deficit of £31,709,076 to carry forward into 2024-25.

As at 31 March 2024 the ICB had net liabilities of £56,665,191. This does not indicate a weak financial position. NHS England provides cash to ICBs only when required to meet its liabilities. As the ICB has liabilities in excess of its assets, it has a negative taxpayers' equity. This represents a common position for Integrated Care Boards since it is inappropriate to draw down cash in advance of need and funding is made available to meet the net liabilities of the ICB as they become payable.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. There is no reason to believe that sufficient funding will not be made available to the ICB in the 12 months from the date of approval of these Financial Statements. As such these Financial Statements have been prepared on a going concern basis.

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Income from sale of goods and services	2	(23,362)	(3,545)
Other operating revenue	2	(141)	(158)
Total operating income		**(23,503)**	(3,703)
Employee Benefits	4	22,245	16,332
Purchase of goods and services	5	1,832,956	1,229,323
Depreciation and impairment charges	5	67	50
Provision expense	5	(2,306)	(1,078)
Other operating expenses	5	166	302
Total operating expenditure		**1,853,127**	1,244,928
Net Operating Expenditure		**1,829,624**	1,241,225
Finance cost	10	12	11
Net expenditure for the Year		**1,829,636**	1,241,236
Net (Gain)/Loss on Transfer by Absorption		-	(56,430)
Total Net Expenditure for the Financial Year		**1,829,636**	1,184,806
Other Comprehensive Expenditure			
Total other comprehensive net expenditure		-	-
Comprehensive Expenditure for the year		**1,829,636**	1,184,806

Revenue does not include allocation or cash received from NHS England. This is drawn down directly into the bank account of the organisation and credited to the General Fund. The cash available in year from NHS England was £1,861,708,947 and the in year allocation was £1,814,754,413.

Notes 1 to 43 form part of these financial statements.

The financial statements on pages 103 to 127 were approved by NHS Lincolnshire Integrated Care Board on 25 June 2024 and signed on its behalf by:

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

NHS Lincolnshire Integrated Care Board - Annual Accounts 2023-24

Statement of Financial Position as at 31 March 2024

	Note	2023-24 £'000	2022-23 £'000
Non-current assets:			
Right-of-use assets	13	284	351
Total non-current assets		**284**	351
Current assets:			
Trade and other receivables	17	24,252	9,117
Cash and cash equivalents	20	37	1
Total current assets		**24,289**	9,118
Total current assets		**24,289**	9,118
Total assets		**24,573**	9,469
Current liabilities			
Trade and other payables	23	(80,778)	(95,059)
Lease liabilities	13a	(68)	(56)
Provisions	30	(152)	(2,754)
Total current liabilities		**(80,998)**	(97,870)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(56,425)**	(88,401)
Non-current liabilities			
Lease liabilities	13a	(227)	(301)
Provisions	30	(14)	(8)
Total non-current liabilities		**(241)**	(309)
Assets less Liabilities		**(56,666)**	(88,710)
Financed by Taxpayers' Equity			
General fund		(56,666)	(88,710)
Total taxpayers' equity:		**(56,666)**	(88,710)

Notes 1 to 43 form part of these financial statements.

The financial statements on pages 103 to 127 were approved by NHS Lincolnshire Integrated Care Board on 25 June 2024 and signed on its behalf by:

Mr John Turner
Chief Executive (Accountable Officer)
27th June 2024

NHS Lincolnshire Integrated Care Board - Annual Accounts 2023-24

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2024

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 01 April 2023	**(88,710)**	**(88,710)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating expenditure for the financial year	(1,829,636)	(1,829,636)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(1,829,636)**	**(1,829,636)**
Net funding	1,861,680	**1,861,680**
Balance at 31 March 2024	**(56,666)**	**(56,666)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity For the 9 month period ended 31 March 2023		
Balance at 31 March 2022	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies under absorption costing	(56,430)	**(56,430)**
Adjusted NHS Integrated Care Board balance at 31 March 2023	**(56,430)**	**(56,430)**
Changes in NHS Integrated Care Board taxpayers' equity for For the 9 month period ended 31 March 2023		
Net operating costs for the financial year	(1,241,234)	(1,241,234)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(1,241,234)**	**(1,241,234)**
Net funding	1,208,954	1,208,954
Balance at 31 March 2023	**(88,710)**	**(88,710)**

Notes 1 to 43 form part of these financial statements.

The financial statements on pages 103 to 127 were approved by NHS Lincolnshire Integrated Care Board on 25 June 2024 and signed on its behalf by:

Mr John Turner
Chief Executive (Accountable Officer)
27th June 2024

Statement of Cash Flows for the year ended 31 March 2024

	Note	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(1,829,636)	(1,241,234)
Depreciation and amortisation	5	67	50
Movement due to transfer by Modified Absorption		-	(52,557)
Interest paid / (received)		12	11
(Increase)/decrease in trade & other receivables	17	(15,135)	(9,117)
Increase/(decrease) in trade & other payables	23	(14,281)	95,059
Provisions utilised	30	(290)	(30)
Increase/(decrease) in provisions	30	(2,306)	(1,078)
Net Cash Inflow (Outflow) from Operating Activities		**(1,861,569)**	(1,208,896)
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(1,861,569)**	(1,208,896)
Cash Flows from Financing Activities			
Net Funding Received		1,861,680	1,208,954
Repayment of lease liabilities		(75)	(56)
Net Cash Inflow (Outflow) from Financing Activities		**1,861,605**	1,208,898
Net Increase (Decrease) in Cash & Cash Equivalents	20	**36**	1
Cash & Cash Equivalents at the Beginning of the Financial Year		**1**	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**37**	1

Notes 1 to 43 form part of these financial statements.

The financial statements on 103 to 127 were approved by NHS Lincolnshire Integrated Care Board on 25 June 2024 and signed on its behalf by:

Mr John Turner
Chief Executive (Accountable Officer)

27th June 2024

Notes to the financial statements

1 **Accounting Policies**
NHS England has directed that the financial statements of Integrated Care Boards (ICB's) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Integrated Care Board for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**
These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

As at 31 March 2024 the ICB had net liabilities of £56,665,191. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. There is no reason to believe that sufficient funding will not be made available to the ICB in the 12 months from the date of approval of these Financial Statements. As such these Financial Statements have been prepared on a going concern basis.

It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2024/25 and Integrated Care Board published allocations can be found on the NHS England website for 2024/25. The commissioning of health services (continuation of service) will continue after 31 March 2024.

Our considerations cover the period 12 months beyond the date of authorisation of issue of these financial statements. Considering the information summarised above, the Board have a reasonable expectation that the Integrated Care Board will have adequate resources to continue in operational existence.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**
These financial statements have been prepared under the historical cost convention modified to account for certain financial assets and financial liabilities.

Due to rounding of transactions, in some places. There may be minor rounding differences in relation to casting/cross casting in these accounts.

1.3 **Movement of Assets within the Department of Health and Social Care Group**
As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**
Arrangements over which the Integrated Care Board has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Integrated Care Board is a joint operator, it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 **Pooled Budgets**
The Integrated Care Board has entered into a pooled budget arrangement with Lincolnshire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Learning Disabilities, Child and Adolescent Mental Health, Community Equipment and Proactive Care in the Community. Note 35 to the financial statements provides details of the income and expenditure.

The pool is hosted by Lincolnshire County Council. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The Integrated Care Board reviews the Section 75 agreements to determine which party has control over the services being delivered, in accordance with IFRS 11 and the accounting policy at 1.4 for joint arrangements.

The Integrated Care Board has considered the NHS lead commissioning arrangement under IFRS 15 Revenue from Contracts with Customers for all elements contained within the individual section 75's and has concluded that the Integrated Care Board is acting as both the 'principal' and the 'agent' for different parts of the arrangement and should therefore account for gross expenditure and income arising from the arrangement within the financial statements and the net expenditure and income arising from the agreement respectively.

1.6 **Operating Segments**
Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board. NHS Lincolnshire Integrated Care Board considers it has only one operating segment, that is commissioning of healthcare services.

1.7 **Revenue**
In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

Notes to the financial statements

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service is recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 **Grants Payable**
Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:
- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Measurement**
All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Notes to the financial statements

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12 **Intangible Assets**

1.12.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:
- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 **Measurement**
Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 **Depreciation, Amortisation & Impairments**
Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **Leases**
A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 **The ICB as Lessee**
A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 under IFRS 16.
Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

Notes to the financial statements

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.13.2 **The ICB as Lessor**
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

When the Integrated Care Board is an intermediate lessor, it accounts for the head lease and the sub-lease as two separate contracts. The sub-lease classification is assessed with reference to the right-of-use asset arising from the head lease.

