NHS
Lincolnshire
Integrated Care Board

# NHS Lincolnshire Integrated Care Board

# Public Board Meeting

## Tuesday, 30th July 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, 30th July 2024**
**Time: 9.30 am – 12.00 noon**
**Location: The Boardroom, Bridge House, Sleaford**

**Chair of the meeting: Dr Gerry McSorley, Acting 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 28th May 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 | - | Mr Andy Fox | 10.00 |
| ii) | Healthwatch | Note | ✓ | Mr Navaz Sutton | 10.10 |
| **4. Population Health Planning** | | | | | |
| i) | Draft Integrated Care System Research and Innovation Strategy | Approve | ✓ | Dr Sunil Hindocha | 10.20 |
| ii) | Health Inequalities Annual Report 2023/24 | Approve | ✓ | Mrs Sandra Williamson | 10.35 |
| **5. System Oversight and Assurance** | | | | | |
| i) | Integrated Performance and Quality Report – July 2024 | Assurance | ✓ | Mrs Clair Raybould/ Mr Martin Fahy | 10.50 |
| ii) | System Financial Report (Month Three) | Assurance | ✓ | Mr Matt Gaunt | 11.05 |
| iii) | GP Collective Action | Note | - | Mrs Sarah-Jane Mills | 11.15 |
| iv) | Update on Cyber Assurance | Assurance | ✓ | Mrs Kathy Fulloway | 11.20 |

| Item | | Action Type (For Approval, Assurance, Discussion or Information) | Enc | Presenter | TIME |
|---|---|---|---|---|---|
| v) | Lincolnshire Health, Care and Education Partnership "Our Ambition" | Endorse | ✓ | Mr John Turner | 11.30 |
| **6. Governance** | | | | | |
| i) | Draft Board Forward Plan 2024/25 | Approve | ✓ | Dr Gerry McSorley | 11.40 |
| **7. Committee Highlight Reports** | | | | | |
| i) | • Service Delivery and Performance<br>• System Quality and Patient Experience<br>• East Midlands Joint Committee | Assurance | ✓ | Committee Chairs | 11.45 |
| **8. Information/Closing items** | | | | | |
| i) | Risks identified during the course of the meeting | Consider | - | Dr Gerry McSorley | 11.55 |
| **9. Date, Time and Venue of the next meeting** | | | | | |
| | Tuesday, 24th September 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
Lincolnshire
Integrated Care Board

# MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD MEETING HELD ON TUESDAY, 28th MAY 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 |
| | Ms Anita Day | Non-Executive Member |
| | 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) |
| | Mr Andrew Morgan | Group Chief Executive, Partner Member, NHS and Foundation Trusts |
| | 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 Director |
| | Dr Kevin Thomas | Partner Member, Primary Medical Services |
| | Mr John Turner | Chief Executive |
| | Mrs Vanessa Wort | Associate Chief Nurse (on behalf of Mr Fahy, Chief Nurse) |
| **REGULAR PARTICIPANTS/ ATTENDEES** | Miss Sarah Brinkworth | Planned Care Programme Lead Director (item on CDC only) |
| | Mrs Jules Ellis-Fenwick | ICB Board Secretary |
| | Mrs Lucy Gavens | Consultant in Public Health (item on health inequalities only) |
| | Mrs Michele Jolly | Voluntary and Care Sector Representative |
| | Mrs Sarah-Jane Mills | Director for Primary Care and Community & Social Values |
| | Mr Dean Odell | Healthwatch Representative |
| | Mr Navaz Sutton | Chief Executive Officer, HWLincs |
| | Professor Derek Ward | Public Health Representative |
| | Mrs Sandra Williamson | Director for Health Inequalities & Regional Collaboration |
| | Cllr Sue Woolley | Chair of the Health and Wellbeing Board |
| **APOLOGIES:** | Ms Charley Blyth | Director of Communications and Engagement |
| | Mr Pete Burnett | Director for Strategic Planning, Integration & Partnerships |
| | Mrs Sarah Connery | Executive Board Mental Health Member |
| | Mr Martin Fahy | Director of Nursing (Chief Nurse) |

## 24/211 WELCOME AND INTRODUCTIONS

Dr McSorley welcomed all those present to the NHS Lincolnshire Integrated Care 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 as a Live Event. This arrangement had been put in place to enable members of the public or staff to either attend and observe the meeting in person or digitally through MS Teams.

Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma which was published on the website.

The Questions and Answers facility had also been made available during the Board meeting as part of the live event. Any questions submitted would be responded to after the meeting subject to inclusion of name and contact details. Questions will be published on the ICB website in future along with the response in terms of being open and transparent.

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 welcomed Mr Navaz Sutton, Chief Executive Officer, HWLincs and advised that he would be attending the Board meetings going forward.

**24/212 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:
No items declared.

The Board agreed to:

- **Note the interest as declared.**

**24/213 MINUTES OF THE PREVIOUS MEETING**

The Board considered the minutes of the previous meeting held on the 26th March 2024 and agreed to:

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

**24/214 MATTERS ARISING**

Dr McSorley presented the Action Log as included in the pack of papers. There was one action, which was identified as in progress, and this would be picked up as part of today's meeting.

The Board agreed to:

- **Note the action log.**

**24/215 CHAIR AND CHIEF EXECUTIVE UPDATES**

**ICB Chair update**

Dr McSorley advised that he had some specific points to highlight for the Board's information, but in the first instance it was important to emphasise that in light of yesterday's announcement about the General Election taking place on the 4th July, the conduct of the meeting must be in line with national guidance. Board Members were asked to bear that in mind and for their co-operation in meeting that responsibility. To add, the agenda and all reports within the pack of papers for today's meeting were compliant with the national guidance.

Dr McSorley advised that as a first point of note, he wanted to formally acknowledge the report recently published on the outcome of the Blood Scandal inquiry and the NHS's role in the scandal. There will have been people in Lincolnshire affected by the events which took place over several decades and it would appropriate to extend the ICB's apologies to those individuals as indeed the national inquiry noted. Hopefully the report and the government's response will go some way in answering the questions of those involved.

Further points highlighted:

- This was Mr Morgan's last ICB meeting in public as he would be retiring at the end of June 2024. Mrs Karen Dunderdale would be the new NHS and Foundation Trust Partner Member from the 1st July 2024. Dr McSorley acknowledged Mr Morgan's hard work and enormous contribution to the NHS in Lincolnshire over a number of years, and on behalf of the Board expressed his appreciation and wished him well in his future endeavours.
- The ICB Annual Public Meeting had now been confirmed in diaries for Thursday, 26th September 2024 at 5.00 pm via Microsoft Teams as was the case the previous year.

Dr McSorley advised there had been a number of meetings and visits since the last Board meeting and advised that he, along with Mr Turner, had recently met with Cllr Martin Hill, Lincolnshire County Council (LCC) Leader and Mrs Debbie Barnes, LCC Chief Executive and had discussed a number of items including an update on the devolution and Greater Lincolnshire combined authority programme, which colleagues would recall the ICB was very supportive of.

Dr McSorley had also met with Mr Chris Wheway, Chief Executive of St Barnabas and Professor Neil Juster, Chancellor of the University of Lincoln. Along with Mrs Mills, Dr McSorley had also met with Dr Simon Lowe and colleagues at the PCN in Mablethorpe and visited the Night Light Cafe in Sleaford. Meetings had also taken place with Mr Sean Lyons, Group Chair, Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust and Dr Sadie Aubrey, Chair of the PCN Alliance.

Mr Turner and Dr McSorley had the opportunity to visit the Bridge Central Wellbeing Hub in Lincoln and they had both attended routine meetings of the Lincolnshire Leaders Group (LLG). Meetings coming up in June included one with the Four Pillars and Healthwatch.

Dr McSorley handed over to Mr Turner at this point to present his Chief Executive update.

**Chief Executive update**

Mr Turner advised that he had several points to share with the Board but firstly wanted to recognise the on-going hard work and focus across the system. Whilst the nation was now well out of winter, the pressures on the NHS are now more recognised as being all year round rather than just seasonal. The edge has come off some aspects of urgent and emergency care but there have continued to be some difficult moments across the county.

Mr Turner advised that the 2024/25 planning round had come to a positive conclusion. Senior colleagues had met with NHSE senior colleagues the previous week and whilst progress to date was recognised, there is a huge amount of work now to be actioned to deliver on those commitments made to NHSE and the people of Lincolnshire.

Some Board Members will be aware, conversations with ICB staff have recently been opened on the Target Operating Model (TOM) and Mr Turner was looking forward to three staff events coming up, the first of which was scheduled to take place on the 20th June, followed by the remaining two on the 3rd and 4th July. The developing TOM will be a key part of those discussions along with a reflection on lots of really positive areas which have happened over the last 12 months.

In terms of conferences which have taken place and some which are coming up in the next few weeks, Mr Turner attended the recent LVET conference in Lincoln, and provided a joint presentation alongside Mr Martin Samuels, Director of Adult Social Services which underlined the NHS and local authority's appreciation and support for the work of the third sector across the county and to encourage colleagues to build on, develop and press forward with their great work.

Further points highlighted:

- Mr Turner will be attending the forthcoming 'It's All About People' Conference (all about co-production) in early July and will be providing a joint presentation alongside Mrs Debbie Barnes in supporting this as a very significant and on-going priority.
- On the 24th June 2024, the first Armed Forces & Veterans and NHS conference will take place, and it is hoped this will become an annual event. The aim of the conference is for the NHS in Lincolnshire to be recognised as a leader in how it supports its armed forces and veterans and identify how this can best be achieved.
- The Board Members were aware of the ICB's involvement in the national GP Operating Model 'testing' work. The ICB along with six other ICBs had been asked to come together and lead on this, which would be instrumental in the development of the ICB's own GP Strategy. Mrs Mills and Dr Hindocha were heavily involved in the early work in establishing all of that.
- Mr Turner had attended a number of meetings in recent weeks and had met with Mrs Hannah Coffey, Chief Executive at Northern West Anglia NHS Foundation Trust (NWAFT) and discussed areas of mutual interest with a fifth of the population of Lincolnshire receiving their secondary care provision from Peterborough City Hospital.
- Mr Turner was also due to meet in the next week with Mr Johnathan Lofthouse, Group Chief Executive Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust.
- The Psychiatric Intensive Care Unit (PICU was scheduled to re-open in the coming weeks, which was very positive news.
- Lincolnshire Cancer Summit would be taking place on the 12th June 2024.
- The Lincolnshire system wide digital review process jointly sponsored by Mr Turner and Mrs Barnes would conclude in June.

At this point Mr Turner referred to questions which had been received from two members of the public. 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.**

## 24/216 KEY UPDATES

**Public Health**

Professor Ward advised that Directors of Public Health in England have a statutory duty to produce an independent report on the state of health of the people they serve on an annual basis. Local authorities have a statutory duty to publish the report and the report should be as accessible as possible to the wider public.

This years' report focused on the importance of addressing the needs of Lincolnshire's ageing population which is exhibited by evaluating the current situation for older residents within Lincolnshire as well as considering how to address some of the key determinants that could positively impact on the health and social issues that affect the ageing population.

Professor Ward advised that he had prepared a presentation to support the report, which was included in the pack of papers, and ran through a series of slides for the Board's information

which covered the following areas:

- Proportion of Population Aged 65+ broken down by area (23% of Lincolnshire's population is aged 65+), which is higher than the East Midlands and England average, both of which are about a fifth. The distribution is not standard with a third of the population over 65 and above in East Lindsey compared to only 14% in Lincoln city. This will be important moving forward in terms of how health and care is provided.
- Lincolnshire's Changing Population Profile 2026 (Male versus Female). This graph showed the proportion of the overall population that are in different five year age bands, with the data taken from 2021. It shows that the ageing population is getting older and older, which is very positive. It is really important to recognise that the reason Lincolnshire has more older people is because of people being kept alive longer.
- Lincolnshire's increasing older population – 180,000 over 65's in Lincolnshire with an increase of over 40,000 predicted in that population in the next twenty years. By 2043, an increase of 41% is projected in Lincolnshire's 65+ population. 94% increase is predicted in the over 85+ population. It is really positive people are living longer, but in terms of health and services and how they are provided, that will be an issue across the county.
- Lincolnshire's population density and deprivation affecting older people. Lincolnshire has a large rural dispersed population, including down the East Coast, but generally people live around the towns in the urban areas, but is spread out all over the county. The maps presented showed the population density and also the deprivation impact. There is a large population down the coast, which is one of the county's biggest areas of deprivation.
- Life expectancy and healthy life expectancy - on average, if someone lives to 65, they have probably got another 20 years left, but only half of those 20 years are going to be in good health and half of that life will be unhealthy with a number of that population living with two or more multiple conditions. It is really important to help people to live longer and also keep them illness free, or at least help them to manage their conditions as well as possible. Life expectancy in Lincolnshire is broadly in line with the national position, but there is a quite a big difference in terms of the most deprived and least deprived population and how long people are going to live.
- Challenging Need in the Next 10-15 Years – it will be key to help prevent people having a fall over the next twenty years because of the ageing population and there will potentially be an additional 7,000 people living with a dementia diagnosis if no action is taken. Physical activity is a key preventative aspect of dementia which is vascular in nature. Over half of 65 - 74 year olds are expected to be multimorbid (2+ Long Term Conditions) by 2035. Over 65s providing unpaid care will increase by 30%.
- Age Friendly Communities Framework – outlined the details of the framework used and which describes what action needs to be taken.
- Case studies – falls, Lincolnshire carers service and One You Lincolnshire and Extra Care Housing – De Wint Court, Lincoln
- Respect and social inclusion
  Communication and information – how we communicate with our population.
- Social participation, civic participation and employment
- Outdoor spaces and buildings
- Transportation and Housing
- What does this mean for Lincolnshire – keeping older people healthy
- Four recommendations pertaining to social inclusion, transportation, digital inclusion and housing.

Dr McSorley thanked Professor Ward for his informative presentation and asked whether there were any questions or observations.

Mrs Robson referred to the section on community support and health services in the report which referenced that in Lincolnshire healthcare provision is centred around hospitals and specialties, and asked how community and primary care partnerships can be harnessed and also the new operating model for GP practices to address the challenges referred to in the

report, adding that it would be good to see that come through as a recommendation. Professor Ward advised that this will be picked up through the Community and Primary Partnership work. There has been a focus on acute services for understandable reasons and whilst that needs to be maintained, the community and primary support model needs to be supported and pushed forward as it is not just about general practice and GPs providing all care; this is about a whole range of both health and care professionals and voluntary communities coming together to deliver those services.

Ms Day commented that the report was very good and well put together, and the recommendations made a lot of sense. Ms Day asked whether Professor Ward had any views on the actions the health and social care sector could be doing. Professor Ward advised that ultimately there needs to be a redesign of the health and care system but that was a significant challenge over the next five to ten years. However, the first step is to have a conversation with both the public and the people who work in and around the system to understand how to do that whilst at the same time dealing with a level of acuity in the acute Trusts that has never been seen before.

Mr Gaunt referred to the section in the report on digital inclusion which stated that age in itself is not a barrier and the recommendation to use all measures possible and sought clarification on who is the lead agency to drive those forward. Professor Ward advised that from a public sector perspective it would be LCC which is working with a whole range of providers to increase 4G, 5G provision connections down the coast in the county, and also fibre-optic connections. There is a whole programme of work in place to support this.

Mrs Jolly asked how the voluntary sector can be included in the further development of services for this age group as they deal with a huge range of services which ties into this and there is a real opportunity to bring this work together. Professor Ward advised that the voluntary and community sector needs to be fundamentally built into service delivery to meet the needs of the population, which links into the personalisation agenda.

Mr Turner advised that the information on data referred to by Professor Ward at the beginning of the presentation was impressive and strengthened the need for this to be central in people's minds and the challenge will be how the information is taken forward.

Dr McSorley thanked Professor Ward for his presentation of the report and supporting presentation.

**Healthwatch**

Mr Odell advised that the report included in the pack of papers summarised patient experience feedback received by Healthwatch and advised that over the last quarter (Jan – Mar) 348 people had shared their views and experiences directly on Health and Social Care in Lincolnshire and an additional 468 people shared their experience through the Menstrual Health Survey.

The service areas commented on the most in the quarter were:

- GP Services (46%)
- All Hospital Services (36%) - (5% of all comments were about A&E)
- Social Care (12%)
- Dentistry (to a lesser extent that has been seen previously; with the majority of comments now related to routine appointments)

In terms of GP services, the access to GP appointments appeared to be a particular concern for those in the east of the county (mainly coastal and Horncastle). Issues highlighted included facing long waits on the phone and by the time they connect the appointments have gone and also on-line services were being closed early in the morning.

As a result of this, some of these individuals were going to UTCs and A&E. Other themes related to incontinence service/supplies and hospital waiting times and cancellations.

Healthwatch had recently undertaken visits to the Grantham Community Diagnostic Centre (CDC) and Grantham and Skegness UTCs. This formed part of a national piece of work being conducted by Healthwatch England around CDCs. Healthwatch Lincolnshire was able to provide local intelligence to support that work. The report presented highlighted the key findings of the visits along with a link to the full report.

Healthwatch had recently carried out 'Enter and View' visits to three Care Homes as part of their work with adult social care. The majority of residents rated the Care Homes positively. Future visits to further Care Homes were planned in the future.

Mr Odell referred to the outcome of the menstrual health survey, advising that 450 service users shared their views and 18 healthcare professionals. Some of the comments received related to diagnosis of specific clinical conditions, with the five main areas highlighted in the report, along with long waiting times (including endometriosis), medication issues and mental health impact. The report also highlighted the areas that people want to see improved. The next piece of work for Healthwatch is on respiratory health and conditions.

On a final note, the latest YourVoice@Healthwatch event had recently taken place and Mr Odell expressed his appreciation to Professor Derek Ward and Mr Martin Fahy for their attendance and presentations on the county's plans to help our people improve their quality of life as they get older and the aims of the ICB to bring together groups to take collective action and focus on prevention and early intervention, as well as tackle inequalities and equity in healthcare. The next event is planned to take place on 31st July and will focus on Community Primary Partnerships.

Dr McSorley thanked Mr Odell for his update and proposed that any issues relating to GP access were picked up as part of item 5 (ii) on the agenda – Primary Care Access Recovery Plan.

Mrs Raybould thanked Mr Odell for the informative report, adding that as the Women's Health Champion many of the areas identified for improvement as part of the menstrual health survey already form part of the Women's Health Strategy launched in 2022 and some of that work is already being progressed in Lincolnshire, such as the Women's Health Hub (One Stop Shop). The feedback received by the ICB is that the services are available, but people do not know how to navigate them.

Mrs Pomeroy referred to the waiting times and asked whether there was any particular reason for this, specifically in relation to endometriosis and what action was being taken to address this. Dr Hindocha advised that in some instances it is incredibly complex to get a diagnosis of endometriosis and going through the diagnostic process can take a considerable amount of time. Whilst the excessive waiting times were not acceptable, there were medical and complexity reasons for this. Mrs Raybould added that from an assurance perspective, routine waits into the gynaecology service are not excessive in Lincolnshire.

The Board agreed to:

- **Note the Director of Public Health Annual Report 2023.**
- **Note the Healthwatch report.**

## CORE PURPOSE 1: HEALTH INEQUALITIES

**24/217 SUPPORTING THE CORE20PLUS5 – CHILDREN AND YOUNG PEOPLE ORAL HEALTH**

Mrs Williamson advised that for the purposes of today's meeting, a paper had been included in the pack which provided the Board with information on the work being undertaken to address health inequalities which is a standing item on the agenda.

The report on this occasion covered improving oral health in children and young people in Lincolnshire. Strategically, there is a major focus on prevention and good oral health in young children as part of the plan to recover and reform NHS Dentistry, and Core20PLUS5 for children and young people has identified oral health as one of five areas of clinical focus.

Mrs Lucy Gavens had joined the meeting to provide a presentation and update on the action being undertaken around oral health which very much linked with prevention and the work being carried out on the dental strategy. Mrs Williamson handed over to Mrs Gavens, Consultant in Public Health at Lincolnshire County Council.

In the first instance, Mrs Williamson had already introduced some of the work being undertaken around oral health, particularly focused on children and young people, which is a really integral part of general health and wellbeing. Most people are at risk of developing some form of oral disease, be that tooth decay, or gum disease in their lifetime, but it is almost entirely preventable, especially if good oral health habits are instilled in young people and young families. Getting into good habits helps protect their oral health across the life course.

Mrs Gavens went through the presentation slides which included information on key findings from recent National Dental Epidemiology surveys in Lincolnshire, an update on water fluoridation and highlighted activities to improve oral health in children and young people, in support of the Dental Strategy and Core20PLUS5.

Mrs Gavens advised that a considerable amount of understanding what is happening in terms of oral health around the county is informed by the Dental Epidemiology Programme which runs almost year on year in different age groups. The Plan to recover and reform NHS dentistry also has a major focus on prevention and good oral health in young children and people which is seen as national driver.

The local authority (LCC) is statutorily required to provide or commission oral health promotion programs to improve the oral health of our local population. As part of that LCC also commission the National Dental Epidemiology programme, which is delivered in Lincolnshire by the Community Dental Service. Surveys have been carried out almost year on year with the most recent one completed of five year olds in 2021/22 and what that showed is that 21.2% of children in Lincolnshire (1587 children examined) had some form of dental decay with the England national average being 23.7% but there are significant inequalities in Lincolnshire, for example of the five year olds sampled in Boston 32% of those children had decayed or missing teeth, whereas in North Kesteven it was only 11.4%. However, the gap has reduced as the previous survey carried out in 2018/19 was 39% for Boston but there is still some way to go. There is currently a five year old survey underway in the current school year which will provide updated data this time next year.

The first survey of six year olds took place in the school year 2022/23. This has given a baseline from which to measure future trends. The outcome of that survey found that 16.8% of children across Lincolnshire had some form of dental decay, again with highest levels demonstrated in Boston at just under 23% and the lowest being in North Kesteven at 7.5%. Professor Ward clarified that this is Year Six children (10-11 year olds).

Water fluoridisation has been described as the single most effective public health measure there is for reducing oral health inequalities and tooth decay rates, especially amongst children and young people but should not be viewed in isolation – it is really important to have good oral health habits and have good access to dentistry provision to ensure those wrap-around interventions are in place.

In Lincolnshire, 250,000 people (approximately a third) have an artificially fluoridated water supply.

In 2022, responsibility for water fluoridation transferred from Local Authorities to the Secretary of State. There is a consultation ongoing at the moment in the North East where they are looking at rolling out water fluoridation on a regional level and everybody's watching to see

what happens there really to understand the direction of travel and what the next steps might be for water fluoridation in other parts of the country.

Mrs Gavens referred to the slide on Fluoridation & DMFT at 11 Years which demonstrated some inequalities in the rates of decayed, missing and filled teeth in our younger children (10-11 year olds). This depends on whether or not they live in areas that have a fluoridated water supply, although it was important to note this would not be the only reason for those inequalities. Boston, East Lindsey and South Holland, which do not presently have a fluoridated water supply, do have a higher percentage of children aged 10 or 11 who have decayed, missing or filled teeth. Those children also have more decayed, missing or filled teeth than children who are living in the West part of the county. Again, this is not the only reason but given the evidence base underpinning this, water fluoridation is one of the reasons that are considered to be contributing to that inequality.

Mrs Gavens advised that whilst this session has focused on children, she wanted to take the opportunity to highlight what is known in terms of adult dental access treatment in terms of areas with water fluoridation versus non fluoridated areas. Again, it is a complicated picture, with more adults accessing NHS dentistry in the parts of the country that are fluoridated that is potentially partly driven by the dentists in those areas. What is seen though is adults requiring more complex dental treatments.

Mrs Gavens went on to highlight some of the key activities underway at the moment, all of which sit under the dental strategy and there is a programme of work around improving people's knowledge and understanding of good oral health within our children and young people.

Dr McSorley thanked Mrs Gavens for her informative presentation and asked whether there were any questions or observations. Professor Ward reiterated the points made by Mrs Gavens at the beginning of the presentation – decayed, missing or filled teeth are all preventable and is a generational issue, with younger people in the present day having much better teeth than those for example who are middle aged. In terms of water fluoridisation, there is a clear difference between Lincoln and Boston and evidence does indicate this is down to fluoride being in the water in the West side of the county and not in the East.

Again, as referred to by Mrs Gavens, there is a pilot on water fluoridisation currently being undertaken in the North East and it will be interesting to see the outcome of that once it is complete.

The Board agreed to:

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

## CORE PURPOSE 2: HEALTH OUTCOMES

**24/218 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, adding this was the first time in 18 months industrial action was not referred to, which was very positive.

- All Type four hour performance for the ICB was set at 74% and 74.4% had been achieved. There did continue to be some improvements with ambulance handovers and Category Two mean response times for EMAS as an ICB was more than a minute better than the Trust average.
- The ICB did not meet the FDS standard for cancer for 2023/24 as a whole, being 0.5% off the target, but the position continued to remain stable. The focus has now shifted back into 62 days – clearling the backlog was essential to improve performance.

- Planned care – 78 week elimination remained on-going and the number of patients waiting more across all providers at the end of April was three, all of which were down to patient choice.
- The number of patients waiting over 65 weeks continued to decrease and all providers are aiming to eliminate over 65 week waits by September 2024. The number of patients waiting over 65 weeks was 525 at the beginning of May 2024. This position had been noted nationally.
- The NHS Talking Therapies (previously IAPT) access rate for 2023/24 (cumulative position) was 23.6%, below the standard of 33%. This was also slightly below plan for the month of March (2% against 2.3% plan) but above national average.
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 85% in March (rolling 12 months) which is above the 60% standard.

In summary, the report was relatively clear in terms of the progress being made.

There were no questions received in relation to this section of the report, so Mrs Raybould handed over to Mrs Wort to present the Quality Section.

**Quality Section**

Mrs Wort presented the Quality Section of the Integrated Quality and Performance Report and highlighted the following from the patient safety quality perspective:

- EMAS: Concerns were highlighted through the Lincolnshire Adults Safeguarding Board (LSAB) regarding high numbers of safeguarding referrals being made by EMAS, however only a small proportion of these referrals met the criteria to progress to Section 42 enquiry. The ICB has met with EMAS to discuss the concern and they have made a commitment to work with the LSAB to understand and progress the actions required to achieve appropriate safeguarding referrals whilst facilitating identification of quality concerns that require reporting through alternative routes.
- Bariatric Surgery: A recent case example has identified the need to look at arrangements for people who access surgery overseas and what measures should be in place for them on their return. This work will involve a review of the existing pathway for bariatric surgery and development of a policy that reflects arrangements within the context of surgery undertaken overseas.
- Oliver McGowan training: From the 1st of July 2022 the government introduced a requirement for CQC registered service providers to ensure their employees receive learning disability and autism training appropriate to their role. The report highlighted good progress against this training and the approach being undertaken nationally and also locally in terms of the Lincolnshire system.
- The Sidings Practice CQC report was published 27 March 2024 and rated the Practice Inadequate. The Practice has been placed into Special Measures. Work is ongoing with the Practice through the ICB and LMC to ensure there is appropriate support to make the necessary improvements.
- In terms of quality improvement information, the General Practice Nurse Team conference took place at the end of April and the report included detail on the individuals and practices who won a variety of awards in terms of best practice.
- The Partnerships for Inclusion of Neurodiversity in Schools (PINS) pilot is a really positive joint piece of work between the ICB, local authority, education and the Lincolnshire Parent Carer Forum that is focusing on how we can work differently as a system to meet the needs of CYP with special educational needs and disabilities. There are 40 schools from the Boston area taking part in that pilot which is due to run until the end of March 2025.

  An evaluation framework is being developed which will look at the outcomes to inform national direction going forward.

- Lincolnshire is one of three local authority areas nationally that are participating in the Families First for Children (FFC) Pathfinder pilots, which has been reported to the Board previously and this is seen as an opportunity to be at the forefront of changes under Working Together which was published in 2023. This has now moved into the implementation phase and an independent evaluation team has been commissioned by the DfE for Pathfinder and initial interviews with key stakeholders have now taken place.
- Emergency / Urgent Care Incidents reported by Health Professionals into the ICB are reported monthly to the UEC Partnership Board to ensure any themes of concern are considered and also to provide oversight of the follow up of these reported incidents. It is emphasised that these are only incidents reported into the ICB via the Health Professional Feedback Route and/or via the Serious Incident Reporting Process. Individual organisations have their own internal incident reporting mechanisms. In consequence the ICB incident data reflected and reported only ever provides a useful snapshot of incidents occurring.
- Vaccination slide – really good progress that has been made in relation to the Spring booster campaign.

The ICB Board agreed to:

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

**24/219 PRIMARY CARE ACCESS UPDATE REPORT**

Mrs Mills presented an update report on primary care access and advised that she would take it the Board had read the document, but just as a reminder, the Primary Care Access Recovery Plan (also known as the Delivery Plan for Recovering Access to Primary Care) was published in May 2023 and the second year of delivery builds on the progress last year and aims to realise the benefits for patients and staff from those foundations.

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

- GP access across the county is in line with both regional and national performance and very good recovery of GP appointments had been made compared to the pre COVID levels. Appointment levels are approximately at 146% compared with 2019. This is actually the highest recovery in the region and a higher number of appointments in March 2024 compared to the Midlands ICBs.
- In terms of day appointment rates, again the ICB is above the regional average at 48%, although is just achieving the 85% of the two week target which is slightly below the regional average. The challenge across Lincolnshire is variation as highlighted by Healthwatch colleagues earlier in the meeting. This is driven by a number of factors, one of which is rurality and access to other services where it is found that people in those areas access general practice rather than other services where there is easier access to areas, such as UTC. This is reflective of previous comments made by colleagues about deprivation and demographics. The general practice operating model is an independent business model, so practices run their businesses very differently and we do see significant variation in terms of how practices utilise areas like online consultations.
- The Primary Care Team is working very closely with all of the PCNs and practices through the capacity access improvement plans and a support level framework which works directly with practices and particularly areas of digital inclusion and making the most of the technology that is available and particularly the NHS app which has a number of helpful features for those who wish to use it.

- The Pharmacy First service launched on 31 January 2024 – this combines the GP community pharmacy referral scheme with an extended range of conditions that pharmacies can treat with prescription only medicines without the need for the patient to see a GP e.g., shingles, acute earache and sore throats. Coverage is good in Lincolnshire with 94% of community pharmacies signed up to provide the service. The only pharmacy which is not signed up is a remote one and it would not make sense for them to choose that model. Very good uptake is being seen in the utilisation of those services with a positive increase in GP referrals.
- Complimentary to Pharmacy First, there is a community pharmacy scheme where GPs can refer and direct people to pharmacists who will be able to support the individual's needs. There has been a positive increase in that.
- Increasingly, there is evidence of patients and the public using self-referrals. A piece of work is currently underway to raise awareness with regards to public information through the ICB website in June and also in terms of the pathways.
- As the ICB recommission services, it will become routine practice to include self-referral into the service model. Mrs Mills advised that there has been a slight delay with the recommissioning of the Any Qualified Provider (AQP) for physios so there will not be the opportunity to undertake that until the end of this year. However, consideration is being given to a pilot with one of the local bidders and see how that improves services.
- In summary, a steady and positive increase in people utilising self-referrals is being seen.
- All of the ICB practices will have digital telephone systems implemented by June and the team continued to work with practices in terms of utilisation of online consultations.

Referring back to the variation which again has been raised and discussed by colleagues earlier in the meeting, some of the practices are turning off the opportunity for on-line consultations. Increasingly it is being seen that if the on-line consultation is provided in an integrated way then it is possible for practices to maintain open access during core hours.

On a final note, there is a well-established primary care secondary care interface group that Dr Hindocha is leading on with colleagues from across the Trusts. Strong engagement is being seen and tackling of some specific issues, particularly with the issue of fit notes, which is anticipated to have a positive impact for general practice in terms of capacity.

Dr McSorley thanked Mrs Mills for the detailed report commenting that it is impressive to see 5.4 million GP appointments in a year within Lincolnshire. In England as a whole there is evidence that one in eight people visits their practice once a week, which is significant. Recovery from COVID is impressive in light of the increased level of demand, and progress would no doubt be considerably reduced if colleagues in general practice were not as innovative as they are. The report demonstrates the on-going commitment and hard work being undertaken to keep up with the level of demand.

Mrs Kenson referred to Did Not Attends and asked what the position is with looking to reduce those numbers. Mrs Mills advised that any DNA is not a good use of capacity, but generally across Lincolnshire the numbers of relatively low compared to both regional and national figures. There are different ways in which practices are tackling that issue, such as through digital facilities and particularly issuing prompt reminders to patients with planned appointments. Prompts are also being issued to those who have not attended their appointment. Dr Hindocha added that there is evidence to indicate the prompts do help.

Ms Day firstly referred to additional roles and asked for clarification on the oversight and checks in place to make sure that practices are first of all using them where appropriate, but equally on the converse side, they are not being used inappropriately.

Secondly, from speaking to friends and families that are GPs there does still seem to be an issue with morale and engagement amongst GPs and asked whether there is more work to be done to support PCNs.

Mrs Mills advised that in terms of the additional roles there is a whole range of those which the PCNs have been able to make use of over the last few years. There is very good oversight in terms of where those roles are and there is a framework which ensures there is effective supervision and training is in place which is led by the People Team of which Dr Thomas is the senior GP lead. The introduction of additional roles across the PCNs very much depends on their maturity and the relationship they have with their individuals practices about how they are utilising those roles to the optimum. Certainly over the last few months where practices have come together in a very coherent way looking at their population and considering how they deploy those roles there is a much stronger service offer in place. The general development going forward will be around PCNs working in the context of the CPP looking at how they are developing and utilising those roles for their population.

In respect of general practice morale, through speaking to GP colleagues Mrs Mills is aware that whilst they are very passionate about the work they do, it is extremely challenging currently. Demand has increased and expectations are much greater than pre-COVID. Morale is a challenge across the county, but not in all areas.

Dr Thomas confirmed he is the Primary Care Workforce Lead and referred back to the ARRS roles and the question about the governance and supervision, which was really important. There is a refresh on this currently taking place around clinical governance and more specificity is being put in place for PCNs to indicate what is appropriate and what is not.

In respect of GP morale, this is very low in certain areas. A piece of work is currently being carried out in relation to the People Promise which the NHS makes to all of its staff in secondary care. This is very embedded in secondary care but does not quite exist in the same level in primary care. Lincolnshire is one the pilot sites to look a bringing these promises into primary care, which will hopefully have a positive impact.

The ICB Board agreed to:

- **Note the progress on local delivery of the Primary Care System Level Access Improvement Plan.**

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

**24/220 ICB BUDGET 2024/25**

Mr Gaunt proposed that the next two items were presented in reverse order, which was agreed.

Mr Gaunt advised that ICB was almost at the end of month two in the current financial year and had only just concluded the planning process. The report presented anticipated that the planning process had not yet concluded as the ICB had not been through the national review meeting. That meeting took place and had already been noted.

The paper therefore only referred exclusively to the ICB, whereas the Board was used to Mr Gaunt referring to the system more widely. Normal practice would resume after the current month.

The paper presented detailed the ICB budget for 2024/25 and makes it clear that the Board is being requested to approve a surplus of £4.7m which does link to the overall system position of break even at year end.

Mr Gaunt went through the contents of the paper which set out the ICB allocations for 2024/25 (as per table one) as notified by NHSE and included within the plan submission.

The allocation is slightly complex with specific ring fenced items and also a split identified between recurrent and non-recurrent items. The total value is £1.83b, of which £1.7b is recurrent.

Mr Gaunt referred to the non-recurrent items in relation to the systems development funding, elective recovery funding and the significant allocation related to depreciation and amortisation that has actually doubled through the last stage of the planning process and consists of work that finance colleagues undertook to secure additional resources which actually helps smooth the break even position.

The expenditure is fairly straight forward, and it is clear that a significant amount of resources are allocated into acute care with the balance split across prevention, primary care and continuing healthcare services.

The other section to note is the significant efficiency challenge set at 5% (Cost Improvement Programme – CIP) which is set across the board. The ICB share of the total system efficiency challenge is £28.9m of which, as it stands, there is a risk of around £1.9m which is currently unidentified. A significant piece of work is underway to mitigate that risk as the work is completed on the Financial Recovery Programme.