Amounts due from lessees under finance leases are recognised as receivables at the amount of the ICB's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the net investment in the lease.

Rental income from operating leases is recognised on a straight-line basis over the term of the relevant lease.

1.14 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.15 **Provisions**
Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate (as published on the https://www.gov.uk/ website) as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 4.26% (2022-23: 3.27%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 4.03% (2022-23: 3.20%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 4.72% (2022-23: 3.51%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 4.40% (2022: 3.00%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.16 **Clinical Negligence Costs**
NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.17 **Non-clinical Risk Pooling**
The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 **Carbon Reduction Commitment Scheme**
The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Integrated Care Board does not meet the qualification criteria for this scheme.

Notes to the financial statements

1.19 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.20 **Financial Assets**
Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
· Financial assets at amortised cost;
· Financial assets at fair value through other comprehensive income and ;
· Financial assets at fair value through profit and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.20.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.20.2 **Financial assets at fair value through other comprehensive income**
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.20.3 **Financial assets at fair value through profit and loss**
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.20.4 **Impairment of financial assets**
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.21 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.21.1 **Financial Guarantee Contract Liabilities**
Financial guarantee contract liabilities are subsequently measured at the higher of:
· The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
· The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.21.2 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.21.3 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements

1.22 **Value Added Tax**
Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 **Foreign Currencies**
The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.24 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.25 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.25.1 **Critical accounting judgements in applying accounting policies**
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- It is appropriate to prepare the accounts on a 'going concern' basis.
- Continuing healthcare claims (CHC) prior to 31 March 2013 and which relate to the population of the Integrated Care Board are not directly recognised in the accounts, rather, they are managed via a national risk pool. There is no contribution to the risk pool by Integrated Care Boards in 2023-24. Payments for claims from NHS Lincolnshire Integrated Care Board residents are made by the Integrated Care Board but are recharged to the central NHS England risk pool.
- That all contract, and other, arrangements are correctly assessed for risk to exposure to additional expenditure that may require provision in accordance with the relevant International Accounting Standard (IAS 37).
- That all arrangements containing leases have been correctly identified in accordance with the relevant interpretation issued by the International Financial Reporting Standard (IFRS 16).
- The Better Care Fund reporting has been agreed with Lincolnshire County Council. This is shown on a net accounting basis in the accounts. Note 35 Joint arrangements - interests in joint operations provides further detail.

1.25.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In the application of the Integrated Care Board's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily available from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions used are continually reviewed. Revisions to accounting estimates are recognised in the period from which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The most significant area of estimation uncertainty relates to the estimation of accruals for healthcare in the latter months of the year for which actual data was not received prior to the closure of the accounts. The material accruals relate to the provision of healthcare by the private sector mainly relating to the provision of Continuing Healthcare and Mental Health complex case provision where the BroadCare system is used to inform forecasts for contracts at individual patient level. In addition, the estimation of accruals for Primary Care Prescribing relies on the forecasting methodology of the Business Services Authority (BSA).

Provisions have been made for the Integrated Care Board's liability for Continuing Healthcare for nursing care provided after 1 April 2013. Claims have been made by the public where they have borne the nursing costs but believe that there was a health need which should have been met by the Integrated Care Board. Each case has its own set of circumstances and appeals can be made against the initial ruling.

1.26 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.27 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
There were no new International Financial Reporting Standards that impacted on the financial year ended 31 March 2024 for NHS Lincolnshire Integrated Care Board.

1.28 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
● IFRS 17 Insurance Contracts – requires entities to disclose details where they have not applied a new IFRS Standard that has been issued but is not yet effective.

● IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

The application of IFRS 14 and IFRS 17 would not have a material impact on the accounts for 2023-24, were they applied in the year.

2 Other Operating Revenue

	2023-24 Total	For the 9 month period ended 31 March 2023 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**49**	17
Prescription fees and charges	**11,785**	1,236
Dental fees and charges	**10,264**	-
Other contract revenue	**1,185**	2,131
Recoveries in respect of employee benefits	**79**	161
Total Income from sale of goods and services	**23,362**	3,545
Other operating income		
Other non contract revenue	**141**	158
Total Other operating income	**141**	158
Total Operating Revenue	**23,503**	3,703

Revenue does not include allocation or cash received from NHS England. This is drawn down directly into the bank account of the Integrated Care Board and credited to the General Fund.

NHS Lincolnshire ICB certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

	2023-24			For the 9 month period ended 31 March 2023		
	Income	**Full Cost**	**Surplus / (Deficit)**	Income	Full Cost	Surplus / (Deficit)
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Prescription fees and charges	**11,785**	**(203,890)**	**(192,105)**	1,236	(123,171)	(121,935)
Dental fees and charges	**10,264**	**(30,428)**	**(20,164)**	-	-	-
Total fees and charges	**22,049**	**(234,318)**	**(212,269)**	1,236	(123,171)	(121,935)

The fees and charges information in this note is provided in accordance with section 6.7.1 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective is to collect charges from those patients that do not meet the eligibility criteria for free prescriptions and dental treatments.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2023/24, the NHS prescription charge for each medicine or appliance dispensed was £9.65. However, the majority of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £31.25 for 3 months or £111.60 for a year. A number of other charges were payable for wigs and fabric supports.

NHS dental charges fall into 3 bands dependent on the level and complexity of care provided. Those who meet the eligibility criteria for exemption are not required to pay such charges. In 2023/24, the charge for Band 1 treatments was £25.80, for Band 2 was £70.70 and for Band 3 was £306.80.

3 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits	Total
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Source of Revenue							
NHS	-	-	-	-	506	77	583
Non NHS	49	11,785	10,264	-	679	2	22,779
Total	**49**	**11,785**	**10,264**	**-**	**1,185**	**79**	**23,362**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits	Total
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Timing of Revenue							
Point in time	-	11,785	10,264	-	949	-	22,998
Over time	49	-	-	-	236	79	364
Total	**49**	**11,785**	**10,264**	**-**	**1,185**	**79**	**23,362**

Integrated Care Board revenue is entirely from the supply of services. NHS Lincolnshire Integrated Care Board receives no revenue from the sale of goods.

The contract income that has been recognised was not included within the opening balances of contract liabilities.

There is no contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2023-24			For the 9 month period ended 31 March 2023		
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	16,585	465	**17,050**	12,564	243	12,807
Social security costs	1,990	-	**1,990**	1,320	-	1,320
Employer Contributions to NHS Pension scheme	3,128	-	**3,128**	2,154	-	2,154
Apprenticeship Levy	76	-	**76**	51	-	51
Gross employee benefits expenditure	**21,780**	**465**	**22,245**	16,089	243	16,332
Less recoveries in respect of employee benefits (note 4.1.2)	(79)	-	**(79)**	(161)	-	(161)
Total - Net admin employee benefits including capitalised costs	**21,701**	**465**	**22,166**	15,928	243	16,171
Less: Employee costs capitalised	-	-	**-**	-	-	-
Net employee benefits excluding capitalised costs	**21,701**	**465**	**22,166**	15,928	243	16,171

4.1.2 Recoveries in respect of employee benefits

	2023-24			For the 9 month period ended 31 March 2023		
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue						
Salaries and wages	(69)	-	(69)	(132)	-	(132)
Social security costs	(7)	-	(7)	(17)	-	(17)
Employer contributions to the NHS Pension Scheme	(2)	-	(2)	(13)	-	(13)
Total recoveries in respect of employee benefits	**(79)**	**-**	**(79)**	(161)	-	(161)

4.2 Average number of people employed

	2023-24			For the 9 month period ended 31 March 2023		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**334.87**	**27.81**	**362.68**	323.72	43.35	367.07
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	-	-	-

4.3 Exit packages agreed in the financial year

NHS Lincolnshire Integrated Care Board agreed no exit packages, that being compulsory redundancies and other, or non-compulsory, departures for the financial year ended 31 March 2024 (2022-23, nil).

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure. These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Where the Integrated Care Board has agreed early retirements, the additional costs are met by the organisation and not by the NHS Pension Scheme. Ill health retirement costs are met by the NHS Pension Scheme and would not be included as an exit package agreed in the year. Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. For the financial year ended 31 March 2024 NHS Lincolnshire Integrated Care Board did not have any ill health retirements.

Zero non-contractual payments (£0) were made to individuals where the payment value was more than 12 months' of their annual salary (2022-23, £0).

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report; this was nil for the financial year ended 31 March 2024 (2022-23, £0).

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision. The Integrated Care Board is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrols the employee into NEST. NEST is a defined contribution scheme.

As at 31 March 2024 there were 389 employees employed by the Integrated Care Board (31 March 2023: 426), of these 336 are members of the NHS Pension Scheme (31 March 2023: 350) , 14 are enrolled within NEST (31 March 2023: 15) and 39 are not currently contributing through a workplace pension scheme (31 March 2023: 61).

5. Operating expenses

	2023-24 Total £'000	For the 9 month period ended 31 March 2023 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	6,625	4,978
Services from foundation trusts	330,045	214,372
Services from other NHS trusts	798,330	567,157
Services from Other WGA bodies	40	21
Purchase of healthcare from non-NHS bodies	264,057	180,898
General dental services and personal dental services	30,428	-
Prescribing costs	174,265	123,171
Pharmaceutical services	29,625	-
General ophthalmic services	7,597	51
GPMS/APMS and PCTMS	176,447	124,587
Supplies and services – clinical	71	1
Supplies and services – general	2,115	1,175
Consultancy services	586	587
Establishment	3,465	2,270
Transport	2,349	6,713
Premises	3,627	2,130
Audit fees	250	457
Internal audit services	81	109
Other audit services	21	(10)
Other professional fees	2,269	464
Legal fees	135	81
Education, training and conferences	528	110
Total Purchase of goods and services	**1,832,956**	1,229,322
Depreciation and impairment charges		
Depreciation	67	50
Total Depreciation and impairment charges	**67**	50
Provision expense		
Change in discount rate	-	-
Provision release	(2,306)	(1,078)
Total Provision expense	**(2,306)**	(1,078)
Other Operating Expenditure		
Chair and Non Executive Members	157	164
Clinical negligence	7	8
Research and development (excluding staff costs)	-	31
Expected credit loss on receivables	(5)	89
Other expenditure	6	11
Total Other Operating Expenditure	**166**	302
Total operating expenditure	**1,830,882**	1,228,596

Statutory Audit is provided by Ernst & Young LLP. The fees, inclusive of non-recoverable VAT, for the period reported was £249,600. In addition to the £249,600 (inclusive of VAT) recognised in these financial statements, there are additional costs relating to the 2022-23 audit for the 9 months ended 31 March 2023 of £63,871.20 (inclusive of VAT). In addition there are costs relating to the former NHS Clinical Commissioning Group for the 3 months ended 30 June 2023 of £48,642.40 (inclusive of VAT).

The Integrated Care Board contracts with its auditors provides for a limitation of the auditor's liability of £2,000,000.

Internal audit services are provided by TIAA Limited, fees for the reported financial year were £81,000.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2023-24 Number	2023-24 £'000	For the 9 month period ended 31 March 2023 Number	For the 9 month period ended 31 March 2023 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	53,478	532,146	37,356	373,569
Total Non-NHS Trade Invoices paid within target	52,797	527,944	37,058	366,481
Percentage of Non-NHS Trade invoices paid within target	**98.73%**	**99.21%**	99.20%	98.10%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,431	1,189,143	1,232	774,880
Total NHS Trade Invoices Paid within target	1,424	1,189,112	1,222	774,704
Percentage of NHS Trade Invoices paid within target	**99.51%**	**100.00%**	99.19%	99.98%

The NHS aims to pay at least 95% of all NHS and non-NHS invoices within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The performance for 2023-24 demonstrates this was achieved.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	-	-

The Integrated Care Board did not incur any interest charges from the late payment of commercial debts during 2023-24.

7 Income Generation Activities

The Integrated Care Board did not undertake any income generation activities where full cost exceeds £1 million or services were otherwise disclosed in Note 2, Operating Revenue, to the financial statements for the Financial year ended 31st March 2024.

8. Investment revenue

The Integrated Care Board received no investment revenue for the financial year ended 31 March 2024.

9. Other gains and losses

Other gains and losses are largely associated with the disposal of fixed assets, and changes in the value of financial assets and liabilities. The Integrated Care Board had no such gains or losses for the financial year ended 31 March 2024.

10. Finance costs

Finance costs are principally associated with interest charges on loans, PFI contracts and LIFT contracts. The Integrated Care Board doesn't have any of these arrangements. The Integrated Care Board has finance costs relating to interest expenses on lease liabilities associated with the rental of corporate premises for financial year ended 31 March 2024.

10.1 Finance costs

	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Interest		
Interest on lease liabilities	12	11
Total interest	**12**	11
Total finance costs	**12**	11

11. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021 that allowed for the establishment of Integrated Care Boards across England and abolished Clinical Commissioning Groups. Integrated Care Boards took on the commissioning functions of the former Clinical Commissioning Groups. NHS Lincolnshire Clinical Commissioning Group transitioned into NHS Lincolnshire Integrated Care Board on 1st July 2022, i.e. financial year 2022-23.

	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Transfer of Right of Use assets	-	401
Transfer of cash and cash equivalents	-	1
Transfer of receivables	-	12,090
Transfer of payables	-	(64,648)
Transfer of provisions	-	(3,870)
Transfer of Right Of Use liabilities	-	(403)
Net loss on transfers by absorption	**-**	(56,429)

12. Property, plant and equipment

The Integrated Care Board did not own any property, plant or equipment for the year ended 31 March 2024.

13a Leases

13a.1 Right-of-use assets

	2023-24		For the 9 month period ended 31 March 2023	
	Buildings excluding dwellings £'000	Total £'000	Buildings excluding dwellings £'000	Total £'000
Opening cost or valuation	418	418		-
Transfer (to) from other public sector body	-	-	418	418
Closing cost or valuation	**418**	**418**	418	418
Opening depreciation	67	67		-
Charged during the year	67	67	50	50
Transfer (to) from other public sector body	-	-	17	17
Closing Depreciation	**134**	**134**	67	67
Closing Net Book Value	**284**	**284**	351	351

The right-of-use asset reported above relates to one building that is leased from from NHS Property Services Ltd within the NHS England Group.

13a.2 Lease liabilities

	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Opening Lease liabilities	(358)	-
Transfer (to) from other public sector body	-	(403)
Interest expense relating to lease liabilities	(12)	(11)
Repayment of lease liabilities (including interest)	75	56
Closing Lease liabilities	(295)	(358)

13a Leases cont'd

13.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2023-24 £'000	Of which: leased from DHSC group bodies £000	For the 9 month period ended 31 March 2023 £'000	Of which: leased from DHSC group bodies £000
Within one year	(75)	(75)	(75)	(75)
Between one and five years	(244)	(244)	(300)	(300)
After five years	-	-	(25)	(25)
Closing Balance	**(319)**	**(319)**	(400)	(400)
Effect of Discounting	24		43	
Included in:				
Current lease liabilities	(68)		(57)	
Non-current lease liabilities	(227)		(301)	
Total	**(295)**		(358)	
Balance by counterparty				
Leased from NHS Property Services		(319)		(400)
Closing Balance		**(319)**		(400)

There are no future cash outflows that the Integrated Care Board is exposed to that are not recognised in the lease liabilities.

13a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Depreciation expense on right-of-use assets	67	50
Interest expense on lease liabilities	12	11
Expense relating to short-term leases	-	(19)

13.5 Amounts recognised in Statement of Cash Flows

	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Total cash outflow on leases under IFRS 16	75	56

There are no restrictions or covenants imposed by the lease agreement and there are no sale and leaseback transactions for the financial year 2023-24.

14 Intangible non-current assets

The Integrated Care Board did not hold any intangible non-current assets for the financial year ended 31 March 2024.

15 Investment property

The Integrated Care Board did not hold any investment property for the financial year ended 31 March 2024.

16 Inventories

The Integrated Care Board had no inventories for the financial year ended 31 March 2024.