Mrs Kenson referred to the ask of ICBs in terms of reducing their running costs and asked whether this is net of everything for the ICB, which was confirmed as correct by Mr Gaunt.

Ms Day referred to the 5% CIP and the role of each providers in achieving the breakeven position and asked what is the level of risk that partners feel they can carry and the ICB's views on that. Mr Gaunt referred back to his previous comment, about this paper referring to the ICB, not the provider organisations on this occasion. However, in response to the question, as part of the system financial framework that all organisations have signed off, there are provisions for risk management across the system and there is small risk pool of which all the partners contribute into, which is the main mechanism for managing financial risk. It is year two of its operation.

The Board considered the report and agreed to:

- **Approve the ICB Budget for 2024/25.**

**24/221 LINCOLNSHIRE SYSTEM FINANCE REPORT**

Mr Gaunt advised that it is not common practice for a finance report to be presented for month one, but this had been produced for the recent meeting of the Finance and Resource Committee and it was felt useful to bring to the Board.

The report provided a projection of the service deficit over the financial year and was more akin to a planning note rather than a reporting one but did provide some useful context in terms of the phasing in respect of the Cost Improvement Programme (CIP), which was similar to the previous financial year.

The other area to note was that the report identified that the position was on plan and there was nothing to raise with the Board at this point in terms of overall delivery.

The Board agreed to:

- **Note the finance report for month one.**

## CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE

**24/222 UPDATE ON COMMUNITY DIAGNOSTIC CENTRES**

Mrs Raybould introduced the next paper which had been produced to provide an update on the development of the two new Community Diagnostic Centres in Lincoln and Skegness which are scheduled to open in Winter 2024.

In addition, the supporting presentation highlighted the social value to date associated with each of the new centres.

Miss Sarah Brinkworth, Planned Care Programme Director for the ICB had joined the meeting to present this item as she had led on the development of this programme but in the first instance Mrs Raybould provided a little insight to the history of CDCs in Lincolnshire. The Board was advised that diagnostics reached a tipping point pre the pandemic and that position significantly worsened.

Professor Sir Mike Richards was commissioned to undertake a review of NHS Diagnostics in 2019/2020 and the outcome of that was published in October 2020. It made a really strong case for clinical change and signalled a major expansion and reform of diagnostics with a number of recommendations; 24 in total. This linked back to Professor Ward's comments about the fundamental need for change.

One of the recommendations was setting out a new strategy for a diagnostics model, and that is where CDCs were born. The philosophy behind CDCs is that they are freestanding and based in locations away from acute hospital sites; preferably based in community locations designed to provide quicker access and easier to access a range of tests, including some on the day. They are also designed to support earlier diagnosis and by being more convenient for patients to help the drive to reduce health inequalities.

A core role of the ICS is around convening and promoting collaboration across the system and championing key priorities, and CDCs were a great opportunity for Lincolnshire to really take those roles really seriously to not only deliver the strategy but also in a way that supports that role of the ICS and Mrs Raybould advised she is very proud of the work with the teams involved who have delivered this.

Slide two of the presentation set out the scene and advised that Grantham CDC was opened in April 2022, which was part of the first wave of CDCs. The ability to be able to do that really built on the work that ULHT did to identify 'green sites' such as Grantham Hospital during the COVID pandemic.

In terms of 2023, the timeline was detailed on the slide (first bullet point) and Mrs Raybould referenced the options appraisal carried out during the Public Health data and stakeholder feedback, including extensive patient and clinical engagement, covering potential future CDC sites in Lincolnshire. In May 2023 options were agreed for Skegness and Lincoln and a workshop was held to discuss the options with stakeholders from the ICB and ULHT, with updates then presented to both Boards and feedback shared with the national team on the proposed way forward. Subsequently, £38m investment was secured for the two CDCs (as referred to in the presentation).

Miss Brinkworth added that the ICB had worked closely with the Public Health Team on the locations of the CDC with Skegness being acknowledged as being a particular area of deprivation that needed to be supported. A considerable amount of public engagement was also conducted, with PPGs helping with the co-production work and on cancer pathways.

The locations chosen do demonstrate the reduction on the environmental impact and the travel implications for people and also they support local communities.

The then Secretary of State for Health visited the Grantham CDC in September 2023, and he was very impressed with the facility. Dr Emily Lawson, NHSE Chief Operating Officer, also visited Grantham in February 2024, and was equally impressed.

The next slide in the presentation referred to the position as at 2024 and several points were highlighted for the Board's information, including the £5m to extend the CDC in Grantham.

The Lincoln and Skegness sites were on schedule to open in the winter 2024/25.

The next slide demonstrated the contribution to social value.

Miss Brinkworth added as a final note, that ULHT was working closely with colleagues from the University of Lincoln to initiate a school of radiology course to support radiographers coming through to work in the Lincoln CDC.

Dr McSorley thanked Mrs Raybould and Miiss Brinkworth for their informative presentation.

Mrs Robson referred to workforce and asked whether the recruitment of 240 staff was a realistic and achievable goal given the issues with workforce generally in Lincolnshire. Mrs Raybould advised that as part of the governance structure there is a separate workforce group established. Miss Brinkworth added that it has been a really attractive proposal and a lot of international recruitment has been carried out and this has been well regarded in the national CDC programme. There are currently no risks identified.

Councillor Bowkett asked whether there was a risk staff could be poached into other service areas as had been seen in Skegness previously. Miss Brinkworth advised that she could not see that happening but could not guarantee it. Work was taking place to bring people in from out of the county and were looking at hybrid roles so they can work within the acute and the CDCs, so they get the depth of experience.

Mr Turner advised that notwithstanding the excellent development in Lincoln, consideration will need to be given to how the CDC in Skegness is promoted.

On a final note, the intention to establish a CDC in Boston continued to be pursued.

The Board agreed to:

- **Note the report**

## GOVERNANCE

**24/223 AMENDMENTS TO THE GOVERNANCE HANDBOOK**

Mrs Ellis-Fenwick advised that the ICB Constitution is supported by a number of documents which provide further details on how governance arrangements in the ICB operate. This includes the Standing Orders but also several other documents which do not form part of the Constitution but are required to be published. These include the Scheme of Reservation and Delegation (SoRD), Functions and Decision map, Standing Financial Instructions and the ICB Governance Handbook, which brings together all the ICB's governance documents.

The paper presented set out the details of proposed changes to the ICB Corporate Governance Handbook, which the Board was asked to consider and approve.

The Board agreed to:

- **Approve the proposed changes.**

**24/224 EAST MIDLANDS JOINT COMMITTEE - BRIEFING**

Dr McSorley presented an advisory report which had been prepared to provide a summary of the East Midlands Joint Committee meeting held on Tuesday, 16 April 2024. The report included the latest set of Terms of Reference for the Committee.

Dr McSorley advised that he would take the report as read, adding this was an advisory note with nothing of specific note to highlight to the Board on this occasion.

The Board considered the paper presented and agreed to:

- **Note the report and approve the revised Joint Committee Terms of Reference.**

**24/225 SYSTEM QUALITY AND PATIENT EXPERIENCE COMMITTEE**

Mrs Robson presented the report from the System Quality and Patient Experience Committee meeting held on the 1st May 2024, and advised that she would take the document as read but wanted to highlight some key points for the Board's information.

Firstly, the Committee undertook a Deep Dive into PEOL (Palliative and End of Life) care which came about following high level reports received from community services and ambulance services in 2023 which raised some issues. The deep dive focused on the journey over the last four years and the integrated working supporting the specialist, core and enhanced workstreams. The update included the vision, the feedback received from patients, families, carers and staff, current status, the successes, challenges, priorities, planned improvements and risks.

Secondly, the Committee received the Public Involvement Annual Report and the People and Communities Strategy Delivery Plan. The Committee was satisfied that the ICB is meeting its statutory duties in this regard. Members endorsed the ICB People and Communities Involvement Annual Report 2023-24 for final approval by the Board, which would be presented in June.

Thirdly, discussions took place regarding the 2024/25 Planning Guidance and that one of the requirements is in relation to a 'focus on quality and safety based on the approach set out in A Shared Commitment to Quality'. It was noted that this details a system approach, and it was agreed that a Task and Finish Group would be formed to lead this area of work.

The final point highlighted related to children safeguarding and an area of risk related to the health input to children at front door strategy meetings. Unlike most areas, there is a not a MASH (multi-agency safeguarding hub) in place. The Committee has oversight of this risk and has gained assurance that a business plan has been developed to address the risk and at this point Mrs Robson handed over to Dr Hindocha to describe this in further detail. Dr Hindocha advised that the details of the output of this work had been presented to the Financial and Sustainability Panel (FSIP) and this was one of two areas the Medical Directors agreed required investment due to the potential risk and assured the Board that this had been approved and was now in train.

The Board agreed to:

- **Note the report and items escalated.**

**24/226 SERVICE DELIVERY AND PERFORMANCE COMMITTEE**

Mrs Kenson presented a report from the Service Delivery and Performance Committee meeting held in March 2024 and advised that she would take the report as read. There were no specific areas to highlight to the Board.

The Board considered the report and agreed to:

- **Note the report.**

**24/227 AUDIT AND RISK COMMITTEE**

The Board was presented with the Annual Report for the Audit and Risk Committee which covered the period 1st April 2023 to 31st March 2024. This had been prepared to brief the Board on the work of the Committee and outlined how it had complied with the duties delegated to it through its terms of reference. The report also detailed key actions to address developments in the Committee's role.

It was noted that the work programme of the Committee for the period specified and was aligned to the Annual Plans agreed with External Audit, Internal Audit and Counter Fraud. The Committee had completed a Self-Assessment of its work, which was attached to the report for consideration by the ICB Board.

The Board considered the report and agreed to:

- **Note the Audit and Risk Committee Annual Report 2023/24.**

**24/228 REGISTER OF DOCUMENTS SEALED**

Mrs Ellis-Fenwick presented a report which had been produced to inform the Board of the details of any documents signed and sealed during the period 2023/24. It was noted that no documents had been signed and sealed in 2023/24.

The Board agreed to:

- **Note the report.**

**24/229 DECLARATIONS OF INTEREST**

Mrs Ellis-Fenwick presented a report which included the Declaration of Interest Registers for 2023/24.

It was noted that the Registers are regularly presented to and considered by the Audit and Risk Committee and the ICB Conflicts of Interest Guardian is Mrs Julie Pomeroy, Non-Executive Director.

The Board agreed to:

- **Note the report.**

**24/230 ANY RISKS IDENTIFIED**

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

**24/231 DATE AND TIME OF THE NEXT MEETING**

The next formal ICB Public Board meeting will take place on Tuesday, 30th July 2024 at 9.30 am at Bridge House, Sleaford.

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**Chair Signature** **Date**

**Questions from the Board meeting held on 28th May 2024**

**Question One**

Given the overwhelming evidence of the benefits to both physical and mental health of participation in exercise and sport, especially in a social setting, would the Lincs ICB be interested in drawing on the insights on community engagement and joint working gained over the past decade by Grantham Tennis Club through its highly successful programmes of special activities for local people deemed “harder to reach” – and to hear imaginative ideas for embedding and integrating the promotion of these opportunities more widely within our NHS services?

**Response:**

The Board welcomed the the question and agreed for this to be taken forward through Dr Sunil Hindocha, ICB Medical Director.

Dr Hindocha met with Dale Wright and colleagues from the Grantham tennis club, along with an Active Lincolnshire team member, which was really positive. Dr Hindocha will be working closely with Mrs Blyth, ICB Communications and Engagement Director and Active Lincs on moving this forward.

**Question Two**

What is your plan for dental treatment?
I am 35yrs old and I have always paid NHS prices where dental treatment is concerned.
Following many medical conditions including cancer six years ago I require regular dental check-ups.

I've been with the same practice for 15 years and every year my appointment is put off and put off because the dentist is not available. 7 month late I have just seen my dentist and I was informed that she is leaving this week to return home to her country.
I was told that I can either stay as a patient at the practice in which case I have to pay a monthly fee of almost 30 pounds a month and also when treatment is required I will have to pay the full private fee amount.

Following my health conditions although I still try to work as often as I can I am a single person with two children the time looking after a numerous health conditions I rely on universal credits my wages would not cover anything and I've been put on an exemption card through UC which has told me I'm entitled to free treatment where dental care is concerned.

However I have been informed by every dentist in Lincoln that even if I have a universal credit exemption card or a medical exemption card the dentist do not take those into account anymore as they are private only and the cards that only valid for current patients on the books.

The practice I was registered with is happy to keep me on the books but only if I pay the full private amount and the monthly price as well. I cannot do this.

What am I supposed to do?
As I said before I have run in contacted every dentist in Lincoln and they have all told me the same thing they are not taking on new patients unless they are private and that regardless of having an exemption form they do not apply to the practice as they are private and full paying only. The exemption card is government issued so I'm really confused as to have this can be denied and refused.

I was told that I had to contact yourselves in order to find treatment at NHS prices or with the use of my exemption cards so I am here reaching out please tell me what the plan is and what I personally am supposed to do.

A detailed letter responding to the member of the public questions and comments has been sent through to them at their home address as per the details supplied.

# ICB Board July 2024
# Healthwatch Updates

healthwatch Lincolnshire

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

This quarter (Apr – Jun) **473** people shared their views and experiences directly with us on Health and Social Care in Lincolnshire, through our Information Signposting Team and an additional **244** people shared their experience through our Respiratory Health Survey.

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

- GP Services (41%)
- All Hospital Services (39%) - (10% of all comments were about A&E)
- Social Care (10%)
- Dentistry (12%)

*Some comments relate to multiple service areas.
**71%** of all comments were negative and **10%** were positive. Many of the experiences shared with us this quarter were very case-specific.

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

healthwatch Lincolnshire

**NRS – Wheelchair provider**

Recent concerns regarding wheelchair provider NRS highlight significant issues with delays, miscommunications, and the overall quality of service.

Users have experienced prolonged waiting times for essential equipment, such as power-aided wheelchairs and necessary accessories like headguards, which are critical for maintaining their quality of life and dignity. Transitioning to NRS as the new provider has been particularly problematic.

These issues have not only caused frustration but have also severely impacted the independence and well-being of vulnerable individuals, prompting calls for improved efficiency and accountability from the provider.

# NRS – Case Study 1

*"They (NRS) had no access to her records and had to remeasure and reorder but they were unable to order it at the time due to the cyber breach. I rang on the 1st of May to see whether it had been ordered they confirmed that yes it had been ordered....wahoo!*

*They were unable to give me a time scale but said ring back in a week and they should know more. 8th may, I rang again still could not confirm time scale but did say it wouldn't be as long as we had waited originally with AJM…….20th July I rang for an update only to be told it hasn't been ordered, It shows 'yet to be processed '. The gentleman on the phone explained they were having problems with the back log of orders and were waiting for authorisation for these to be ordered.*

*I am breaking my back transferring my daughter, and she is at risk in a dangerous chair that is no longer suitable for her needs and does not support her and I am extra concerned of her safety.*

*Her chair is her lifeline to be able to get out about and excess the world around her. She is extremely difficult to transfer into the car on a good day and impossible to transfer after a seizure as she becomes dead weight, so we are stuck wherever we are until she can help transfer herself. I am a single parent with no other adult support, and I cannot lift 36kg and neither can my 6-year-old daughter!"*

# NRS – Case Study 2

A lady with MND is not getting the appropriate equipment she needs for her wheelchair and it is really affecting her quality of life and dignity.

This was previously sent to AJM in December 2023 the lady is still waiting for a headguard - MND condition has deteriorated, none verbal so needs to liaise with daughter.

Head is currently being kept in place by a make-do sweatband, Occupational Therapist requested a Headrest/guard to NRS as knew it was changing over.

This is obviously unacceptable and shows a lack of dignity and respect for a vulnerable person in great need, Parent/patient is very distraught as they are unable to do anything

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

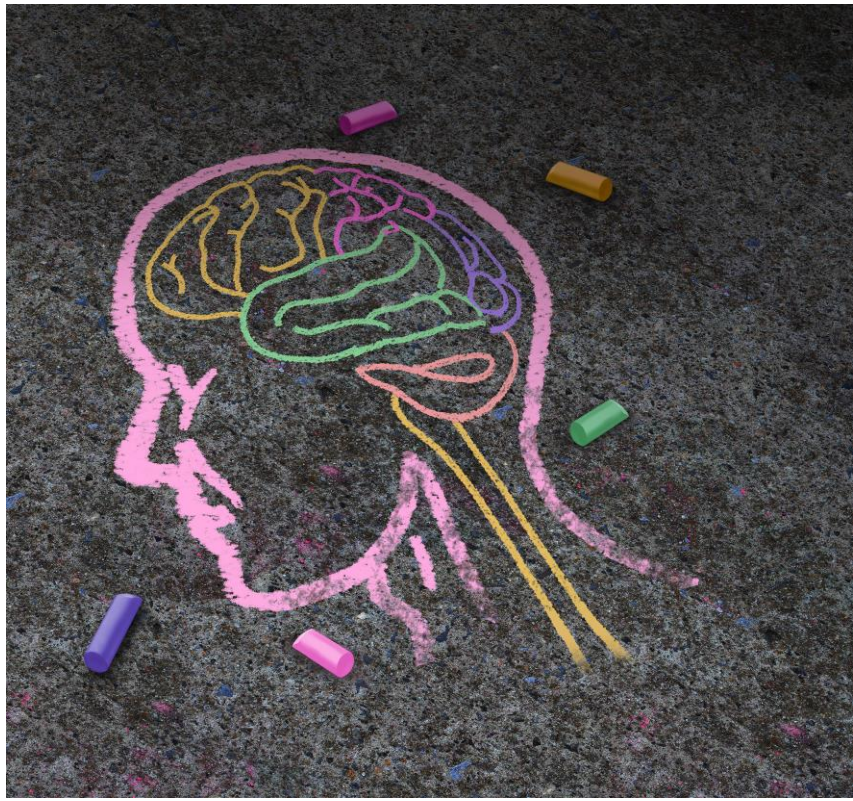
healthwatch Lincolnshire

**Autism/ADHD neurodiverse pathways**

There are significant concerns regarding the difficulties in obtaining diagnoses and subsequent support for Autism, ADHD, and Tourette syndrome. Patients often face prolonged periods before receiving a correct diagnosis, with some initially misdiagnosed and treated for unrelated conditions like depression.

Once diagnosed, individuals frequently encounter a lack of local support and resources. General practitioners often state they are not commissioned to make referrals for assessments, leaving parents and carers frustrated and without clear pathways to diagnosis and care.

Additionally, the scarcity of local support groups and specialist's forces residents to travel long distances for necessary services, further complicating care for those with additional caregiving responsibilities. These challenges highlight a systemic issue in accessing timely and adequate support for these neurodevelopmental conditions.



# Autism/ADHD neurodiverse pathways – Case Studies

healthwatch Lincolnshire

**Case 1:**
*It took many years to be diagnosed with high functioning autism, Aspergers, instead of being treated for depression. Once Aspergers was diagnosed the doctor at Johnson Hospital wrote me off the books saying there's no meds for it and gave me a list of groups to join which were miles away from me. It threw me back into depression and I felt abandoned.*

**Case 2:**
*Parent rang Healthwatch and discussed frustration about getting there 6-year-old female child assessed for ADHD, Autism. When visits GP Surgery, GP says that they are not commissioned to make referrals for assessment of ADHD, Autism.*

**Case 3:**
*Resident of Mablethorpe diagnosed with Autism, no local support groups anymore, previously was a group, but no longer. Resident also commented that there is no specialist in the Surgery for patients with Autism. Has to go to Sheffield for review as nothing in Lincolnshire available. Unable to go tothis as caring for parent with Leukaemia .*

# Healthwatch Actions

**The concerns highlighted here around NRS and Neurodiverse pathways have been raised with the Healthwatch Lincolnshire Steering Group (HSG). As a result, the following actions have been agreed:**

- Both issues have been raised at the System Quality and Patient Experience Committee (SQPEC), which have agreed to take a deeper look at both areas at future meetings, the experiences have been shared with ICB colleagues following the meeting.

- Meeting with Health Scrutiny and Health and Wellbeing board Chairs raised the same concerns with agreement that NRS will be a future agenda item to report current performance at the Health Scrutiny committee and address such concerns.

- The Healthwatch Steering group agreed to make contact directly with NRS to understand the current challenges and hope they will support the individuals who Healthwatch have identified.

- A campaign will also look to invite other wheelchair users to come forward if they are not receiving the support they require from NRS.

# YourVoice@Healthwatch Lincolnshire

**Community Primary Partnership (CPP) Co-Production Opportunity**

**Event Date:** July 31st, 2024
**Location:** Rustons Sport and Leisure Club, Lincoln

Healthwatch Lincolnshire is supporting the current work being undertaken jointly by Public Health and ICB looking at Community Primary Partnerships (CPPs), utilising our successful YourVoice@Healthwatch event platform we are bringing a variety of people together to gather invaluable insights and shape the future of integrated care in our community through Community Primary Partnerships.

A round table discussion workshop with presentations by the team on CPPs as well as My shared Agreement.

# 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 |

Currently live: Have Your Say on Neurological Health Conditions

- Brain Injury
- Chronic pain
- Dementia
- Epilepsy
- Fibromyalgia
- Functional Neurological Disorder (FND)
- Migraines
- Multiple Sclerosis (MS)
- Stroke
- Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) Other neurological conditions


**Patient Survey**

**Professional Survey**

# 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.

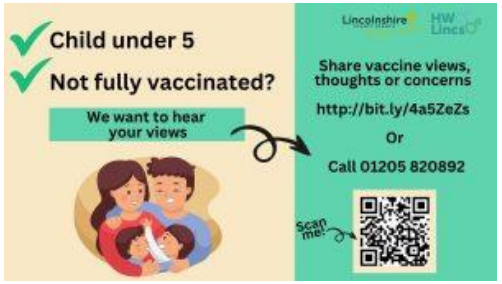
**Agreed Areas of Focus:**

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, ie. 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).




## For more information

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healthwatch Lincolnshire

Item 04 (i)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 4 (i) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | Draft Integrated Care System Research and Innovation Strategy |
| **Report Author:** | Kirsten Guy, ICS Research Lead |
| **Presenter:** | Sunil Hindocha, ICB Medical Director |
| **Appendices:** | Draft Integrated Care System Research and Innovation 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

This report asks the Board to approve the ICS Research and Innovation Strategy.

## Summary

We launched our ICS Research and Innovation Hub, strategy and Hub webpage 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.

This 5 year strategy is a key milestone and reflects our ambition for Research and Innovation to drive excellence in rural and coastal health and wellbeing for the benefit of our Lincolnshire public and staff. The strategy builds on the foundations of established relationships and partnerships allowing us to be ambitious so we can aim higher and move at pace to help transform health and care in our county. By 2029 we want to be a leading system in rural and coastal research and innovation.

The Health and Care Act 2022 sets new legal duties on ICBs around the facilitation and promotion of research, and the use in the health service of evidence obtained from research. ICSs are strongly encouraged to develop a research strategy that aligns to or could be included in their integrated care strategy.

The ICS aims to work collaboratively to focus on the prevention of poor health and wellbeing, to tackle inequalities, and deliver change to improve the health and wellbeing for the people of Lincolnshire.

Research and Innovation underpins all of these aims and has a central role to play in providing the evidence for change, ensuring that outcomes are improved for the people of Lincolnshire who access our services. Research and Innovation also offers staff opportunities to develop and can attract new staff into the county. We know that research active organisations have improved outcomes and satisfaction for their service users, lower death rates, and greater staff satisfaction and retention.

Developing this strategy has provided the opportunity to co-develop system-wide areas of focus for Research and Innovation, ensuring that there is alignment with wider strategies and the aims and vision of the Lincolnshire ICS. This strategy will be followed by the development of an implementation plan which will be the blueprint of how we will achieve our goals.

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, face challenges that need to be acknowledged. Finances are stretched and we have difficulties recruiting and retaining staff, which means we do not always deliver the care and wellbeing we would like to. Collaboration and partnerships are a way to maximise our collective resources to provide the opportunities for improvement. It also allows us to create a supportive, learning environment where we can grow together, work through challenges and celebrate successes. We are stronger together.

This strategy sets out four principles. That Research and Innovation in Lincolnshire will:

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

These principles provide a collective focus for our system organisations, partners and our public, and outlines the way we will work together to drive research and innovation within our county.

This strategy has been produced collaboratively, including with members of the Lincolnshire public, and demonstrates the strong base of expertise, knowledge and enthusiasm which already exists across our system. We will harness this to ensure we embed our strategic principles and deliver against our goals.

| **How does this paper support the ICB's core aims to:** | |
|---|---|
| Aim 1: Improve outcomes in population health and healthcare. | Research, Innovation and utilising evidence is key to improvement. This strategy supports the delivery of our long-term population health improvement goals. Principle 3: to have Research, Innovation and Evidence embedded in everything we do highlights an objective to support our workforce at all levels to understand evidence and how it can be used to add value and improve health and wellbeing in our communities. |
| Aim 2: Tackle inequalities in outcomes, experience and access. | This strategy has a specific outcome to have increase diversity of those getting involved in research and innovation, with special focus |

| | |
|---|---|
| | on under-served communities, ensuring greater equity of access across our county. This is core to Principle 1, that by 2029 Research and Innovation will reflect the needs of our communities. |
| Aim 3: Enhance productivity and value for money. | This strategy is focused on collaborative, coordinated, and trusted partnerships (Principle 2) which seeks to utilise collaboration across our ICS and key partners to produce research and innovation outcomes and impact, and to have approaches in place to maximise the financial opportunities available from research and innovation. |
| Aim 4: Help the NHS support broader social and economic development. | The links with inequalities and improving health outcomes will impact the broader socio economic factors. |
| **Conflicts of Interest** | **Summary of conflicts** |
| No conflict identified | N/A |
| **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? | A Band 5 Project Officer fixed term secondment has been appointed to support the implementation of the strategy and R&I Hub activity. This is currently externally funded from the Clinical Research Network East Midlands, but it is intended to become a substantive post, using a top slice of the Research Capacity Funding (RCF) to fund this post in the future. |
| Does the report highlight any quality and patient safety implications? | Research and Innovation is key to improvement by ensuring that evidenced based practice is embedded within our system. Using EBP is essential for assuring quality and therefore there are associated patient safety implications if EBP, research and innovation is not embedded at all levels of decision making. |
| Does the report highlight any health inequalities implications? | This strategy acknowledges the ongoing work to address health and care inequalities within our system and highlights how research and innovation can be used as a vehicle for addressing these inequalities. |
| Does the report demonstrate patient and public involvement? | This strategy has been co-produced with members of the public. Principle 1 identifies that we will have approaches in place to |

| | |
|---|---|
| | increase awareness, understanding and opportunity for our communities to get involved in all stages of research and innovation. Research and Innovation will be done with, rather than done to, members of the public. |
| Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here) | Although not specifically noted, this strategy complements the E3 University of Lincoln Institute for Rural and Coastal Health (LIRCH) Research bid which has a strong reference to environmental factors affecting our county and the impact of health and wellbeing. |

| **Inclusion : These are currently being undertaken.** | | | |
|---|---|---|---|
| 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 ☒

Research and Innovation Hub

# Lincolnshire ICS Research & Innovation Strategy

2024-2029

# Contents



# Executive Summary

This is our first Research and Innovation Strategy for the Lincolnshire Integrated Care System (ICS) and sets out our collective vision for the next five years.

This strategy is a key milestone and reflects our ambition for Research and Innovation to drive excellence in rural and coastal health and wellbeing for the benefit of our Lincolnshire public and staff. The strategy builds on the foundations of established relationships and partnerships allowing us to be ambitious so we can aim higher and move at pace to help transform health and care in our county. By 2029 we want to be a leading system in rural and coastal research and innovation.

Lincolnshire is a large, rural and coastal county with over 80 km of coastline and a population of 768,400 (Census 2021). The Lincolnshire Integrated Care System (ICS) is known as 'Better Lives Lincolnshire' (BLL). This partnership of local organisations come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in our county.

The ICS aims to work collaboratively to focus on the prevention of poor health and wellbeing, to tackle inequalities, and deliver change to improve the health and wellbeing for the people of Lincolnshire. Research and Innovation underpins all of these aims and has a central role to play in providing the evidence for change, ensuring that outcomes are improved for the people of Lincolnshire who access our services and the staff that are employed by our ICS organisations.

Developing this strategy has provided the opportunity to co-develop system-wide areas of focus for Research and Innovation, ensuring that there is alignment with wider strategies and the aims and vision of the Lincolnshire ICS. This strategy will be followed by the development of an implementation plan which will be the blueprint of how we will achieve our goals.

**Dr Sunil Hindocha**
Medical Director
NHS Lincolnshire ICB

# Executive Summary

The organisations that make up Better Lives Lincolnshire (Figure 1) have agreed a shared ambition:

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

Non- ICS Partners

UNIVERSITY OF LINCOLN

BISHOP GROSSETESTE UNIVERSITY


*Figure 1 - The Lincolnshire Integrated Care System*

# Executive Summary

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, face challenges that need to be acknowledged. Finances are stretched and we have difficulties recruiting and retaining staff, which means we do not always deliver the care and wellbeing we would like to. Collaboration and partnerships are a way to maximise our collective resources to provide the opportunities for improvement. It also allows us to create a supportive, learning environment where we can grow together, work through challenges and celebrate successes. We are stronger together.

This strategy sets out four principles. That Research and Innovation in Lincolnshire will:

**Reflect the needs of our communities**

**Be built on collaborative, co-ordinated and trusted partnerships**

**Have research, innovation and evidence embedded in everything we do**

**Be delivered by a sustainable, capable and confident workforce**

These principles provide a collective focus for our system organisations, partners and our public, and outlines the way we will work together to drive research and innovation within our county.

This strategy has been produced collaboratively, including with members of the Lincolnshire public, and demonstrates the strong base of expertise, knowledge and enthusiasm which already exists across our system. We will harness this to ensure we embed our strategic principles and deliver against our goals.

We are looking forward to the next 5 years and are pleased to share this strategy with you.

# What is research and innovation?

It is important to recognise that research and innovation mean different things to different people. We also want to highlight that there are other components to evidence that are used by health and wellbeing services.

These are often vital for local improvements, and contribute to the evidence required, and also provide the steppingstones to research and innovation.

For clarity we have listed our definitions below:

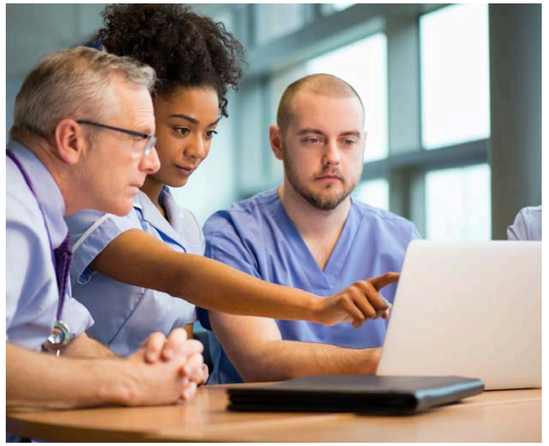
**Research:** the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods as defined in the UK Policy Framework for Health and Social Care Research [1]. Research may involve a completely new treatment, practice, or completing a survey or interview.

It is also important to explain within this strategy that research can be further divided into:

**Delivery:** recruitment and delivery (providing the treatment or intervention to gather the data required) of research studies to time and target. These are often studies that are eligible for support from the National Institute for Health and Care Research in England and have met specific criteria.

**Governance:** the broad range of regulations, principles and standards of good practice that ensure high quality research.

**Development:** creating and delivering new research.



# What is research and innovation?

**Innovation: encompasses invention and adoption where new ideas are developed to solve problems, improve outcomes, save lives, and the best ones spread quickly for wider benefit [2].**

**Service evaluation:** a process of investigating the effectiveness or efficiency of a service with the purpose of generating information for local decision making about the service. This provides the evidence required to make improvements.

**Quality improvement (QI):** is a systematic and co-ordinated approach to solving a problem using specific methods and tools with the aim of bringing about measurable improvement [3].

**Clinical audit:** a way to find out if services and care are being provided in line with standards. Where there could be improvements, changes should be undertaken. Standards may be NICE guidelines or standards related to a specific profession or speciality.

**Evidence:** facts or information that indicate whether something is valid or true. Evidence can take a variety of forms including, but not limited to, research projects, evaluations, audits and quality improvement projects.

# Why is research and Innovation important?

Research is a core function of health and social care and is essential for our wellbeing and the care we receive. Research, Innovation and evaluating our services is key to allowing us to make positive changes that will benefit our population.

Research and innovation can provide the evidence to drive better treatments and interventions to improve the outcomes for the users of our services. It provides the evidence to improve the quality, accessibility and organisation of services to enhance the strategic focus that matters to our ICS organisations. Research and Innovation will help us to achieve our system wide goals.

Research and Innovation takes place in many settings across our system and spans across our populations life course, from birth to end of life. The rural and coastal evidence base is limited, and participation is a challenge due to the county's geography and limited transport network. There are also challenges with recruiting and retaining our staff.

Research and Innovation offers staff opportunities to develop and can also attract new staff into the county. We know that research active organisations have improved outcomes and satisfaction for their service users, lower death rates, and greater staff satisfaction and retention.

Our local and regional stakeholders (Figure 2) play key roles in ensuring research and innovation takes place in Lincolnshire. They work together with our NHS and providers of care, voluntary sector colleagues and members of the public to make sure that research and innovation meets the needs of our communities.

This strategy is designed to build on these established partnerships and collaborations, and to work with organisational research strategies to support system wide working across all partners and stakeholders within the ICS. This will enable us to provide everyone with the opportunity to participate in, and benefit from, the growing range of research and innovation activity within health and care.


*Figure 2: Local and regional research and innovation stakeholders*

# Overarching principles

Our ICS Research and Innovation Strategy has been developed collaboratively through a series of workshops with representation from across our NHS, Local government, voluntary sector, our public and other partners. Four overarching principles have been identified and have corresponding goals that are broad in nature but have been loosely selected with short, medium and longer term timeframes.

These principles are inter-related and co-dependent on each other, and all have equal importance for research and innovation in Lincolnshire.

**Reflect the needs of our communities**

**Be built on collaborative, co-ordinated and trusted partnerships**

**Have research, innovation and evidence embedded in everything we do**

**Be delivered by a sustainable, capable and confident workforce**

# Principle 1: Research and innovation will reflect the needs of our communities

**By 2029 we will:**

- Understand the needs of our communities in relation to research and innovation.
- Map the current Patient and Public Involvement and Engagement (PPIE) opportunities across our system and identify approaches to address gaps.
- Have approaches in place to increase awareness, understanding and opportunity for our communities to get involved in all stages of research and innovation.
- Develop a research charter to set out the expectation regarding public engagement in research across our system.
- Have increase diversity of those getting involved in research and innovation, with special focus on under-served communities, ensuring greater equity of access across our county.
- Have further growth and embedding of community research champions across our county.

Developing a new relationship with the public is a priority for our ICS. We know that research and innovation bring benefits to communities and individuals, and we want to ensure that our public have the opportunity to access all aspects of research and innovation from identifying priorities, study design, volunteering to take part in the research study and sharing the findings. Research and innovation can empower our population to learn more about their conditions and support prevention, to try a new treatment, and see improvements in the services and care they receive. Improving outcomes and reducing health inequalities underpins this strategy.

Research and Innovation in Lincolnshire should be driven by the real challenges faced by the system and co-produced with our communities. We want to create an environment where communities are seen as equal partners, and where we communicate with people in ways that they understand to build trust and engagement. Recent initiatives have demonstrated that we are good at involving our communities and getting initial engagement in research and innovation projects, but maintaining these relationships is a greater challenge. By working together, we can harness the expertise in our system to reach out to our seldom heard rural and coastal communities to ensure greater equity and opportunities to participate in research and innovation across our county.

To achieve the best outcomes for our population, our research and innovation must be centred on, accessible to and ultimately benefit the communities that we serve.

# Case study 1: Targeting under-served communities project

This project is a collaboration between the Lincolnshire Integrated Care Board, Every-One, and Lincolnshire Voluntary Engagement Team (LVET), funded by the Clinical Research Network East Midlands, under-served communities in research fund.