17.1 Trade and other receivables

	Current	Non-current	Current For the 9 month period ended 31 March 2023	Non-current For the 9 month period ended 31 March 2023
	2023-24 £'000	**2023-24 £'000**	£'000	£'000
NHS receivables: Revenue	139	-	357	-
NHS accrued income	6,958	-	3,293	-
Non-NHS and Other WGA receivables: Revenue	1,194	-	1,476	-
Non-NHS and Other WGA prepayments	2,685	-	2,010	-
Non-NHS and Other WGA accrued income	3,522	-	1,511	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	8,156	-	-	-
Expected credit loss allowance-receivables	(6)	-	(11)	-
VAT	1,470	-	401	-
Other receivables and accruals	133	-	80	-
Total Trade & other receivables	**24,252**	**-**	9,117	-
Total current and non current	**24,252**		9,117	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2023-24	2023-24	For the 9 month period ended 31 March 2023	For the 9 month period ended 31 March 2023
	DHSC Group Bodies	**Non DHSC Group Bodies**	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	**£'000**	£'000	£'000
By up to three months	42	99	69	249
By three to six months	-	6	-	1
By more than six months	-	8	-	22
Total	**42**	**113**	69	272

17.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies	Other financial assets	Total
	£'000	**£'000**	**£'000**
Balance at 01 April 2023	**(11)**	**-**	**(11)**
Lifetime expected credit losses on trade and other receivables-Stage 2	5	-	**5**
Amounts written off	0	-	**0**
Total	**(6)**	**-**	**(6)**

18 Other financial assets

The Integrated Care Board had no other financial assets for the financial year ended 31 March 2024.

19 Other current assets

The Integrated Care Board had no other current assets for the financial year ended 31 March 2024.

20 Cash and cash equivalents

	2023-24	For the 9 month period ended 31 March 2023
	£'000	£'000
Opening Balance	1	-
Net change in year	36	1
Closing Balance	**37**	1
Made up of:		
Cash with the Government Banking Service	37	1
Cash and cash equivalents as in statement of financial position	**37**	1
Total bank overdrafts	**-**	-
Closing Balance	**37**	1
Patients' money held by the integrated care board, not included above	-	-

21 Non-current assets held for sale

The Integrated Care Board has no non-current assets held for sale to disclose for the financial year ended 31 March 2024.

22 Analysis of impairments and reversals

The Integrated Care Board had no property, plant or equipment, intangible assets, inventories or financial assets during 2023-24. There were no impairments or reversals for the financial year ended 31 March 2024.

23 Trade and other payables

	Current	Non-current	Current For the 9 month period ended 31 March 2023	Non-current For the 9 month period ended 31 March 2023
	2023-24 £'000	**2023-24 £'000**	£'000	£'000
NHS payables: Revenue	5,602	-	5,425	-
NHS accruals	3,412	-	24,000	-
Non-NHS and Other WGA payables: Revenue	7,666	-	12,268	-
Non-NHS and Other WGA accruals	41,085	-	29,409	-
Non-NHS and Other WGA deferred income	-	-	25	-
Social security costs	224	-	237	-
Tax	212	-	203	-
Other payables and accruals	22,577	-	23,492	-
Total Trade & Other Payables	**80,778**	**-**	95,059	-
Total current and non-current	**80,778**		95,059	

Included above are liabilities of £0, for people, due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £945,978 outstanding pension contributions at 31 March 2024 (£1,049,113 at 31 March 2023). This includes amounts related to GP pensions (£648,059) and outstanding contributions to the NHS Pension Scheme (£296,251) and NEST scheme contributions (£1,668).

24 Other financial liabilities

The Integrated Care Board had no other financial liabilities for the financial year ended 31 March 2024.

25 Other liabilities

The Integrated Care Board had no other liabilities for the financial year ended 31 March 2024.

26 Borrowings

The Integrated Care Board had no borrowings for the financial year ended 31 March 2024.

27. Private finance initiative, LIFT and other service concession arrangements

The Integrated Care Board had no private finance initiative, LIFT and other service concession arrangements for the financial year ended 31 March 2024.

28. Finance lease obligations

The Integrated Care Board had no finance lease obligations for the financial year ended 31 March 2024.

29. Finance lease receivables

The Integrated Care Board had no finance lease receivables for the financial year ended 31 March 2024.

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30 Provisions

	Current	Non-current	Current	Non-current
			For the 9 month period ended 31 March 2023	For the 9 month period ended 31 March 2023
	2023-24 £'000	**2023-24 £'000**	£'000	£'000
Continuing care	41	14	2,294	8
Other	111	-	460	-
Total	**152**	**14**	2,754	**8**
Total current and non-current	**165**		2,762	

	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2023	**-**	**2,301**	**460**	**2,762**
Arising during the year	-	80	69	**150**
Utilised during the year	-	(7)	(283)	**(290)**
Reversed unused	-	(2,321)	(135)	**(2,456)**
Balance at 31 March 2024	**-**	**54**	**111**	**165**
Expected timing of cash flows:				
Within one year	-	41	111	**152**
Between one and five years	-	14	-	**14**
After five years	-	-	-	**-**
Balance at 31 March 2024	**-**	**54**	**111**	**165**

Continuing Care

The Integrated Care Board is responsible for liabilities, legal and financial elements relating to NHS Continuing Healthcare claims connecting to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups (1 April 2013). The total value of NHS Continuing Healthcare provision at 31 March 2024 is based on live claim cases, including appeals, and has been evaluated based on historical experience of claim success rates and average rates within the Integrated Care Board and legacy Clinical Commissioning Groups and is £54,630.

Under the accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the former Clinical Commissioning Groups. The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare claims relating to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups.

The Integrated Care Board included a provision for Funded Nursing Care Continuing Healthcare as an estimate of likely costs of outcomes of Decision Support Tools. The historic success rate for each type of Continuing Health Care has been used alongside average costs of that care to identify a provision value. This previous provision was unused and was therefore reversed as it was no longer required by the Integrated Care Board.

The provision reported in prior years of £1,381,302 in respect of historical VAT charges relating to a key care provider has been reversed in the financial year ended 31 March 2024 following circulation of official publication.

Other

The Integrated Care Board included other provisions for building works at primary care premises and Mental Health Investment Standard audit fees for the 2023/24 financial year where the timing of committed expenditure was unknown.

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31 Contingencies

	2023-24 £'000	For the 9 month period ended 31 March 2023 £'000
Contingent liabilities		
Continuing Healthcare	376	160
Net value of contingent liabilities	**376**	160

The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare (CHC) claims for periods of care since the establishment of the Integrated Care Board and former Clinical Commissioning Groups. The Integrated Care Board has provided for the anticipated costs of continuing care claims (see Note 30 Provisions above) where it is probable that it will incur costs. Note 31 Contingencies discloses the difference between the estimated value of claims and the recorded provisions as £375,985.27 as at 31 March 2024.

Contingent assets

The Integrated Care Board had no contingent assets as at 31 March 2024.

32 Commitments

The Integrated Care Board had no capital or other financial commitments for the financial year ended 31 March 2024.

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Lincolnshire Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Lincolnshire Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Lincolnshire Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Lincolnshire Integrated Care Board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Lincolnshire Integrated Care Board and internal auditors.

33.1.1 Currency risk

The NHS Lincolnshire Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Lincolnshire Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The NHS Lincolnshire Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS Lincolnshire Integrated Care Board therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS Lincolnshire Integrated Care Board revenue comes parliamentary funding, NHS Lincolnshire Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33 Financial instruments cont'd

33.1.4 Liquidity risk

NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

33.1.5 Financial Instruments

As the cash requirements of NHS integrated care board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS integrated care board's expected purchase and usage requirements and NHS integrated care board is therefore exposed to little credit, liquidity or market risk.

33.2 Financial assets

	Financial Assets measured at amortised cost	Financial Assets measured at amortised cost
		For the 9 month period ended 31 March 2023
	2023-24 £'000	£'000
Trade and other receivables with NHSE bodies	1,519	2,883
Trade and other receivables with other DHSC group bodies	8,902	2,267
Trade and other receivables with external bodies	9,681	1,568
Cash and cash equivalents	37	1
Total Closing Balance	**20,140**	6,719

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost	Financial Liabilities measured at amortised cost
		For the 9 month period ended 31 March 2023
	2023-24 £'000	£'000
Loans with group bodies	-	-
Loans with external bodies	-	-
Trade and other payables with NHSE bodies	613	980
Trade and other payables with other DHSC group bodies	8,397	28,446
Trade and other payables with external bodies	71,627	65,527
Total at 31 March 2024	**80,637**	94,953

33.4 Maturity of Financial Liabilities

	Payable to Department of Health and Social Care Group 2023-24 £'000	**Payable to Other Bodies 2023-24 £'000**	**Total 2023-24 £'000**
In one year or less	9,010	71,627	80,637
In more than one year but not more than two years	-	-	-
In more than two years but not more than five years	-	-	-
In more than five years	-	-	-
Total at 31 March 2024	**9,010**	**71,627**	**80,637**

33.3 Financial liabilities cont'd

33.4 Maturity of Financial Liabilities

	Payable to Department of Health and Social Care Group For the 9 month period ended 31 March 2023 £'000	**Payable to Other Bodies For the 9 month period ended 31 March 2023 £'000**	**Total For the 9 month period ended 31 March 2023 £'000**
In one year or less	29,426	65,527	94,952
In more than one year but not more than two years	-	-	-
In more than two years but not more than five years	-	-	-
In more than five years	-	-	-
Total at 31 March 2023	**29,426**	**65,527**	**94,952**

34 Operating segments

NHS Lincolnshire Integrated Care Board considers it has only one operating segment: commissioning of healthcare services.