10 people from under-served communities within Lincolnshire who have lived experience of involvement in, and awareness of clinical and applied health and care research programmes will have their stories captured and utilised.

The project will be the start of a People Library, where people share their experiences of being involved in research. The videos will provide insight into our communities and will help us ensure research is more accessible and inclusive in the future.

The project is an example of how research and innovation align with ICS priorities, including improving health inequalities.

# Principle 2: Built on collaborative, co-ordinated and trusted partnerships

**By 2029 we will:**

- Define what good collaboration and co-ordination looks like in research and innovation.
- Map the research and innovation infrastructure across the system, identifying what we have, our areas of expertise, and what resources we have including specialist equipment.
- Have an established and impactful Research Leaders Group and Research & Innovation Hub
- Scope and implement a system-wide communication strategy for Research and Innovation
- Utilise collaboration with our academic partners to produce research and innovation outcomes and impact.
- Have approaches in place to maximise the financial opportunities available from non-commercial and commercial sources.
- Have identified research and innovation system priorities.

# Principle 2: Built on collaborative, co-ordinated and trusted partnerships

As with many of our system strategies, our ability to deliver rest on the success of our collaboration. There is a willingness to work together with transparency and trust and to build on the established partnerships that already exist. We also want to explore new collaborations to maximise future opportunities and ensure we are more business-like in our approach to securing funding, building infrastructure, and developing research that aligns to our system priorities.

Collaboration and co-ordination are a vital element that runs like a thread through all the principles outlined in this strategy.

This approach will allow opportunities to standardise processes, reduce duplication, and pool our resources to generate flexibility to respond to the changing research and innovation landscape. It will support the creation of a learning environment, to help our workforce to grow and develop and will ensure we offer research and innovation opportunities without overburdening our communities.

We are committed as a system to move towards a more sustainable research and innovation model and to become a valued partner to our stakeholders and partners. We want to be an attractive place to undertake research and implement innovations. To influence the national research and innovation agenda to better meet local priorities and needs, so that our system and population can benefit from regional, national and international research and innovation.

Building further relationships with our academic partners (Higher Educational Institutions), professional and voluntary sector groups, and independent sector partners will allow greater opportunities to develop research and innovation that matters to our population and that will have local, national, and global impact. We are ambitious and want to be a leading system in rural and coastal research and innovation.

Our ICS Research Leaders Group will provide strategic and operational direction, and drive research and innovation across the system. Our Research and Innovation Hub will be a central platform to bring our system, partners, and the public together to co-ordinate our approach to embedding research and innovation in everything we do.

# Case study 2: Join Dementia Research (JDR)

Join Dementia Research is funded, operated, and supported by several different organisations, including the National Institute of Health and Care Research (NIHR), and the three main UK dementia charities (Alzheimer's Society, Alzheimer's Research UK and Alzheimer Scotland).

The overall purpose of Join Dementia Research is to make it easier for people to take part in research and to support dementia researchers to find volunteers. JDR was launched nationally in 2015 and is delivered in partnership across the four nations of the UK and works to ensure that people can take part in more research, more quickly and more cost effectively. This leads ultimately to better outcomes for people living with dementia.

Within Lincolnshire, Lincolnshire Partnership Foundation NHS Trust research team has championed JDR since its launch in 2015 and with the Dementia Programme Board (previously the Dementia Officers Group), was part of developing the countywide dementia pathway. In 2022 the JDR Advocates programme for health/care professionals was launched to promote JDR within work areas, and in 2023 a specific collaboration was formed with Age UK Lincoln and South Lincs to support them in promoting and engaging with research, including JDR. Our Age UK Lincoln and South Lincs collaboration is one example of successful collaboration with system partners to support engagement and involvement in research.

# Principle 3: Have Research, Innovation and Evidence embedded in everything we do

**By 2029 we will:**

- Identify expectations and the commitment required to create a positive shift in our research and innovation culture.
- Understand and identify what opportunities and barriers there are to ensuring embedding of Research and Innovation within system organisations.
- Influence and support partners to incorporate research and innovation into pathway or service redesign, service transformation and planning.
- Scope or develop a tool for measuring our research and innovation outcomes, maturity, and our collective impact as an ICS.
- Support our workforce at all levels to understand evidence and how it can be used to add value and improve health and wellbeing in our communities.
- Have approaches within communities to promote registration with Be Part of Research and Join Dementia Research.

This principle is purposely ambitious and reflects our collective vision to improve the research and innovation culture and use of evidence within our ICS organisations. We want to create an environment where research and innovation is embraced and encouraged at all levels in our organisations and within our communities for everyone's benefit.

Despite the well documented benefits of research and innovation, historically it has been seen as an 'add on' and not part of core business. If we want to deliver on local and national priorities then it is essential that we have an efficient, innovative and effective health and care system that is underpinned by the evidence provided through research and innovation. It needs to be embedded in everything we do.

We need to utilise evidence from evaluations, audits, and quality improvement projects as well as research projects to shape our service transformations and in designing new services and pathways.

Utilising Population Health Management data and joining up our intelligence, data and information sharing across the system is essential to enable us to measure our outcomes, our impact and identify gaps within our system that can support our research and innovation priorities.

It is acknowledged that our ICS organisations are at different stages of their journeys to embed research and innovation. Our ICS Research Leaders Group and Research and Innovation Hub will be instrumental in ensuring we share expertise and learning to support and facilitate approaches that suit individual organisations on their journeys.

# Case study 3: Proportionate Training of Paramedic Colleagues

East Midlands Ambulance Service Trust employs a large number of paramedics who provide life-saving clinical care in the community. To increase the number of frontline paramedics delivering clinical research, EMAS has advocated for, and works with study sponsors to deliver proportionate training to clinical staff. Advice on proportionate training was published by the Medicines and Healthcare products Regulatory Agency and Health Research Authority with their joint statement on the application of Good Clinical Practice in 2020 [4].

Whilst our clinical staff are extremely busy delivering patient care, this approach means that as a Trust we have increased the number of paramedics who are able to deliver research within their roles, which in turn increases our research capacity. With almost a third of EMAS paramedics currently trained to deliver a large randomised controlled trial, this proportionate approach sees us working towards embedding research within clinical care.

# Principle 4: Delivered by a sustainable, capable and confident workforce

**By 2029 we will:**

- Understand our workforce and their needs in relation to those that are research and innovation aware, interested and active.
- Co-ordinate our approaches for building research and innovation capacity and capability in delivery, development and support services across the system.
- Use research and innovation to attract staff into our system, support retention and keep our students within Lincolnshire.
- Influence partners to embed research and innovation within workforce strategies and job planning.
- Identify clear multi-professional research career pathways and co-ordinate approaches to grow our own research and innovation workforce.

The workshops identified an appetite and passion for research and innovation amongst our workforce. We have colleagues within our ICS that are research development trailblazers, and we have delivery colleagues that are experienced at successfully delivering research studies. It is acknowledged that our workforce are less equipped to drive and lead innovation currently and that this is an area requiring greater focus.

It is important to acknowledge that research careers are not for everyone, and the expectation for research and innovation knowledge and skills will differ accordingly. Loosely we are defining three research and innovation capability groups with flexibility interwoven between them.

Our ambition is to raise awareness amongst all colleagues through all levels of the organisations within our ICS. To increase the number of colleagues who are research and innovation interested as these colleagues will identify and conduct meaningful research and explore innovations that matters to the Lincolnshire public. And increase the number of research and innovation active colleagues, who will drive development and act as role models and trailblazers, creating a pipeline for sustainability.

1. Research and Innovation **Aware:** an understanding of research and innovation, it's importance and how to apply evidence into practice.
2. Research and Innovation **Interested:** colleagues have had additional research and/ or innovation training and are able to engage in research and/or innovation activity within their workplace to drive improvement.
3. Research and Innovation **Active:** colleagues on a research career pathway or delivering innovation programmes of work. Our research and innovation leaders.

We want to develop a system which has a positive research and innovation culture, where our workforce feels supported and empowered to access the research and innovation opportunities available. Engaging with research and innovation that is relevant to practice and service delivery will support the use of evidence into practice.

# Case study 4: Foundation Research Training Programme

The foundation research training programme has been created following survey feedback from our Allied Health Professionals (AHPs) and Lincolnshire County Council (LCC) workforce. Both staff surveys highlighted a need for basic research training. The ICB, Lincolnshire County Council and the University of Lincoln have developed the programme to address this training need, and the programme has been offered to all colleagues from Lincolnshire County Council and across all Lincolnshire Health and Social Care organisations. No prior knowledge of research is required, and it is for all staff, both registered and unregistered.

The programme has been joint funded by the CRN, Lincolnshire County Council and United Lincolnshire Hospitals NHS Trust and reflects the commitment to building research capacity and capability within our workforce. The course started at the end of March 2024 with over 100 people attending an introductory session online. The subsequent 7 sessions will be provided over 5 months and culminate in an in-person celebration marketplace event to explore the ‘what next’.

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.

# Next steps

This strategy is a starting point for our system and sets out our collective principles and goals which we will work together to deliver. We are ambitious and want to be a leading system in rural and coastal research and innovation.

Our strategy development workshops included representation from all organisations within our Lincolnshire ICS and local and regional partners. We have tried to capture the passion and enthusiasm for research and innovation and the desire to collectively work together to make positive changes to our research and innovation culture within our system.

We have synthesised the guidance from local and national research and innovation strategies and have used guidance documents including the NIHR Best Research for Best Health: The Next Chapter [5] and Maximising the benefits of research: Guidance for integrated care systems [6] from NHS England. We have also aligned our principles with Lincolnshire ICS strategies: The NHS Lincolnshire Joint Forward Plan [7], Health and Wellbeing Strategy [8], and the Integrated Care Partnership Strategy [9].

The next step is to use the strategy to develop an implementation plan. This will draw in wider enablers and expertise from within our system which will also bring the added benefit to communicate our strategy and vision to a wider audience. Success will be measured against this plan and monitored and communicated annually through our Research Leaders Group and the ICB Annual Report.

We are delighted to share this strategy and look forward to working together to ensure that research and innovation is fundamental to improving the lives of the people that live and work in Lincolnshire.

# References


[1] UK Policy Framework for Health and Social Care Research

[2] CQC – Innovation and why it is important

[3] The Health Foundation (2021) Quality improvement made simple: What everyone should know about health care quality improvement

[4] Medicines and Healthcare products Regulatory Agency & Health Research Authority (2020) The application of Good Clinical Practice

[5] NIHR (2021) Best Research for Best Health: The Next Chapter

[6] NHS England (2023) Maximising the benefits of research: Guidance for integrated care systems

[7] The NHS Lincolnshire (2023) Joint Forward Plan

[8] Lincolnshire Health and Wellbeing Board (2024) Health and Wellbeing Strategy

[9] Better Lives Lincolnshire Integrated Care Partnership Strategy (2024)


# Acknowledgements

This strategy has been facilitated by Lincolnshire ICB through the Lincolnshire Research and Innovation Hub, and developed by representatives from the following organisations:

- **NHS Lincolnshire Integrated Care Board (ICB)**
- **United Lincolnshire Hospitals NHS Trust (ULHT)**
- **Lincolnshire Community Health Services (LCHS)**
- **Lincolnshire Partnership Foundation Trust (LPFT)**
- **East Midlands Ambulance Service (EMAS)**
- **Lincolnshire Primary Care Network Alliance**
- **Lincolnshire County Council**
- **Lincolnshire Voluntary Engagement Team (LVET)**
- **Healthwatch**
- **AgeUK**
- **Lincolnshire Care Association Limited (LinCA)**
- **University of Lincoln**
- **Bishop Grosseteste University**
- **NIHR Clinical Research Network East Midlands (CRNEM)**
- **The Lincolnshire public**

We thank everyone for their input and feedback.

Item 4 (ii)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 4 (ii) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | Statement of Information on Health Inequalities |
| **Report Author:** | Sandra Williamson Director of Health Inequalities, Prevention & Regional Collaboration |
| **Presenter:** | As above |
| **Appendices:** | Appendix 1: Statement of Information on Health Inequalities Draft 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

The Board is asked to approve the draft Statement of Information on Health Inequalities report.

## Summary

The NHS Act 2006 (as amended, by the Health and Care Act 2022) places a range of health inequalities duties on the NHS. Changes arising from the Health and Care Act 2022 provided extended legal duties on reducing and tackling health inequalities.

NHS commissioners (NHS England and ICBs) are under specific legal duties to take account of health inequalities issues in the exercise of their functions.

Under duty s. 13SA of the National Health Service (NHS) Act 2006 NHS England has published (27th November 2023) its first Statement on Information on Health Inequalities which sets out requirements for ICBs (and trusts) to collect, analyse and publish information relating to health inequalities for the periods 2023/24 and 2024/25.

ICBs and Trusts are required, in their annual reports, to review the extent to which they have exercised their functions regarding the Statement and explain whether the information has been published, summarise the inequalities it reveals, and state how the information has been used in the relevant period to guide action.

This is the first statement on Health Inequalities produced by Lincolnshire ICB. This statement as been developed to report alongside the ICB Annual Report 2023/24, which describes our system wide approach to addressing inequalities in health and inequalities in healthcare. Underpinning all our approaches is the need to ensure we are collecting accurate and complete information.

The information contained within the statement covers a snapshot in time for the mandated indicators and provides a baseline performance for future reports so that we can monitor trends to track improvements and include any other supplementary local indicators as necessary. This statement shows inequalities in most areas of health and health care in Lincolnshire and identifies areas for our focus to understand why those inequalities exist and what can be done to address them. For example:

Elective Recovery

- Key inequality here is known from the literature, which is variation in health-seeking behavior by socioeconomic status (SES), for example need is greater but uptake lower for lower SE groups in elective care. Age isn't such an issue as we know healthcare need increases with age; and therefore, not necessarily inequality in access however we have observed longer waiting for Children and Young People and working age adults.
- Key message increasing access to elective care any proactive/ preventive care in lower SE groups is a top system priority

Urgent and Emergency Care (UEC)

- Key point is the same as above, but need is higher and uptake of emergency care is also relatively higher in lower SES groups, and therefore a focus on reducing / removing barriers to access of preventative and proactive care in lower SE groups, will reduce demand on UEC.

Ethnicity and good quality of data reporting

- There is a proportion of patients do not have their ethnicity recorded in data systems and therefore can affect our understanding and interpretation of inequalities by ethnicity.
- Examination of the prevalence of a health condition and the access of services rely on good quality data for example a low prevalence of a health condition or a low access rate may be the result of low recording or underdiagnosis.

In addition to the main statement, we have included some of the work we are doing to understand inequalities and action taken to address these inequalities during 2024/25, so that by the time of this statement next year we will have made a difference.

While the work reported looks at the needs of many key groups it does not cover others which have been identified as Lincolnshire Core20PLUS groups such as people who are homeless, miliary personal and their families, military veterans and those from Gypsy Roma Traveller backgrounds or who are refugees. We are working with our Population Health Management programme and partners to further develop the Lincolnshire joint linked data set to include inclusion health in our next statement on inequalities.

This report has been presented, discussed and approved at the relevant programme boards with actions identified for 2024/25 embedded within their programme operational plan and governance arrangements. Oversight through the Health Inequalities Programme Governance arrangements including. The Health Inequalities programme also includes specific projects working with the relevant Programmes for delivery e.g. Bowel Cancer programme; SMI health checks.

| How does this paper support the ICB's core aims to: | |
|---|---|
| Aim 1: Improve outcomes in population health and healthcare. | The duty to report information on health inequalities will encourage better quality data, completeness and increased transparency and support ICBs and Trusts to use the data to shape and monitor improvement activity and drive improvement in the provision of good quality services, improving population outcomes and reducing healthcare inequalities. |
| Aim 2: Tackle inequalities in outcomes, experience and access. | Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which people are born, grow, live, work and age. These conditions influence how people think, feel and act and can affect both physical and mental health and wellbeing.<br><br>Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs.<br><br>NHSE's Healthcare Inequalities Improvement Programme vision is for the NHS to deliver "exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes".<br><br>Lincolnshire's Health Inequalities Programme Vision is **"to increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county".**<br><br>The duty to report on information on health inequalities enables the ICB to understand more about the populations it serves. Identifying groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and delivering targeted action to reduce healthcare inequalities. |

| | |
|---|---|
| Aim 3: Enhance productivity and value for money. | There is a clear business case for improving equity and that reducing health inequalities can even contribute to an improved financial position both in the short term and long term. For example focusing on understanding the reason for did not attends or could not attend in outpatients setting which are having an impact on Trusts productivity – may be as result of need for interpretation, or transportation issue and with some interventions to address the issues may not involve significant sums of money to fix could see a major reduction of was-not-brought within three months (example shared from a case study of Birmingham Women's and Children's NHS Foundation Trust). |
| Aim 4: Help the NHS support broader social and economic development. | Michael Marmot's work that calculated the treatment costs of health inequalities to be in the region of £5.5bn a year. Productivity losses in the economy due to health inequalities amount to £33bn, while a further £32bn a year is spent on higher welfare payments. Add to this the fact that those from the most deprived areas with lower life expectancy also exhibit the highest healthcare costs – helps support the social economic case. |
| **Conflicts of Interest** | **Summary of conflicts** |
| No conflict identified | |

**Risk and Assurance**

No risks have been noted in relation to the completion of the work for publication by September 2024.

Scoping has confirmed that the resource to support ongoing monitoring is required to support the ICB monitor improvement against the indicators set out in the report and progress on the actions agreed for 2024/25 through the relevant Programme structures and governance. The ICB is in discussion with ICBs across Midlands and with Midlands and Lancashire CSU on the development of Dashboard to support future requirements and enable trend comparisons to understand which standards are improving or getting worse over time.

Risks are managed within the Health Inequalities Programme governance arrangements.

| **Implications (legal, policy and regulatory requirements)** | |
|---|---|
| Does the report highlight any resource and financial implications? | Resource to support ongoing monitoring is currently being scoped both for the ICB and across Midlands.<br><br>Expectation that the Statement on Information on Health Inequalities will be |

| | |
|---|---|
| | used to inform service improvements, e.g. through changes to resource allocation and targeting resource to identified population groups |
| Does the report highlight any quality and patient safety implications? | No |
| Does the report highlight any health inequalities implications? | Yes – details provided within the appendix |
| Does the report demonstrate patient and public involvement? | The Statement on Information on Health Inequalities includes a duty to publish information on health inequalities within or alongside annual reports in an accessible format. |
| 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 ☒ |

NHS
Lincolnshire
Integrated Care Board

# Statement of Information on Health Inequalities

## Lincolnshire Integrated Care Board

## About this document

This report demonstrates how as Lincolnshire Integrated Care Board (ICB) we are meeting our duties to understand the health inequalities in Lincolnshire and how to reduce them.

This requires us to collect, analyse and publish information in relation to the Statement on Information on Health Inequalities as given by NHS England (NHSE) further to its duty under section 13SA of the National Health Service (NHS) Act 2006.

This Statement provides the opportunity:

- To help the Integrated Care System identify disparities in access to services and patient outcomes, highlighting where change is needed.
- To improve data collection and recording, for example ethnicity recording which will support action on reducing health inequalities
- To distill key messages and explain what the data is saying – leading to more detailed and robust analysis to further reduce inequalities.

## About us in Lincolnshire

The Integrated Care System (ICS) was established on the 1st July 2022 to arrange the provision of services for the purposes of the health service in Lincolnshire in accordance with the Health and Care Act 2022. It is a statutory organisation bringing the local NHS together to improve Lincolnshire's health and wellbeing.

The ICB and Lincolnshire County Council have established a joint committee known as an Integrated Care Partnership. This Partnership has developed an Integrated Care Strategy which sets out how the needs identified in Lincolnshire are being met by the NHS and Lincolnshire County Council.

Our Integrated Care System is a partnership of organisations that come together to plan and deliver joined up health and care services, and aim to improve the lives of people who live and work in their area. In Lincolnshire, our ICS is known as Better Lives Lincolnshire – for more information click here.

## About our county

- Lincolnshire is the fourth largest county in England with an area of 5,921 sq. km.
- It has 778,000 residents (2021) and there are 819,837 registered patients dispersed across city, market towns, rural and coastal areas. The nature of our geography and communities make up alone is incredibly diverse and varied.
- Lincolnshire is predominately rural, being the fourth most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which which presents a number of challenges in terms of service provision.
- The population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
- The combination of an ageing population, a rural geography and areas of high socio-economic deprivation defines the specific challenges of delivering high-quality and effective treatment and preventative services in Lincolnshire.



This is the first Statement on Information on Health Inequalities produced by Lincolnshire ICB. Addressing inequalities in health and healthcare is a core duty of ICBs and is a key priority of the ICS. The document details how we are performing against a set of indicators for the period 1st April 2023 to 31st March 2024 unless otherwise stated, alongside a narrative on how we are working to tackle healthcare inequalities in these areas and ensure improvements against these indicators.

As set out in the ICB Annual Report 2023/24, we have a system wide approach to reducing inequalities. Underpinning all our approaches is the need to ensure we are collecting accurate and complete information.

## How the Statement on Information on Health Inequalities has been used by Lincolnshire ICB

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.

It is intended that the information within this report should be used by services and decision makers to inform service improvement and reductions in healthcare inequalities. This lets us tailor services to the needs of people in each area, improve people's health, prevent illnesses, and make better use of public resources.

This includes, but is not limited to, using the information to inform:

### Understanding general healthcare needs

- Adopt a population health management approach, which helps us understand people's health and care needs and how they are likely to change in the future, underpinned by hearing from our people and communities.
- Build from Joint Strategic Needs Assessments (JSNA) to support strategy development.

### Understanding healthcare access, experience and outcomes

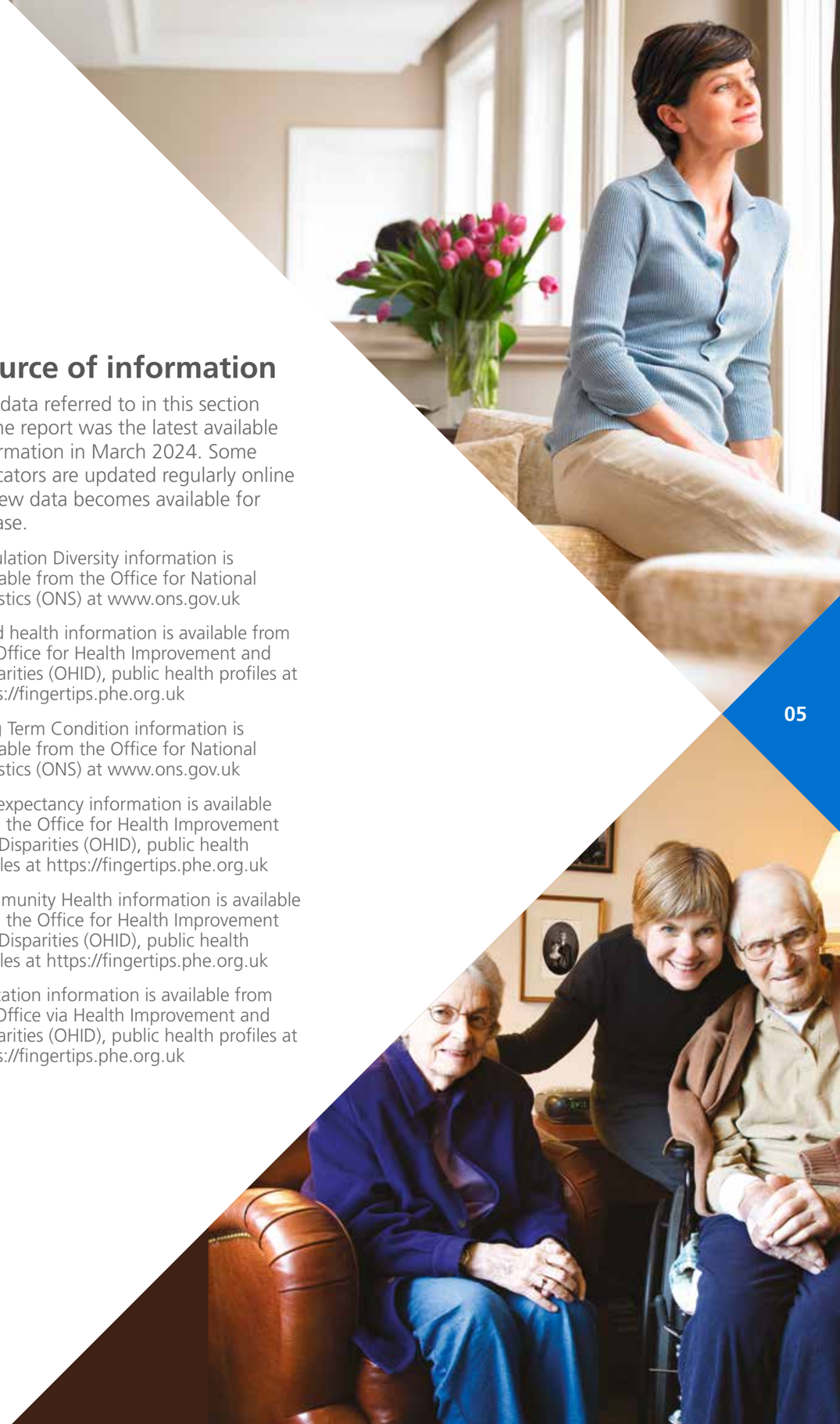
- Collate, analyse and publish performance information disaggregated by a limited number of variables where available (mainly age, sex, ethnicity, deprivation).
- Access to healthcare refers to the availability of services and can be measured by monitoring uptake of services and referrals. Some factors may be more likely to negatively impact those in the most deprived areas and people from minority ethnic groups. Other barriers such as location of services, transport, and work commitments may also affect ability to access healthcare.
- Experience data alongside other insights such as patient feedback and listening to those with lived experience are key in helping healthcare drive forward positive, patient centred change and embedding personalised care approaches which will help reduce health inequalities.

### Informing service improvements and reductions in healthcare inequalities

- Enabling preventative healthcare, equitable access to health services and co-producing services with people with lived experience to support improvement in outcomes and reducing inequalities.
- Use data to inform service improvements, e.g. through changes to resource allocation.
- Encouraged to collect, analyse (and publish) other information.
- Support service evaluations and commissioning and delivery decisions.

# Health Inequalities Lincolnshire

1.Population Diversity
2.Child Health
3.Long Term Conditions
4.Life Expectancy
5.Community Health
6.Education
7.Deprivation

## Source of information

The data referred to in this section of the report was the latest available information in March 2024. Some indicators are updated regularly online as new data becomes available for release.

Population Diversity information is available from the Office for National Statistics (ONS) at www.ons.gov.uk

Child health information is available from the Office for Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

Long Term Condition information is available from the Office for National Statistics (ONS) at www.ons.gov.uk

Life expectancy information is available from the Office for Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

Community Health information is available from the Office for Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

Education information is available from the Office via Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

# Domains covered by the Statement

This report covers eleven domains and where possible focuses on variables by: sex/gender, age, deprivation and ethnicity. The indicators align to the five priority areas for addressing healthcare inequalities set out in the NHSE planning guidance and the Core20PLUS5 approach.

Data has either been sourced from existing anonymised data sources, Lincolnshire Joint data set or tools/dashboards that have been made available by NHSE.

## Indicators related to inclusive recovery of services

### 1. Elective care

Indicators include:

- Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks.
- Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances.
- Elective activity versus pre-pandemic levels for under 18s and over 18s.

### 2. Urgent and emergency care

Indicators include:

- Emergency admissions for under 18s.

## Indicators related to Core20PLUS5 for adults or children and young people

### 3. Uptake of Covid-19 and flu by socio-demographic group

Indicators include:

- Available to an ICB level only.

### 4. Mental health

Indicators include:

- Overall number of Severe Mental Illness (SMI) physical health checks
- NHS Talking Therapies (formerly IAPT) recovery.
- Rates of total Mental Health Act detentions.
- Rates of restrictive interventions.
- Children and young people's mental health access.



### 5. Cancer

Indicators include:

- Percentage of cancers diagnosed at stage one and two, case mix adjusted for cancer site, age at diagnosis, sex.

### 6. Cardiovascular Disease (CVD)

Indicators include:

- Stroke rate of non-elective admissions (per 100,000 age-sex standardised).
- Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised).
- Percentage of patients aged 18 and over with GP recorded hypertension in whom last blood pressure reading is below age-appropriate treatment threshold.
- Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy.
- Percentage of patients aged 18 and over with GP recorded atrial fibrillation and record of a CHAD2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy.

### 7. Diabetes

Indicators include:

- Variation between % of referrals from the most deprived quintile and % of Type Two diabetes population from the most deprived quintile.
- Variation between % of people with Type One and Type Two diabetes receiving all eight care processes.

Key: ICB and Trust level

ICB level only

### 8. Smoking cessation

Indicators include:

- Proportion of adult acute and mental health inpatient settings offering tobacco dependency treatment services.
- Proportion of maternity settings offering tobacco dependence treatment services.

### 9. Oral health

Indicators include:

- Number of admissions for tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under.

### 10. People with a learning disability and/or autism

Indicators include:

- Learning Disability Annual Health Checks.
- Adult mental health inpatient rates for people with a learning disability and/or autism.

### 11. Maternity and neonatal care

Indicators include:

- Preterm births under 37 weeks.

# Health Inequalities Legal Duties – Lincolnshire ICB Results Summary

This table summarises the differences seen across the data broken down by health inequalities dimensions (age, sex, deprivation and ethnicity). It highlights where we have a significant difference where available and also describes any variation between groups for each metric.

| Elective Recovery | | | | |
|---|---|---|---|---|
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks | | | | |
| Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks | | | | |
| Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks | | | | |
| Age Standardised activity rates with 95% CI for elective inpatient admissions | | | | |
| Age Standardised activity rates with 95% CI for non-elective inpatient admissions | | | | |
| Age Standardised activity rates with 95% CI for outpatient attendances | | | | |
| Age Standardised activity rates with 95% CI for virtual outpatient attendances | | | | |
| Elective activity vs. pre-pandemic levels for CYP and adults | | | | |
| **Urgent and Emergency Care** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Emergency admissions for under 18s (under 19s) | | | | |
| **Respiratory** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Uptake of Covid-19 vaccines by socio-demographic groups | | | | |
| Uptake of flu vaccines by socio-demographic groups | | | | |
| **Mental Health** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Overall number of Severe Mental Illness (SMI) physical health checks | | | | |
| Rates of total Mental Health Act detentions | | | | |
| Rates of restrictive interventions | | | | |
| NHS Talking therapies (formerly IAPT) recovery | | | | |
| CYP Mental Health access | | | | |
| **Cancer** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex | | | | |

- No Health Inequalities identified by statistical tests
- No Health Inequalities identified (but not statisticaly tested)
- Health Inequalities identified (but not statistically tested)
- Health Inequalities identified by statistical tests
- Data not stratified by this characteristic

| Cardiovascular Disease | | | | |
|---|---|---|---|---|
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Stroke rate of non-elective admissions (per 100,000, age-sex standardised) | | | | |
| Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) | | | | |
| % of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold | | | | |
| % of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy | | | | |
| % of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy | | | | |
| **Diabetes** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Variation between % of people with type 1 diabetes receiving all 8 care processes | | | | |
| Variation between % of people with type 2 diabetes receiving all 8 care processes | | | | |
| Variation between % of referrals from the most deprived quintile and % of type 2 diabetes population from the most deprived quintile | | | | |
| **Smoking Cessation** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Proportion of adult acute inpatient settings offering smoking cessation services | | | | |
| Proportion of maternity inpatient settings offering smoking cessation services | | | | |
| **Oral Health** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions, not number of teeth) | | | | |
| **Learning disability and autistic people** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Learning Disability Annual Health Checks | | | | |
| Adult Mental Health inpatient rates for people with a learning disability and autistic people | | | | |
| **Maternity and neonatal** | | | | |
| Indicator | Sex | Age | Deprivation | Ethnicity |
| Pre-term births under 37 weeks | | | | |

## Elective Recovery

### Indicators

Size and shape of the waiting list.
Rates of hospital activity.
Elective activity in under 18s and over.

### Age

Waiting Lists: Almost half of those on waiting lists are of working age (18-64). A greater proportion of the working age population are waiting longer than those in older age groups, which may be explained by the fact those of working age may not be able to take time off work to attend appointments. This may lead to poorer outcomes.

Under 18 year olds accounts for 15% of the waiting list volume and are waiting longer on average than the rest of the population.

The greatest level of activity in under 18 year olds is observed in Ear, Nose & Throat (ENT) and Paediatric appointments.

### Ethnicity

Waiting Lists: 19% of those on a waiting list (waiting 18-51 weeks) have no recorded ethnicity.

Small numbers in ethnic minority groups, especially compared to White British population, although we can't see this clearly in the data, these groups are known to experience inequalities and we would expect this in Lincolnshire.

Inpatient admission rate per 100,000 people is statistically higher in the ethnic minority groups when compared to the White British this is compared to the Lincolnshire average.

### Deprivation

Hospital activity: Significantly higher rates in the most deprived quintile for non-elective admissions may be caused by acute admissions which could have been prevented by better access to preventative care.

A decrease in the proportion of those from most deprived deciles (for adults and Children & Young People (CYP)) may indicate poorer access to healthcare for those in more deprived areas as part of the Covid-19 recovery.

CYP living in the most deprived decile, who are on an ENT or a paediatrics waiting list, had longer average waits than those in less deprived areas.

### Other supporting narrative

More than half of those on a waiting list have been waiting longer than 18 weeks.

Geographic hotspots of longer waiting times for dermatology appointments noticed in southeast of the county, potentially due to no hospitals offering dermatology clinics (even out of county), but this does not necessarily correlate with the most deprived areas.

As a proportion of the population, there are almost twice as many missed appointments in the most deprived areas than in the least deprived areas.

### Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Targeted work to reduce long waiting times in Ear, Nose & Throat (ENT) appointments, particularly in children/young people.
- Targeted work on reducing the number of missed appointments in ULHT. Missed appointments are almost twice as prevalent in the most deprived population. Various reasons including poor administration, digital exclusion, unstable accommodation (amongst others) contribute to missed appointments, which in turn may lead to missed opportunities for medical intervention.



## Urgent and Emergency Care

### Indicators

Emergency Admissions for under 18s.

### Age

Most activity seen in the 0-1 age group. Babies/infants are most vulnerable to a range of health conditions, and parents/caregivers are more likely to seek medical attention when their child develops symptoms.

### Ethnicity

High proportion (9.1%) of activity from those without a stated/known ethnicity.

Activity not reflective of the ethnic breakdown of Lincolnshire, raising questions about equality of access. This is particularly noticeable in the 'Other' 0-19 population, which accounts for 8.6% of the population; but only accounts for 1.3% of the non-elective activity.

### Deprivation

Despite accounting for about 15% of the 0-19-year-old population, children in the most deprived quintile account for just over 20% of the activity. Conversely, 0-19 year olds in the least deprived quintile account for 18.5% of the population, but only account for about 10% of the non-elective activity. This raises questions about those in the most deprived quintile seeking care when they are at a crisis point, rather than taking preventative measures.

### Other supporting narrative

Children & Young People (CYP): Poor asthma management due to lack of annual asthma reviews, amongst other reasons, may be contributing to an increase in the rate of A&E attendances for asthma exacerbations in CYP.

### Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Analyse GP practice data to identify trends, prioritising deprived areas for interventions (especially annual asthma reviews), ensuring personalised asthma action plans for all CYP, monitoring prescribing practices, addressing the challenges of passive smoking, and disparities in A&E attendances.
- System-wide efforts aim to reduce high A&E attendance among 0-4 year olds, and utilise National Child Measurement Programme (NCMP) data for better tracking of CYP weight and height. Implementing post A&E/admission reviews, and the development of a local asthma dashboard to monitor the effectiveness or interventions.

# Mental Health

## Indicators

Overall numbers of Severe Mental Illness (SMI) physical health checks.
Rates of total Mental Health Act (MHA) detentions.
Rates of restrictive interventions.
NHS Talking Therapies (formally IAPT) recovery.
Children and Young Peoples mental health access

### Age

**SMI**: Younger ages have the lowest achievement for all six health checks at 21.7% which may be explained by various factors including personal, societal, and psychological changes during a critical part of young people's development.