35 Joint arrangements - interests in joint operations

Information is disclosed in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

The 2023-24 pooled budgets are for Learning Disabilities, Child and Adolescent Mental Health Services (CaMHS), Proactive Care and Integrated Community Equipment Services (ICES). These budgets are predominantly hosted and managed on a day to day basis by Lincolnshire County Council, in instances where this is not the case the Integrated Care Board jointly host and manage. As a commissioner of healthcare services, the Integrated Care Board makes a contribution to the pool which is then used to purchase healthcare services. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement in line with the 2023-24 Group Accounting Manual and as defined in IFRS 11.

The pooled budget represents contributions to the areas of identified spend; it is quite likely that the respective organisations have spend relating to the schemes over and above these contributions.

All cash is transacted by all parties in the month concerned. There are no outstanding cash balances or liabilities at each period end for all organisations concerned.

Lincolnshire County Council is responsible for the production of memorandum accounts for the pooled budget. These will not be produced until after the publication of the Integrated Care Board's accounts.

The Integrated Care Board's share of the income and expenditure as handled by the pooled budgets for the financial year ended 31 March 2024 were:

	NHS Lincolnshire Integrated Care Board 2023-24 £'000	**Lincolnshire County Council 2023-24 £'000**	**Total Pooled Budget 2023-24 £'000**	NHS Lincolnshire Integrated Care Board 2022-23 £'000	Lincolnshire County Council 2022-23 £'000	Total Pooled Budget 2022-23 £'000
Income						
Section 75 - Proactive Care		(13,833)	(13,833)	-	(10,106)	(10,106)
Section 75 - Integrated Community Equipment Services		(4,178)	(4,178)	-	(3,242)	(3,242)
Section 75 - Learning Disabilities		(31,678)	(31,678)	-	(21,128)	(21,128)
Section 75 - Child and Adolescent Mental Health Partnership Framework		(16,481)	(16,481)	-	(10,552)	(10,552)
		(102)	(102)	-	(225)	(225)
	-	**(66,272)**	**(66,272)**	-	(45,253)	(45,253)
Expenditure						
Section 75 - Proactive Care	27,422	51,647	79,069	20,991	38,982	59,973
Section 75 - Integrated Community Equipment Services	4,178	3,224	7,402	3,242	2,994	6,236
Section 75 - Learning Disabilities	31,678	61,472	93,150	21,128	45,933	67,061
Section 75 - Child and Adolescent Mental Health Partnership Framework	16,481	725	17,206	10,552	543	11,095
	102	102	204	225	56	281
	79,861	**117,170**	**197,031**	56,138	88,508	144,646
Assets	-	-	-	-	-	-
Liabilities	-	-	-	-	-	-
Grand Total	**79,861**	**50,898**	**130,759**	56,138	43,255	99,393

36 NHS Lift investments

The Integrated Care Board had no Lift investments for the financial year ended 31 March 2024.

37 Related party transactions

During the reported period none of the Governing Body Members or parties related to them have undertaken any material transactions with NHS Lincolnshire Integrated Care Board, other than those set out below (transactions identified were not with the member but between the Integrated Care Board and the related party).

Details of related party transactions with individuals for the financial year ended 31 March 2024 are as follows:

Board Member	Related Party Name	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Dr Sunil Hindocha	Heart of Lincoln Medical Group	3,915	-	-	-
Total at 31 March 2024		3,915	-	-	-

Details of related party transactions with individuals for the 9 months ended 31 March 2023 are as follows:

Board Member	Related Party Name	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Dr James Howarth	Spilsby Surgery	1,750	-	-	-
Dr Majid Akram	The Deepings Practice	1,563	-	55	-
Dr David Baker	Vine Street Surgery	827	-	-	-
Dr Sunil Hindocha	Heart of Lincoln Medical Group	2,726	-	1	-
Total at 31 March 2023		6,866	-	56	-

The disclosure for the current year has been adjusted to no longer classify Dr. James Howarth and Dr. Majid Akram as related parties, reflecting that they have not been Board members of the ICB, with their membership on the Board ceasing with the cessation of NHS Lincolnshire Clinical Commissioning Group on 30 June 2022. As the disclosure is not considered to be either quantitively or qualitatively material to the financial statements, no amendment has been made to the prior year disclosures

The Department of Health & Social Care is regarded as a related party. During the reported period the Integrated Care Board had a significant number of material transactions with entities for which the Department of Health is regarded as the parent. For example:

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Arden and Greater East Midlands Commissioning Support Unit

Details of such organisations with whom the Integrated Care Board had contracts with for the financial year ended 31 March 2024 are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	2023-24 £'000	2023-24 £'000	2023-24 £'000	2023-24 £'000
Cambridge University Hospitals NHS Foundation Trust	5,406	-	-	-
Cambridgeshire & Peterborough NHS Foundation Trust	1,222	-	-	-
Doncaster And Bassetlaw Hospitals NHS Foundation Trust	1,868	-	-	-
East Midlands Ambulance Service NHS Trust	46,378	-	-	-
Hull University Teaching Hospital NHS Trust	4,707	-	-	-
Lincolnshire Partnership NHS Foundation Trust	120,651	48	1	48
Lincs Community Health Services NHS Trust	115,077	30	(211)	-
NHS Arden And Gem CSU	7,953	-	392	-
NHS England	25	5,710	-	68
Norfolk & Norwich University Hospitals NHS Foundation Trust	1,061	-	-	-
North West Anglia NHS Foundation Trust	95,792	-	-	-
Northern Lincolnshire And Goole Hospitals NHS Foundation Trust	66,270	-	-	-
Nottinghamshire Healthcare NHS Foundation Trust	429	67	-	-
Nottingham University Hospitals NHS Trust	24,749	10	(81)	0
Royal Papworth Hospital NHS Foundation Trust	2,120	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	2,610	-	-	-
Sherwood Forest Hospitals NHS Foundation Trust	6,147	-	-	-
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust	15,261	-	-	-
United Lincolnshire Hospitals NHS Trust	626,122	144	13	-
University College London Hospitals NHS Foundation Trust	769	-	-	-
University Hospitals Of Derby & Burton NHS Foundation Trust	3,261	-	-	-
University Hospitals Of Leicester NHS Trust	6,224	16	-	-
Total at 31 March 2024	**1,154,102**	**6,025**	**114**	**116**

In addition, the Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies, namely Lincolnshire County Council.

NHS Lincolnshire Integrated Care Board also has material transactions with all the GP Practices within its locality and membership.

The Integrated Care Board has not made any provision for doubtful debts for any of the above related parties.

38 Events after the end of the reporting period

There have been no post Statement of Financial position events which have had a material effect on these financial statements.

39 Losses and special payments

39.1 Losses

The total number of NHS Integrated Care Board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases	Total Value of Cases	Total Number of Cases	Total Value of Cases
	2023-24 Number	2023-24 £'000	For the 9 month period ended 31 March 2023 Number	For the 9 month period ended 31 March 2023 £'000
Administrative write-offs	1	0	2	90
Total	**1**	**0**	2	90

During the financial year 2023/24 the ICB had one loss. This was for the value of £18.08.

39.2 Special payments

The Integrated Care Board did not hold any third party assets during the financial year ended 31 March 2024.

40 Third party assets

The Integrated Care Board did not have any third party assets for the financial year ended 31 March 2024.

41 Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	2023-24 Target £'000	2023-24 Performance £'000	2023-24 Duty Achieved	For the 9 month period ended 31 March 2023 Target £'000	For the 9 month period ended 31 March 2023 Performance £'000	2023-24 Duty Achieved
Expenditure not to exceed income	1,838,257	1,853,139	No	1,233,381	1,244,937	No
Capital resource use does not exceed the amount specified in Directions	-	-	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	1,814,754	1,829,636	No	1,229,678	1,241,234	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	16,166	15,504	Yes	12,900	12,515	Yes

42 Analysis of charitable reserves

The Integrated Care Board did not hold any third party assets during the financial year ended 31 March 2024.

43 Impact of International Financial Reporting Standards

Please see Note 1.28.