**Talking therapies:** Younger ages have the lowest achievement of recovery outcome at 27% (18 year olds) and 18-25 at 41%. A possible explanation for poorer outcomes in the younger population may be the lack of life experience and coping strategies younger people have when engaging with therapeutic interventions.

### Ethnicity

**SMI health checks:** 11.4% of those eligible for all six SMI health checks had no ethnic recording. Low counts in ethnic minorities raise questions about access to SMI diagnosis.

**MHA detentions:** Low counts in ethnic minority groups may account for the variation and higher than average rate of MHA detentions.

**Talking therapies:** Low counts in ethnic minorities raise questions on access to the service – with 95% White and 2% of those accessing had no ethnic recording.

### Deprivation

**SMI:** Despite nearly a quarter of the SMI population living in the most deprived quintile, achievement of all six health checks is the lowest in this cohort.

**Talking therapies:** 42% of those living in the most deprived decile had a 'recovery' outcome, compared to 57% of those living in the least deprived decile.

**MHA Detentions:** 15% of the population consists of those who live in the most deprived 20%, but this cohort accounts overwhelmingly for the dominant rates of detentions made under the Mental Health Act.

### Other supporting narrative

**SMI health checks:** on average 51.5% of those with SMI achieving all six health checks, with notable disparity between the most and least deprived population. Noticeable difference in female achieving better outcomes compared to male.

**Talking therapies:** On average 50% of people who accessed had an outcome of recovery. Those aged 65 plus have a better outcome exceeding 50%.

More than twice as many females than males engage in talking therapies. This may point to higher levels of anxiety and depression in females compared to males, or reluctance for males to seek psychological interventions to deal with their mental health.

### Areas of focus 2024/25:

- The highest rates of MHA detentions are represented by the PLUSS5 CORE20 population. Further deep dive is planned to understand the data and potential additional metrics which would help inform the targeted support on future preventative measures and to ensure more effective primary and secondary care approach in meeting the needs of the population.
- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Further work required to understand gender differences and ethnicity uptake and access for both SMI health checks and Talking Therapies.

**Mental Health Areas of focus 2024/25 (continued):**

- **SMI**
  - Validation of SMI registers with primary care including improving the recording of ethnicity data.
  - Stakeholder engagement with Inclusion Health groups such as people experiencing homelessness and Gypsy, Roma, Travellers is priority for 2024/25 to better understand how we can support all communities to engage with health services.
  - This information, alongside the results of our extensive stakeholder engagement will be used to inform our next steps in service development.

We will work with our stakeholder and co-production network to develop a range of options for delivery. Ambition to pilot options during 2024/25.

- **Talking Therapies**
  - LPFT to review service offer to target more deprived areas and ethnic communities.
  - Exploring interventions linked to participation in community activities (for example Wellbeing Hub/ Community Connector contact/Night Light Café attendance).
  - Through the work of the Adult Community Mental Health Transformation, Primary Care Networks (PCNs) all have dedicated primary care mental health professionals in place which is strengthening the link between primary and secondary care and improving quality of referrals and uptake to services.



# Oral Health

## Indicators

Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under.

### Age & Ethnicity

Number of under 10-year-olds with tooth extraction due to decay too low to derive any meaningful narrative.

### Deprivation

Decay-related hospital extraction rates for children were nearly three times higher for those living in the most deprived communities than those in the most affluent (national data).

### Other supporting narrative

- The National Dental Epidemiology Programme (NDEP) Surveys amongst children identify that children in the most deprived areas of the country are more likely to experience tooth decay than those living in the least deprived areas.
- Nationally, tooth decay was the most common reason for hospital admission in children aged between 5-9 years (2022-23). From the children examined in Lincolnshire as part of the latest NDEP surveys, 21.2% of 5 year old, and 16.8% of Year 6 children (10/11 year olds) had dentinal decay.

### Areas of focus 2024/25:

To continue to deliver the Prevention Theme of the Lincolnshire Dental Strategy. This includes a wide range of actions to support the oral health amongst children, in relation to improving the population knowledge and understanding of good oral health, creating healthy places and supporting behaviour change. Targeted work will take place with for example, nurseries and schools, Family Hubs, Holiday and Food Programmes.

## Indicators

Stroke rate of non-elective admissions.

Myocardial infarction – rate of non-elective admissions.

% of patients aged 18 and over, with GP recorded hypertension whose blood pressure reading s below the age-appropriate treatment threshold.

% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more on lipid lowering therapy.

% of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy.

### Age

Optimal management of hypertension, cholesterol, and atrial fibrillation (AF) is worse in under 40 year olds. Which may be explained by the fact those of working age may not be able to take time off work to attend appointments. This may lead to poorer outcomes.

For cholesterol, in addition to the above we can also see an observed drop in outcomes for the age 60-79 cohort.

Generally, there are fewer people under 40 with a diagnosis of these cardiovascular conditions despite lifestyle factors such as stress and poorer diet which contribute to the onset of cardiovascular conditions.

### Ethnicity

Hypertension management is poorer in ethnic minority groups. Potential undiagnosed hypertension and AF in ethnic minorities also a concern, particularly in the Black population.

Variation across different ethnic groups may be explained by low counts in ethnic minority population.

### Deprivation

Higher rates of strokes and myocardial infarctions in the most deprived quintile suggest poorer preventative practice which increases likelihood of acute admissions.

Hypertension management in the most deprived quintile is worse in comparison to the least deprived population; noticeable slope of inequality observed.

Lower levels of adherence to treatment regiments for cardiovascular conditions, especially in younger and more deprived populations, may explain the observation of higher levels non-elective admissions for stroke and myocardial infarctions.

### Other supporting narrative

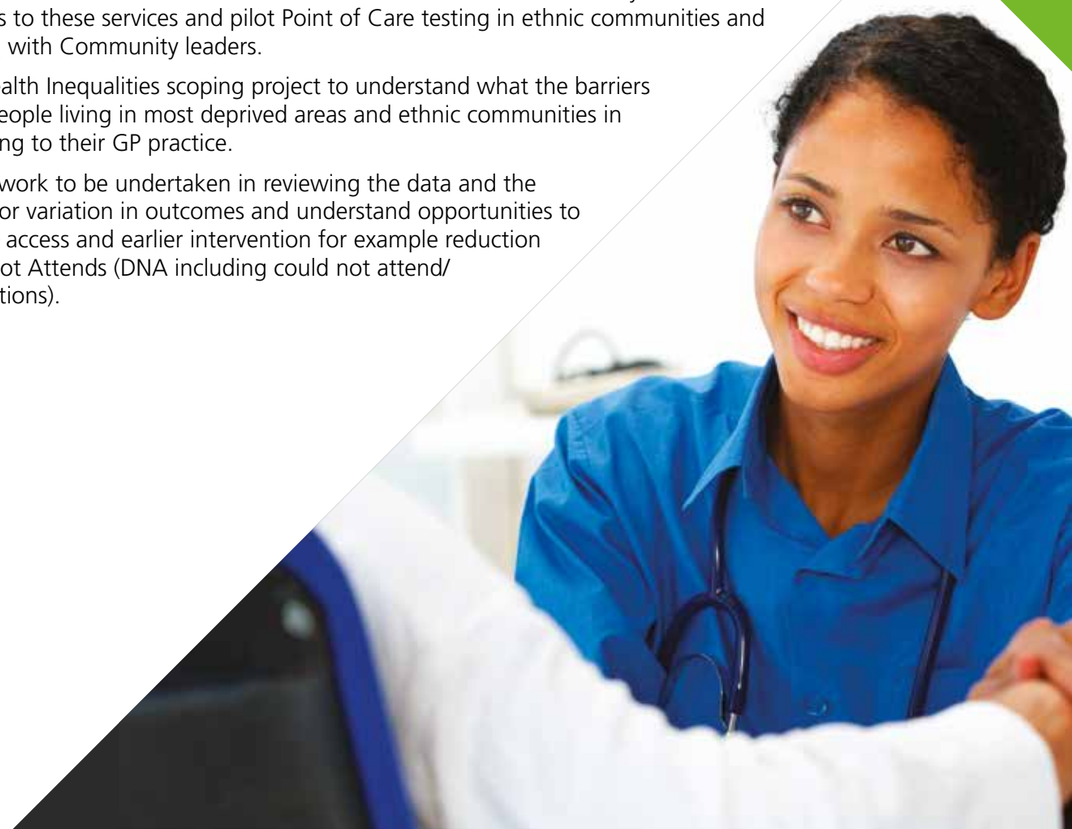
Current focus on secondary prevention in cholesterol with introduction of lipid specialist nursing to review the highest risk patients and support management with active caseloads.

Hypertension: on average 70.2% of patients over 18 with GP recorded blood pressure reading in the last 12 months, with notable disparity between the most and least deprived population and 18-59 years ranging from 51.7% and 59% . Note Lincolnshire is 3rd highest performing ICB in the country for blood pressure control.

AF: on average 93.5% of patients over 18 with GP recorded atrial fibrillation who are currently treated with drug therapy, with notable disparity between the 40-59 years at 89.9% identified inequalities for patients with learning difficulties and patients who are carers.

### Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Targeted communication and Public Health awareness campaigns in relation to healthy lifestyles, and review with Public Health on opportunities for targeted support to specific population groups (ethnicity, age, IMD).
- Assess the feasibility of weekend/out of hours clinics/ outreach to support improvement in uptake for targeted population cohorts.
- Ethnicity: Further work to be undertaken in 2024/25 to understand any cultural barriers in access to these services and pilot Point of Care testing in ethnic communities and working with Community leaders.
- IMD: Health Inequalities scoping project to understand what the barriers are to people living in most deprived areas and ethnic communities in presenting to their GP practice.
- Further work to be undertaken in reviewing the data and the drivers for variation in outcomes and understand opportunities to improve access and earlier intervention for example reduction in Did Not Attends (DNA including could not attend/ cancellations).



## Other supporting narrative

Diabetes is highly prevalent in Lincolnshire (22/23 QOF estimates suggest 8.4% of the population aged 17 years and over have diabetes). Lack of resources to administer all eight care processes, especially in more deprived areas of the county and to those whose first language is not English (or who do not speak English), may introduce inequalities in provision of the care processes. Lack of awareness of optimal diabetes management in these cohorts may also explain poorer adherence to health checks.

There is a variation in T1 and T2 care process - a significant portion will be because ULHT are reviewing the patient and not informing GPs, or GPs receive letters but don't code the information onto system records.

# Diabetes

## Indicators

Variation between % of people with Type one and Type two diabetes receiving all eight care processes.

Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile.

## Age

Lower uptake of all eight care processes in the under age 50 population for both Type One (T1) and Type Two (T2) diabetes. Much lower T2 Diabetes Management (T2DM) referrals in older age groups which may result in greater levels of undiagnosed T2DM, leading to poorer outcomes.

T1 Diabetes information (especially those in paediatrics/ transition where they are exclusively managed by secondary care) is not always recorded in primary care Quality Outcomes Framework (QOF).

## Ethnicity

Receipt of all eight care processes in ethnic minorities is generally lower than the Lincolnshire average. It's possible there are greater levels of undiagnosed diabetes in ethnic minority populations as well. These phenomena combined make it likely those from ethnic minorities will have poorer diabetes related outcomes.

There are some cultural barriers to understand and how we can support / address improving uptake.

## Deprivation

Those in most deprived areas achieving about 50% less completion of eight care processes compared to the least deprived population.

Much lower T2DM referrals in the most deprived areas, which may result in undiagnosed T2DM and poorer outcomes in those living in CORE20PLUS5 areas.

## Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Targeted communication and Public Health awareness campaigns in relation to healthy lifestyles to specific population groups.
- Greater outreach and T2DM testing in more deprived communities.
- The T2 Remission programme and continue to target populations groups to access the National Diabetes Prevention Programme e.g. areas of deprivation. Further work to understand why people decline and how we can best support them.
- Data recording: Undertake sample audits across primary care and secondary care in Children and Younge People and Adults cohort to understand the actual % completion and what data is missing from the reported outcomes/ performance.
- Age: Targeted support for the under 40 cohort as part of the Type 2 day programme, which is funding for GP practices based on under 40 diabetic population to have an additional review/ care process completed if it is outstanding/ advice from a health and wellbeing coach/pre-pregnancy advice (such as stopping lipid lowering therapy).
- Transformation pilot – Piloting an Multidisciplinary Team (MDT) concept in one Primary Care Network (PCN) to learn from and then plans to roll out across Lincolnshire.
- Prevention focus - Improve coordination with diabetes and obesity/weight management programmes to ensure improving access to target population group for both weight management and access to the Diabetes prevention programme.
- Management of Diabetes in Pregnancy including gestational diabetes working with the local maternity and neonatal system (LMNS)

# Cancer

## Indicators

Percentage of cancers diagnosed at stage one and two.

### Age

Older people are typically staged later, having lived with the condition for some time before becoming symptomatic.

Age inequalities in Lincolnshire is also linked to areas with higher deprivation, in particular East Lincolnshire and has a high proportion of disengaged patients.

### Ethnicity

Ethnicity has not been identified as inequality due to small numbers.

Correspondence sent to patients whose first language isn't English, or who don't speak English, is likely to result in a lack of uptake in cancer screening.

### Deprivation

This seems to be intrinsically linked to age with populations in our highest deprivation areas, typically having an older population.

Some of these areas seem to be disengaged with personal health and are being targeted for engagement and screening uptake.

Transport/distance has also been an issue for non-engagement after referral. The Bowel Screening inequality programme is currently in progress and findings will be shared across all screening programmes.

### Other supporting narrative

Cancer Staging and reporting in Lincolnshire has historically been poor. An education programme was put in place in 2019/20 for clinicians, which has resulted in significantly improved reporting e.g. skin staging was also previously poor with only those staged at levels III & IV being reported, and the greater volume of Stage I and II's not being.

Initial findings from the Bowel Screening Inequality programme has potentially identified inequalities for patients with learning difficulties and patients who are carers.

## Areas of focus 2024/25:

- Data: Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed. Future data sets are currently being scoped to include other health inequalities characteristics for future reporting e.g. Learning Disabilities.
- Targeted communication is being done in multiple languages, including leaflets, posters, videos and texts, to improve knowledge about general cancer warning signs and screening uptake.
- Improvement of clinical coding relating to cancer staging to determine if improvements are being made in early diagnosis.
- Continue bowel cancer screening health inequalities programme which includes engagement work with patients in most deprived areas and plus population groups.
- Improve education on warning signs and improve screening programme uptake to identify cancers earlier. Findings from the Bowel Screening Inequality programme will also be applied here.
- Staging: Reporting improvements continue to be a focus for ULHT in 2024/25.
- Targeted Lung Health Checks (TLHC) is a national priority and will contribute to the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer, expected to be implemented 2025. The TLHC will target those most at risk of lung cancer. People over 55 years old but less than 75 years old that have ever smoked will be invited to a free lung check.



# Respiratory

## Indicators

Uptake of Covid-19 and Flu by sociodemographic group.

### Age

The data that relates to Covid-19 vaccination uptake - the findings relate to a period when all adults were eligible for a Covid-19 vaccination (doses one to three), since then there has been a considerable change to the programme.

Covid-19 vaccines are no longer offered to everyone as standard. This means that unless you are eligible for a vaccination based on Joint Committee on Vaccination and Immunisation (JCVI) guidance you can no longer come forward for a vaccination even if you were eligible in a previous programme (e.g. a 25-year-old with no underlying health conditions who has not had a Covid-19 vaccination will be unlikely to now receive a vaccination until they fall into an age group that is recommended).

### Ethnicity

Those whose first language is not English, or who do not speak English, will find it difficult to engage with health promotion campaigns in terms of vaccination uptake.

White-Other (within Lincolnshire is predominantly people from Eastern Europe) is the second largest ethnicity group in Lincolnshire and the population that we have struggled with the most in terms of coming forward for vaccinations.

Variation across different ethnic groups may be explained by low counts in ethnic minority populations.

### Deprivation

Compared to national and regional uptake rates, Lincolnshire is performing well in addressing the variation between most affluent and most deprived areas with a variance of 14.6% (nationally 30.5% and regionally 29.4%).

Limited availability of places to receive vaccines, coupled with poor transport links for remote parts of Lincolnshire, are likely to have hindered uptake of Covid-19 vaccines in the most deprived areas.

### Other supporting narrative

Mistrust in healthcare professionals and vaccinations are likely drivers of vaccine hesitancy in various population groups.

## Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Uptake performance and areas of focus for Covid-19 and flu are reviewed at the Lincolnshire Immunisation Programme Board that currently meets monthly.
- Task and finish group that focuses on respiratory cohort for all immunisations and actions to improve uptake.
- Addressing variation across areas of deprivation – We will continue working with practices that fall in areas of high deprivation looking at how we can improve vaccination services that are provided. This will include putting on additional pop-up/outreach clinics, working with community pharmacies to provide additional access and supported by a detailed comms and engagement plan or the implementation of a detailed comms and engagement plan.
- Addressing variation across ethnicity - improving uptake in "White – Other" cohort.

# Smoking Cessation

## Indicators

Proportion of adult acute inpatient setting offering smoking cessation services.
Proportion of maternity inpatient settings offering smoking cessation services.

### Age

Those aged 25 to 34 years continue to have the highest proportion of current smokers (15.8%, around 1.3 million people), when compared with any other age group, and those aged 65 years and over continue to have the lowest proportion of current smokers (8.0%, around 900,000 people).

Smoking prevalence data for young people in Lincolnshire is unavailable, however the smoking rate of 15-year-olds nationally is around 5%. Those under 25 years have a higher prevalence of smoking at time of delivery.

### Ethnicity

Smoking prevalence is higher in ethnic minority populations, particularly from those from an Eastern European background where cultural norms around smoking are different.

Tobacco causes health problems across all ethnicities, but the way people from different ethnic backgrounds use tobacco varies considerably, leading to health disparities. Some ethnic minorities are more likely to use smokeless tobacco and shisha pipes.

Disparities in smoking rates in early pregnancy are also seen in some migrant communities within Lincolnshire. For example, migrants from countries in Eastern Europe, such as Bulgaria and Romania, where 'background' rates of smoking are higher than the UK.