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Lincolnshire Integrated Care Board ("the ICB") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 43, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2023-24 as contained in the Department of Health and Social Care Group Accounting Manual 2023 to 2024, and the Accounts Direction issued by NHS England in accordance with the National Health Service Act 2006.
In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Lincolnshire Integrated Care Board as at 31 March 2024 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023 to 2024; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Social Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the ICB's ability to continue as a going concern.

Other information

The other information comprises the information included in the Annual Report and Accounts for the year ended 31 March 2024, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the Annual Report and Accounts for the year ended 31 March 2024.

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Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023 to 2024.

Matters on which we are required to report by exception

We are required to report to you if:

- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the ICB under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024; or
- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2023 to 2024.

We have nothing to report in these respects.

In respect of the following, we have matters to report by exception:

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

At 31 March 2024, Lincolnshire Integrated Care Board reported a deficit of £14.882 million against its Revenue allocation for the financial year.

Under section 223GC(1) of the National Health Service Act 2006, an ICB must ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board.

We therefore referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that Lincolnshire Integrated Care Board, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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We are required to modify our report as we are making a referral to the Secretary of State under s30 of the Local Audit & Accountability Act 2014.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on page 74, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant are the National Health Service Act 2006, Health and Social Care Act 2012 and Health and Care Act 2022, and other legislation governing NHS ICBs, as well as relevant employment laws of the United Kingdom. In addition, the ICB has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.
- We understood how NHS Lincolnshire Integrated Care Board is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, Head of internal audit, Local Counter Fraud and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. This includes the oversight of those charged with governance the culture of honesty and ethical behaviour and a strong emphasis is placed on fraud prevention, which reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment. We corroborated this through review of the ICB's board and committee meeting minutes, through enquiry of management, those charged with governance and employee's, review of the ICB's policies and through inspection of other information.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the ICB is engaging in any transactions outside the usual course of business. We also assessed the susceptibility of the ICB's financial statements to material misstatement in relation to the risk of fraud in expenditure recognition, specifically those entries and adjustments that understate expenditure accrual balances at the year-end as well as risk of fraud due to improper Revenue Recognition related to the overstatement of Income from goods and services balances at the reporting year end.
- Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with governance reading and reviewing relevant meeting minutes of those charged with governance and the Board and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.
- We addressed our fraud risk related to understatement of expenditure accruals by undertaking testing to gain assurance over the completeness and valuation by performing ovrall analytical reviews to identify unusual movements, testing accrual balances, and assessing expenditure estimates for management bias. We conducted cut-off testing to ensure transactions were recorded in the correct financial year and evaluated unrecorded liabilities for completeness. Furthermore, we examined the Agreement of Balances with reported figures and employed data analytics to identify any irregular trends.
- We addressed our fraud risk related to overstatement of income from goods and services by undertaking testing to gain assurance over occurrence transactions made close to the year end. We reviewed and tested the income recognition policies, tested a ample of income transactions and conducted overall analytical procedures, including month-to-month comparisons, to detect any unusual income movements.
- We addressed our fraud risk related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias, and evaluating the business rationale for significant unusual transactions. This included testing postings in the general ledger that fell outside of the standard transactions process flow.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in May 2024 as to whether the ICB had proper arrangements for financial sustainability, governance and improving economy, efficiency, and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the ICB put in place proper arrangements for securing economy, efficiency, and effectiveness in its use of resources for the year ended 31 March 2024.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the ICB had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the ICB has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the NHS Lincolnshire Integrated Care Board's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Qualified opinion in regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them, except for the incurrence of expenditure in excess of the specified revenue resource limit as set out in Note 41 – Financial Performance Targets to the financial statements.

The ICB has reported a deficit of £14.882 million for the 2023/24 financial year.

We referred this matter to the Secretary of State on 27 June 2024 under section 30 of the Local Audit and Accountability Act 2014.

Certificate

We certify that we have completed the audit of the accounts of NHS Lincolnshire Integrated Care Board in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of NHS Lincolnshire Integrated Care Board in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Hayley Clark
Ernst & Young LLP

Hayley Clark (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Birmingham
Date: 27 June 2024

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Documents are available in different formats
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Item 7 (i)

NHS
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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	Tuesday, 24th September 2024
Title of Report:	System QPEC (Quality and Patient Experience) Committee
Report Author:	Sharon Robson, Non-Executive Director (Chair) Martin Fahy, ICB Chief Nurse Sarah Bates, Deputy Board Secretary
Presenter:	Sharon Robson, Non-Executive Director (Chair)
Appendices:	N/A

To approve ☐	For assurance ☒	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g., approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Board is asked to note the oversight and assurance work of the Committee.

Summary

The System Quality and Patient Experience Committee took place on 4th September 2024 and focused on the following agenda items:

- **SQPEC Planner/Cycle of Business:** members received a copy of the proposed Cycle of Business and noted the routine agenda items, principles and the proposed topics for future focus/deep dive. Discussions took place regarding the themes acknowledging that there may be some additional ad hoc areas that will need to be included and that there needs to be some flexibility within the schedule. Furthermore, the updates need to be presented on a system wide basis and encompass all patient pathways. It was suggested that an update on safeguarding, mortality and infection prevention and control and system complaints would be added to the cycle.

- **Board Assurance Framework:** an update was provided on the principal risks for the Committee. Discussions took place regarding the mitigations in place and that work is taking place to strengthen these.

- **Lincolnshire System Priorities Quality Register:** the latest detail was shared with members and the following high risks noted:-

  - Urgent and Emergency Care Pathways
  - Elective, Diagnostic, Cancer and Community Pathways
  - Workforce challenges
  - Financial challenges

Discussions took place regarding the process for managing harm reviews and how this is undertaken within each organisation and sharing the wider system for learning. It was discussed that the key themes are highlighted on the Patient Safety Incident and Response Framework and that a system wide Mortality Group is in the process of being formulated which will have oversight of this area. An update would be brought to a future meeting.

- **HealthWatch Update:** an update was provided on the main areas of note that include access to GP appointments and access to dental treatment. It was highlighted that a Dental Strategy is being developed for Lincolnshire of which will help to address some of the areas of concern.

  It was reported that positive feedback had been shared in relation to the A&E department at Pilgrim Hospital in terms of the management of waits. In addition, following on from the previously reported concerns and the wheelchair service it was noted that the new service provider has made contact with patients within the service and progress is being made.

  A concern had been raised regarding the soft intelligence received and a GP Practice not providing access to Pharmacy First of which is largely due to the multi factorial authentication software. Discussions took place that this issue is being investigated and only affects a small number of Practices and that alternative desktop software is being explored.

  Discussions took place regarding future reporting and that members felt that it would be beneficial to receive reports that include the key themes accompanied by the plans in place to address the issues raised. HealthWatch confirmed that a new report format be developed and shared at future meetings.

- **Complaints Update:** an update was provided on the backlog of complaint activity requiring logging for audit and reporting purposes, due to operational pressures within the team and that the Committee had requested further detail at the last meeting. It was reported that a number of factors had contributed to the issues including:-

  - Delegation of responsibilities from NHSE July 2023 and a change of process in handling primary care (GP; pharmacy; optometry; and dental) complaints.
  - Complexity of cases.
  - Team resilience.
  - Compliance with statutory and mandatory requirements needs.

  Discussions took place that it would be beneficial to see an agreed trajectory and timeline of when the backlog would be addressed.

  It was also discussed that the Committee would benefit from having a report on the key thematics for each organisation and that this area is included within the Deep Dive cycle of business.

- **Healthy Children Programme Update:** it was reported that In 2017 Public Health England published the revised Health Visiting service delivery model (updated in May 2021). The programme is designed to be 'universal in reach and personalised in response'. It was noted that the new model included some key changes including the mandated reviews and how services are delivered in the most effective way. An update was provided on the key responses to health needs in Lincolnshire including the:-

  - Collaboration and co-delivery methods.
  - Antenatal education and through the Family Hub programme new roles were developed and an Antenatal Education team is now in place and deliver the Solihull Antenatal Programme in all Family Hubs including evenings and weekends.
  - Breastfeeding and through the Family Hub this has enabled the recruitment of eight peer support workers who are all parents with breastfeeding experience. Alongside this a specialist health visitor for infant feeding has been recruited and leads the infant feeding agenda within the Children's Health service and across Children Centres. Along with champion health visitors they provide the UNICEF two-day breastfeeding training to a variety of staff ensuring high quality standards in service provision and mothers receiving the same advice regardless to who they speak to.

In addition, the first infant feeding strategy is being developed for Lincolnshire which is a whole systems approach to this topic, which will be taken to the LMNS Board later this year for final sign off.

- A specialist health visitor for parental and infant mental health has been recruited and leads the mental health agenda within the Children's Health service, working in collaboration with the Family Hub leads and LPFT to ensure that service provision is streamlines and support is available at the most appropriate level for parents and children.
- Was not brought - a pilot was developed following analysis of high numbers of children 'was not brought' to appointments. Actions taken to address this were using SystmOne digital conferencing. The pilot reported favorable and staff and parents highlighted further areas of improvement.

The key challenges were highlighted including workforce, and the delivery of the full Healthy Child Programme. An update was provided on the positive progress being made on workforce and the grow your own and that in the first year nine students will be commencing later this month adding additional nurse skill mix capacity. The position has improved from 35 WTE vacancies to 18 further reducing this to nine with the most recent student cohort intake.

Members commented on the positive progress made that demonstrates the collaborative work across partners.

- **Parliamentary and Health Service Ombudsman Recommendations:** members were asked to note and endorse the request to support the proposal to reimburse the cost of private treatment for one individual (£2,736) from the Parliamentary and Health Service Ombudsman (PHSO) Recommendations. Members supported the proposal.

- **Maintaining Focus and Oversight on Quality of Care and Experience in Pressurised Services:** it was noted that in June 2024 NHS England wrote to all systems about the need to maintain focus and oversight on the quality of care and experience in pressurised services. The letter recognised the work being done but acknowledged that despite this there are occasions where the care and experience patients receive does not meet the high standards expected and that for some patients is not always acceptable. The letter asked organisations to assure themselves that they are working with system partners to do all they can to:-

  - provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.
  - maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility.

  A System Patient Safety and Quality of Care in Pressurised Services meeting took place 5th July 2024 in response to the letter from NHSE to provide assurance and consider further options. As part of the assurance processes going forward a number of steps were identified including clinical audits commissioned by the UEC Clinical Reference Group on 12 hour waits along with clinical audits on discharge and virtual wards, clinical leaders to have a physical presence in departments, daily UEC audits are conducted, the Patients' Panel reviews services and provides feedback to ensure quality is maintained, system executives and non-executives have oversight and assurance. It was reported that the first audit is due to take place on 6th September 2024.

  Discussions took place regarding utilising the finite resources appropriately and avoiding duplication in particular the audits/visits and the non-executive roles within the provider organisations.

- **Statement of Information on Health Inequalities Report 2023/24:** it was noted that this is the first publication of the report of which has been shared at the ICB Board and System Programme Committees. It was noted that the report highlights the areas of variation and equity of access. Discussions took place regarding the collection of ethnicity data and that this area is being strengthened. Members commented that the report provides a useful insight and highlights areas of future focus. Members requested that future iterations are shared with the Committee.

- **Lincolnshire Community and Hospitals NHS Group Highlight Report:** it was noted that the main areas of concern relate to:-

  - Discharge Lounges and that there had been some extended length of stays for complex needs patients. Subsequent to this a review has commenced which is being overseen by the Urgent and Emergency Care Board.
  - ULHT cancer pathways and following routine data checks a potential error was highlighted in relation to the pathway for a patient concluding before a diagnosis had been made. Subsequent to this an internal review has been undertaken of which identified a further four patients. An external review is in the process of being commissioned of which the Terms of Reference are in the process of finalising.
  - LCHS and the management of pressure ulcers and that this area sees the most frequently reported Serious Incident within the community.

  A further area of concern that was noted that had been escalated at the Group Board meeting on 3 September 2024 was the Children in Care and the processes to support the Initial Health Assessments of which are presenting some timely challenges. It was discussed that a financial business case is in the process of being presented to the Finance Investment Panel to seek additional resource. It was agreed that this risk would be included on the ULHT/Group Corporate Risk Register. It was highlighted that the Lincolnshire system is one of the better performing organisation in relation to this area within East Midlands, however we would aspire to achieve the 20 day standard.

- **LPfT Highlight Report:** an update was provided in terms of the learning from incidents from the recent CQC Valdo Calocane report that had been published. It was noted that the Trust are reviewing its DNA (do not attend) policy and discharge processes in particular following the decommissioning of the assertive outreach teams and the transfer to the Community Mental Health Teams. It was discussed that the Trust are leading on the system review of the learning contained within the report and that a Summit will be organised of which will bring together all partners later in the year.

- **EMAS Highlight Report:** it was reported that there had been four patient safety incidents since the last meeting, three of which related to delayed responses and one to care delivery.

- **Primary Care Update including Primary Care Commissioning Committee Update:** it was reported that the National GP Survey had been published and that a review of the data, benchmarking, key themes and learning is being undertaken.

  An update was provided in terms of the support from the CQC and following a change to internal structures a process has been put in place to provide soft intelligence to the ICB before formal notices are published. This was discussed that this is a positive and very much welcomed step in supporting primary care.

  Lastly work is taking place collaboratively across the system with reviewing vulnerable Practices and issues that sit outside the normal business continuity processes such as single-handed GP practitioners and the processes that can be put in place to ensure that Practices continue to function both operationally and contractually.

- **Operational Quality Assurance Group Update**: members were asked to approve the revised Terms of Reference for the Operational Quality Assurance Group, these were approved. Two new areas of concern that were reported relate to clinical interventions in schools and the asthma diagnosis pathway for children and young people. It was noted that work is taking place with the local authority to provide additional support to schools and in terms of the asthma diagnosis pathway progress is being made with the facility to provide spirometry for children within the Community Diagnostic Centres.

- **System Quality Group Update:** it was reported that an update had been provided by Public Health and concerns noted in relation to patients presenting with Hepatitis B and the Occupational Health coverage for Care Homes of which may have implications for GP Practices. It was discussed that the Public Health team are reviewing the learning on a system-wide basis to ensure there are appropriate mechanisms in place to support all organisations.

  A thematic discussion had taken place in relation to the Community Primary Partnerships and the engagement exercises. Lastly discussions had taking place on the positive progress being made with the PSIRF (Patient Safety Incident Review Framework) process.

Items for escalation to the ICB Board:-

- The SQPEC Business Cycle/Planner was noted and approved. Discussions took place regarding encompassing topics e.g., System learning from harm reviews and progress with enhancing dental provision in the county.
- The backlog in complaints was discussed and the issues with the East Midlands Hub and the transition of complaints from NHS E. Further work is required to build confidence levels on recovery and trajectory timescales.
- The committee received an detailed update on the Healthy Children Programme noting the good progress made in this area and the progress made to maintain health visitors numbers.
- The Committee endorsed the request to support the proposal to reimburse the cost of private treatment for one highly unusual case (£2,736) as per Parliamentary and Health Service Ombudsman (PHSO) Recommendations.
- The Committee were assured on the progress being made and that appropriate arrangements are in place to support the oversight on quality of patient care and experience on pressurised services in both ED departments in particular as winter approaches.
- The Committee received the Statement of Information on Health Inequalities Report 2023/24 and welcomed the format of the report.
- The Committee approved the revised Operational Quality Assurance Group Terms of Reference.
- The Committee agreed to escalate the issue of noncompliance against Children in Care Initial Health Assessments (IHA) standard, the system is not achieving the 20 days standard at present. It was agreed that this would be included on the System Quality Priority Risk Register.
- The Committee recognised the system work taking place on the MH pathways following the Valdo Calocane tragedy.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
A System Risk Register and ICB Risk Register is in place of which is shared at the meeting.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	Health inequalities considered in all aspects of the work programme.
Does the report demonstrate patient and public involvement?	Patient and public involvement and engagement is embedded within the System QPEC.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
The Board receives regular reports from each of its Committees at every meeting.

Is the report confidential or not?
Yes ☐ No ☒

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PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	2024
Title of Report:	Update from the Service Delivery & Performance Committee for July and August 2024
Report Author:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Presenter:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	None

To approve ☐	For assurance ☒	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g., approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Board is asked to note and consider this report.

Summary

July 2024

System Infrastructure Strategy - In March 2024 NHS England published guidance on a requirement for ICS systems to develop a draft Infrastructure Strategy by 31st May 2024 and a published document by end of July 2024.

The Committee considered and recommended approval of the proposed Lincolnshire strategy based on the approach to developing this. It was noted that:

- The NHS in Lincolnshire has been working on developing a high-level strategy for several years and a draft was produced in 2023 in anticipation of the guidance. Individual trusts have their own estates strategies and the Primary Care directorate has been working with practices and the PCNs on their estates/clinical needs and aspirations.
- Within the parameters of the national guidance being published in late March 2024 and the requirement for publication in July, the development of the strategy has been

led by a working group involving the provider estates leads and ICB strategy and finance representatives.

- The strategy development stages included
    - Initial groundwork – collating estates strategy work to date, drafting the system vision and principles, establishing the current estates and digital position (identifying draft priorities).
    - Sharing a draft strategy with NHS England 31/05/24.
    - System workshop on 14/06/2024, involving estates, digital, clinical, operational and planning representatives from across the Lincolnshire NHS, EMAS, Lincolnshire County Council, NHS Property Services and NHS England.
    - Finalising the strategy for support and sign-off by organisational and system governance arrangements.
    - Publication of the strategy 31/07/2024.

Health Inequalities

NHS commissioners are under specific legal duties to take account of health inequalities in the exercise of their functions and ICBs and trusts are now required to collect, analyse and publish information relating to health inequalities for the periods 2023/24 and 2024/25.

The Committee was presented with Lincolnshire's first Statement of Information, this has been developed to report alongside the ICB Annual Report 2023/24 and describes the system wide approach to addressing inequalities in health and inequalities in healthcare.

The information contained within the statement covers the mandated indicators and provides a baseline performance for future reports so that trends can be monitored to track improvements and areas of focus to be addressed.

The report has been presented, discussed and approved at the relevant system programme boards with actions identified for 2024/25 embedded within their programme operational plans and governance arrangements.

The Committee agreed to recommend the Statement of Information on Health Inequalities to be presented to the ICB Board for approval.

Womens Health
The Department of Health & Social Care published in Summer 2022 the Women's Health Strategy for England. This sets out the plans to boost the health outcomes of women and girls, reduce disparities and improve how the healthcare system listens to women.

The Committee received an update on the development of the Lincolnshire Women's Health hub and the various initiatives that are progressing within the County, including a Women's Health Conference planned for November 2024.

Provider Performance Committee Feedback
The Non-Executive Directors from each provider gave updates on the current focus and activity across the system's organisations.

Q1 Performance Overview
The report recently presented to an NHS England quarterly review meeting was presented to members for information. Feedback from NHS England was very positive.

Dashboard

The monthly dashboard was discussed particularly in the context of providing assurance over performance trajectories across the rest of the year.

August 2024

Population Health Management Update & System Intelligence Infrastructure

The Committee received a presentation on the Lincolnshire joint intelligence data set, this has been created as one of the most comprehensive, person-level, linked datasets which includes acute, community care, mental health, adult social care and primary care in the country.

The joint intelligence data set allows whole person, whole cohort, whole population and whole system understanding, supporting opportunity identification, evaluation, options appraisal, personalisation, health equity and equality and major system change. The data also includes indicative average cost data for certain types of care to provide comparative intelligence on whole system activity, implications and opportunities.

Training opportunities were discussed to support utilisation and facilitate PHM approaches with local teams. All PCNs have been supported to undertake at least one PHM project with several having completed a full project cycle in 2023. System programme teams have been engaged in using the population intelligence and insights in their programme delivery and future planning activities. ICS partner organisations have started to adopt PHM infrastructure and approaches to support their planning and improvement initiatives.

65 weeks

A presentation was given regarding the up to date position on performance against the 65 weeks waiting list target. It was confirmed that the system would not achieve zero on the 65 week waiting list by the end of September, the activity that has been in place to tackle this as quickly as feasible was discussed in depth with a realistic expectation of achievement by the end of November.

Part of this activity is focused on 'Did Not Attends' (DNA) and a pilot has been implemented involving more proactive contacting of outpatients before their appointments. DNAs can be sitting as high as almost 12% but over a three-month period, the resultant figure has reduced to 8.9%.

GP Collective Action

A presentation was given regarding the scope of potential impact of GP Collective Action.

A~~n~~ structure has been stood up within Lincolnshire using EPRR methodology to ensure that there is oversight across the whole system in order to monitor intelligence, impact and develop any necessary mitigation plans.

Although there is limited information regarding GP practices' intentions, the ICB has requested feedback from practices about the action(s) they are taking or considering taking and this information will used as described above. It is likely based on limited feedback that the limit of patient contacts to 25 per day and non-commissioned activity are likely to be action~~s~~ that some practice~~s~~ will take.

Guidance has been produced for GPs and ICBs on the requirements of both parties during the collective action.

Lincolnshire has a GP strategy already in development and is one of seven ICBs that are part of an NHS pilot which will give visibility and voice on where there are genuine pressures within GP services and PCN provision. The pilot will also help to inform the national development of the contract moving forward.

NHS Population Health Strategy & Planning report

The Committee received a report on the approach and associated process for population health planning work in 2024/25. The proposal has been developed to understand the key drivers at both a system level (planning review) and national level (the new government's emerging plans).

The aim of the approach is to strike the balance of supporting the delivery of the long-term population health improvement goals, as well as care delivery to meet today's challenges, while shaping the landscape of tomorrow. The key elements to this are that it would be expert-led; intelligence-driven; an integrated process; an all year round process and have a multi-year scope. In this way it will achieve a longer term strategy and allow a more sophisticated approach to resource allocation to maximise the health gain for the Lincolnshire population.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	
Risk and Assurance	
See main body of report.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications/	Yes - Health inequalities considered in all aspects of the work programme.

Does the report demonstrate patient and public involvement?	Not applicable.		
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.		
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
Not applicable			
Is the report confidential or not?			
Yes ☐ No ☒			

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PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	24th September 2025
Title of Report:	Audit & Risk Committee Update
Report Author:	Karen Bates & Emma Rhodes
Presenter:	Mrs Margaret Pratt
Appendices:	N/A

To approve ☐	For assurance ☒	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Board is asked to note the update and progress.

Summary

The Audit & Risk Committee meeting held on 4 September 2024 focused on a number of areas including the following:

- Governance Report
- Corporate Risk Register
- HFMA Governance Action Plan Update
- Audit Yorkshire Counter Fraud Update
- TIAA SICA Report
- Ernst & Young Reflection of 23/24 Audit and Action Plan for 24/25

Key points for noting were as follows:

Governance Report
A summary of amendments to the declarations of interest register were included. There had been no declarations of hospitality or sponsorship and there were no losses to report. Two waivers were presented for approval, one was for the System Improvement Director, which has now extended to 31 March 2025. The other was for consultancy support for the

Social Finance project. Both waivers were approved by the Committee.

Corporate Risk Register
The corporate risk register was presented to provide an update on it's current status. Two new risks had been added around safeguarding and the risk around Cyber Security still require further update.

HFMA Governance Action Plan Update
In 2022 there was a requirement for all NHS organisations to complete a self-assessment against the HFMA Checklist and create action plans for any rating of below 4. This was then subject to audit. The ICB did reasonably well in the initial assessment, however, there were areas which required further evidence. A recent assessment has been carried out and progress has been made, particularly with the CIP financial recovery plan. IA recommended a clear plan be put in place and we intend to follow the successful template used previously with ISFE metrics.

Audit Yorkshire Counter Fraud Update
There had been two fraud alerts, checks were made on the organisations, and there has been no activity with the ICB. The national fraud initiative update is restarting as we have come to the end of the current cycle and comms will be shared with staff around data usage towards the end of Q3. New referral regarding a PHB package and work is underway with the PHB team to establish the expenditure involved.

TIAA SICA Report
A draft report will be presented at the November meeting around key financial controld audit. An update around progress against the annual plan was provided.

Ernst & Young Reflection of 23/24 Audit and Action Plan for 24/25
Improvements made since the last year and there are still things being worked on as timeframes are set for 24/25. An action plan will be put into place with dates and deliverables.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	
Aim 2: Tackle inequalities in outcomes, experience and access.	
Aim 3: Enhance productivity and value for money.	
Aim 4: Help the NHS support broader social and economic development.	
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
A indicated in the report.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report highlight any quality and patient safety implications?	If yes, include the details otherwise state 'No or Not Applicable'

Does the report highlight any health inequalities implications/	If yes, include the details otherwise state 'No or Not Applicable'
Does the report demonstrate patient and public involvement?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	If yes, include the details otherwise state 'No or Not Applicable'

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☒	N/A ☐
Has an equality impact assessment been undertaken?	Yes ☐	No ☒	N/A ☐
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☒	N/A ☐

Report previously presented at:

Regular updates provided to the Board.

Is the report confidential or not?

Yes ☐ No ☒