### Deprivation

Smoking is approximately twice as prevalent in those living in more deprived areas than those living in less deprived areas. This will have adverse health effects including cancer, further widening health outcomes between the most and least deprived.

In Lincolnshire, women in the most deprived decile have a higher prevalence of smoking in early pregnancy compared to those women living in the least deprived area. Younger women are also more likely to smoke.

### Other supporting narrative

Rates of smoking during pregnancy, or at the time of delivery, in Lincolnshire are the worst in the East Midlands. Smoking during pregnancy increases the risk of low birth weight in babies, which in turn increases the risk of a child start life in poor health. Lincolnshire has one of the highest "smoking at time of delivery" (SATOD) rates, above the national and regional average and much higher than the national ambition – whilst rates remain high there are signs of more momentum in reduction. (Rate for 2023/24 12% compared to England average of 7.4%).

While smoking prevalence at England level continues to decline each year, In Lincolnshire we have a smoking prevalence rate of 16% which has seen an increase by 2.7% from 2021 data. Smoking rates are declining more slowly in the more deprived communities than they are in more affluent ones.


### Areas of focus 2024/25:

- Smoking cessation services in acute inpatient settings going live in March 2024.
- Exploring expanded workforce offer in collaboration with Public Health and One You Lincolnshire (OYL).
- Development of Community Mental Health Services/ Outpatients offer for high-risk Mental Health population.
- Expansion of Community Hospital and Acute Hospital inpatient Tobacco Dependency Service (following commencement of services in March 2024).
- Exploring with Public Health – access to the Local Stop Smoking Services Grant and expanding the Lincolnshire.
- Development of smoke free pregnancy and smoke free homes action plan to support reduction of smoking during pregnancy and increase the number of smoke free homes.
- Tobacco Dependency Services and the continued development of integrated smoking cessation pathways with OYL.
- Development of Expression of Interest (EOI) with LMNS on the Pregnancy financial incentive scheme.
- Approval and implementation of e-cigarettes/vapes available to patients within the NHS Tobacco Dependency Service.
- Promotion of smoking cessation within the NHS – strengthening smoke free site polices, develop strategies to implement new staff offer.
- Review the opportunities for joint pathways – Targeted Lung Health checks, Emergency departments and outpatient pathways on pre assessment checks.

# Learning Disability (LD) and/or Autism

## Indicators

Learning Disabilities Annual Health Checks.
Adult mental health inpatient rates for people with learning disability and/or autism.

### Age

LD is more prevalent in younger people, although the proportion of those who received all six health checks is lower than those over the age of 40.

This mirrors other health interventions where uptake is generally poorer in the younger population, meaning chances may be missed to identify health issues earlier. Note that LD health checks start at age 14.

### Ethnicity

Number of ethnic minorities with an LD diagnosis appears to be low, even as a proportion of the ethnic minority population. This may indicate under diagnosis of LD in ethnic minority population.

14.7% of those receiving LD health checks had no ethnic recording.

### Deprivation

The prevalence of LD in 14+ year olds in the most deprived decile is three times that of those living in the least deprived decile. Despite this, LD health checks are lowest in most deprived decile (78.2%), with higher completion of health checks being observed in people living in less deprived parts of the county (85%). This indicates a widening of health inequalities related to health checks for people with learning disabilities.

### Other supporting narrative

Generally, LD health checks are high (81.2% of the population), with males (particularly younger males) having the lowest proportion of health checks in the eligible population.

Lower rates of completing health checks in more deprived populations, who are more likely to have undiagnosed and/or diagnosed health issues, is likely to exacerbate inequalities in outcomes for those from a more deprived background.

Cancer was one of the four top causes of death for people diagnosed with a learning disability and/or autism in Lincolnshire in 2022/23 - where there was no screening, diagnosis and treatment plan.



### Learning Disability (LD) and/or Autism Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Ongoing work on annual health checks to understand the barriers to those health checks which are not completed. Support the work to ensure that annual health checks are completed.
- Support the work to develop LD friendly GP practices.
- The CYP Autism pathway is being finalised across the Lincolnshire system and we have just held workshop three of four.
- Local key priorities from learning taken from LeDeR and reviews are:
  - Inconsistencies in application and use of RESPECT/DNACPR across Lincolnshire identified from LeDeR Reviews. Working Group reaching out across residential, nursing home, community supported living providers, day care provisions, NHS Trust provider teams and primary care teams.
- The LD & Epilepsy Delivery Work Group is working in conjunction with the Lincolnshire LeDeR programme and the Lincolnshire ICS system partners with a focus on embedding SUDEP Checklist, promoting the use of SUDEP and the importance of the SUDEP Checklist.
- The Governance Panel has identified cancer as being a cause of death meeting local criteria for a focussed review in Lincolnshire. The LD & Epilepsy Delivery Work Group will hold a Webinar in April 2024 to promote equal access to screening to avoid missed opportunities and health inequalities for Lincolnshire citizens who have a learning disability and/or autism.

# Maternity and neonatal

## Indicators

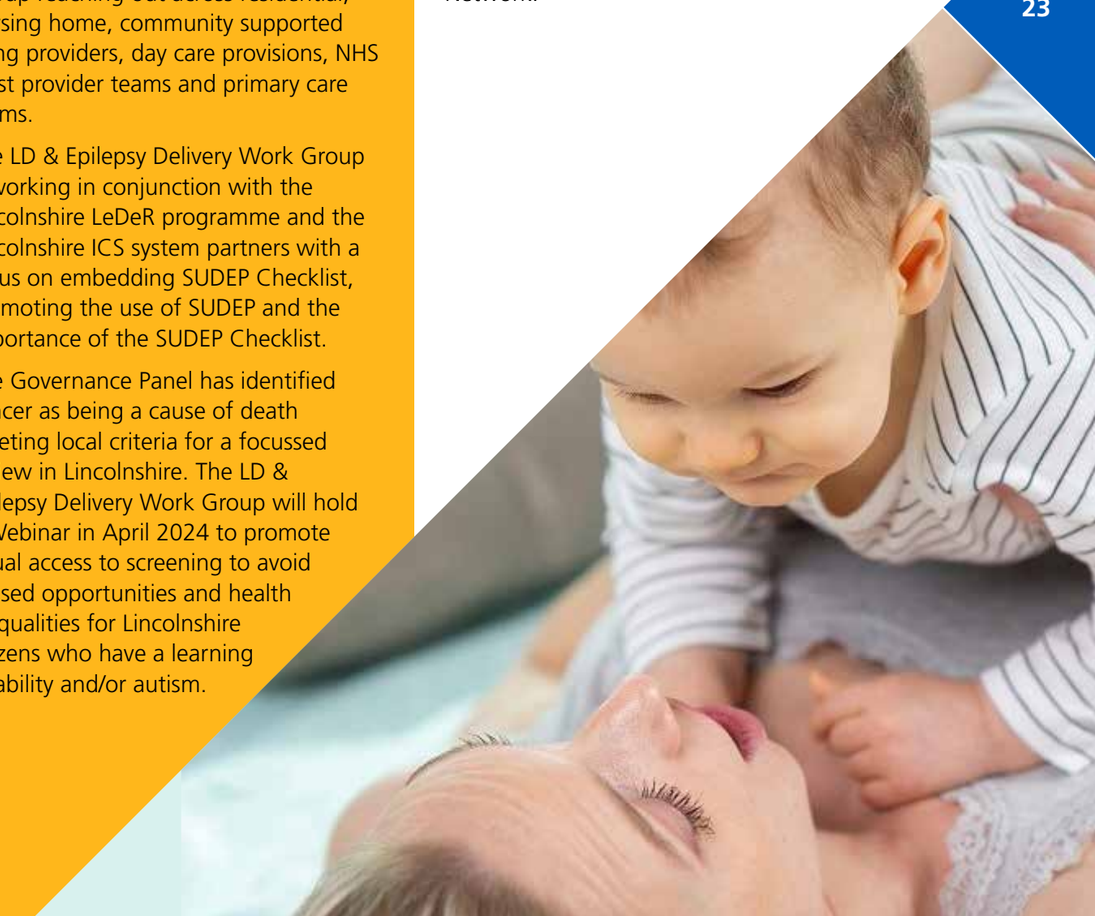
Preterm births under 37 weeks.

### Age, Ethnicity and Deprivation

Data collection is in early infancy and it is too soon to determine health inequalities in different age groups, ethnicity and areas of deprivation.

### Other supporting narrative

Pre-term birth data not stratified. In past 2.5 years, pre-term births have generally been lower (better) than the national average of 60 pre-term births per 1000. This indicator is reviewed as part of the LMNS and East Midlands Neonatal Operational Delivery Network.



NHS
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# Glossary

| Word or Phrase | Definition |
|---|---|
| Direct Age Standardised Rate (DASR) | A statistical method used to compare disease rates among populations with different age structures. |
| Deprivation Decile/ Quintile | The way areas in England are categorised into different levels of deprivation. Areas in the decile or quintile 1 are the most deprived, and areas in decile 10 or quintile 5 are in the least deprived. |
| Elective Inpatient Admission | When a patient is admitted to a hospital for planned and scheduled medical treatment or surgery that requires an overnight stay. |
| Elective Care | Medical treatment or surgery that is pre-planned and scheduled in advance, rather than being done as an emergency. |
| A 95% Confidence Interval (CI) | A 95% confidence interval is a range of values that likely includes the true value we're trying to estimate, with a 95% chance of being correct. The range of values, or the margin of error, is linked to the sample size. A larger sample size makes the 95% confidence interval narrower, meaning we can be more precise about our estimate, while a smaller sample size results in a wider interval, indicating more uncertainty about the true value.çs |
| Non-elective admissions | Hospital admissions that are not planned or scheduled in advance, for example because of attending Accident and Emergency. |
| Outpatient attendances | When a patients visits a healthcare setting for treatment, but they are not admitted for an overnight stay. This can include day cases or follow-up appointments. |
| 'Other' Ethnicity | Generally, someone is from an 'Other' ethnic background if they do not identify as Asian/Asian British, Black/Black British/Caribbean/African, Mixed/Multiple ethnic groups, or White. These are taken from the list of ethnic groups used in the 2021 Census. |
| Patient Pathways | The steps a patient goes through from referral with the NHS to the conclusion of their care. Note that one patient (an individual) who is on more than one waiting list will have a pathway for each waiting list they are on. |
| Pre-term births | When a mother gives birth to a baby before completing 37 weeks of pregnancy. |
| * | Counts between 1 and 5 have been replaced with a *, as well as other values within the data that cannot be used to recalculate the original small numbers. Suppressing these numbers is done to reduce the risk of identifying individuals. |
| Virtual Outpatient attendances | Medical appointments or consultations with a medical professiona l that takes place over the phone, by a video-call, or other online platforms. |
| 8 care processes (for someone with Diabetes) | 8 health checks which consist of an hbA1c blood test, blood pressure reading, cholesterol level reading, kidney function, urine albumin, foot surveillance, BMI (height and weight), and smoking status. |
| 6 health checks (for someone with Severe Mental Illness, or SMI) | 6 health checks which consist of checking someone's weight, heart rate, blood pressure, a urine test, a blood test, mental wellbeing, medicines, vaccinations, and any long term conditions such as asthma or diabetes. |

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Item 5 (i)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 5 (i) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | Integrated Quality & Performance Report – July 2024 |
| **Report Author:** | James Singleton, Performance Manager |
| **Presenter:** | Clair Raybould, Director for System Delivery<br>Martin Fahy, Chief Nurse |
| **Appendices:** | Performance & Quality 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 June 24 was 72.7% below the planned local position of 75% (95% constitutional target).
- Category 1 mean response times for EMAS Trust was 09:59 minutes against a standard of 07:00 minutes during June 24.

- The Category 2 mean response time for EMAS trust was 38:04 minutes against an expectation of 30 mins (18:00 constitutional target). The Lincolnshire ICB Category 2 mean response time was 39:36 minutes during June.

**Cancer**

- 172 patients were waiting over 62 days, the surgical division accounts for the largest percentage of the backlog at 27%, second largest being urology accounting for 23% of the backlog closely followed by H&N at 20%. In total the surgical divisions backlog totals 70% of the overall backlog. Working closely with the surgical division to understand the issues leading to the rise in backlog especially in H&N.
- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral decreased to 57.2% in May from 64.2% in April, but unvalidated performance for June demonstrates a further improvement with performance currently being reported at 64.8%.
- The faster diagnosis standard was achieved in May, overall performance was 78.1% 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 21 at the end of May 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. The number of patients waiting over 65 weeks was 710 at the end of May.

**Mental Health, Learning Disabilities & Autism**

- The NHS Talking Therapies (previously IAPT) waiting times standards were both achieved in May. 94.8% 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 75% in May (rolling 12 months) which is above the 60% standard.
- LDA adult inpatients remain above trajectory and is expected to recover during quarter 2 as delays to LTS17(3) project have been resolved.

**Primary Care**

- CQC report for Caskgate Street Surgery published August 2023 rated the practice 'Inadequate' and placed into special measures, following issuing of section 29 warning notices June 2023. A further inspection was undertaken by CQC 24th May 2024, awaiting outcome.

| 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

July 2024

26/07/2024

# Contents

# Executive Summary

NHS Lincolnshire Integrated Care Board

**Overview**

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

**Urgent & Emergency Care**

- All Types 4 hour performance for Lincolnshire ICB for June 24 was 72.7% below the planned local position of 75% (95% constitutional target).
- Category 1 mean response times for EMAS Trust was 09:59 minutes against a standard of 07:00 minutes during June 24.
- The Category 2 mean response time for EMAS trust was 38:04 minutes against an expectation of 30 mins (18:00 constitutional target). The Lincolnshire ICB Category 2 mean response time was 39:36 minutes during June.

**Cancer**

- 172 patients were waiting over 62 days, this is an improvement from May where we finished with 175 in the backlog
- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral decreased to 57.2% in May from 64.2% in April but unvalidated performance for June demonstrates improvement with performance currently being reported at 64.8%.
- The faster diagnosis standard was achieved in May, overall performance was 78.1% 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 21 at the end of May 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. The number of patients waiting over 65 weeks was 710 at the end of May.

**Mental Health, Learning Disabilities & Autism**

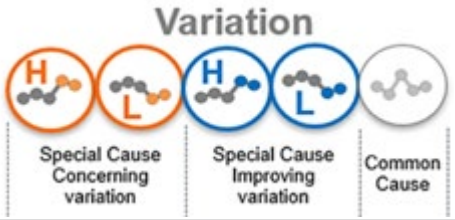
- The NHS Talking Therapies (previously IAPT) waiting times standards were both achieved in May. 94.8% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 99.4% received their first treatment appointment within 18 weeks, against the 95% standard.
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 75% in May (rolling 12 months) which is above the 60% standard.
- LDA adult inpatients remain above trajectory and is expected to recover during quarter 2 as delays to LTS17(3) project have been resolved

**Primary Care**

- CQC report for Caskgate Street Surgery published August 2023 rated the practice ‘Inadequate’ and placed into special measures, following issuing of section 29 warning notices June 2023. A further inspection was undertaken by CQC 24th May 2024, awaiting outcome.

# Key to Run Charts

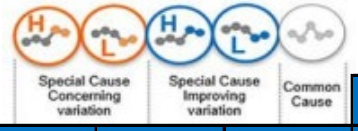
NHS Lincolnshire Integrated Care Board




| | 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.<br>Is it a one-off event that you can explain?<br>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.<br>**Celebrate** the improvement or success.<br>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

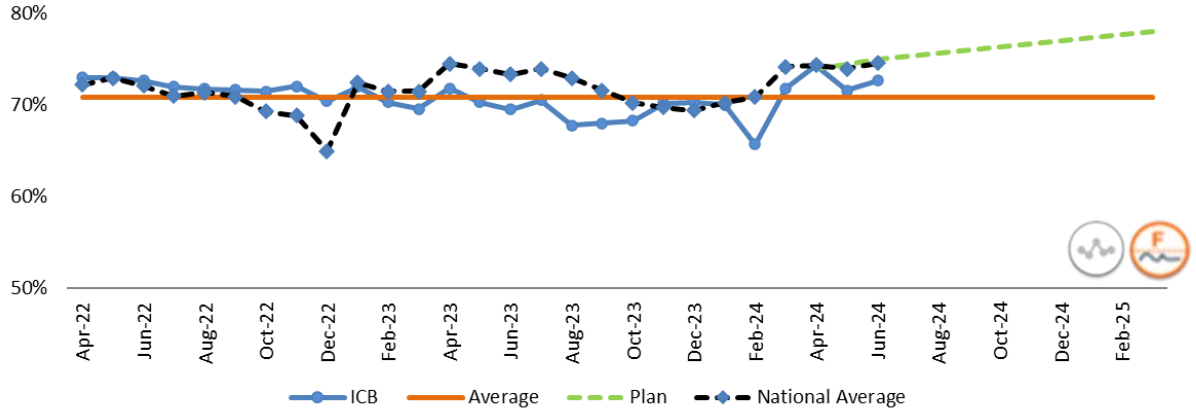



| Programme | Indicator | Standard | Plan | Period | Performance | Midlands | England | Trend | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Sparkline | Variation | Assurance |
| Urgent & Emergency Care | A&E admission, transfer, discharge within 4 hours (ICB) | 95% | 75.0% | Jun-24 | 72.7% | 72.8% | 74.6% | | | |
| | Ambulance response times - Mean response time- Category 1 (EMAS) | 00:07:00 | - | Jun-24 | 00:09:09 | 00:08:36 | 00:08:21 | | | |
| | Ambulance response times - Mean response time- Category 2 (EMAS) | 00:18:00 | 00:30:00 | Jun-24 | 00:38:04 | 00:33:15 | 00:34:38 | | | |
| Cancer | Patients receiving treatment for cancer within 31 days of decision to treat | 96% | - | May-24 | 87.5% | 90.4% | 91.8% | | | |
| | Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade | 85% | - | May-24 | 57.2% | 60.8% | 65.8% | | | |
| | % of patients told cancer diagnosis outcome within 28 days (ICB) | 75% | - | May-24 | 78.1% | 78.4% | 76.4% | | | |
| Elective Care | RTT: % of incomplete pathways within 18 weeks | 92% | - | May-24 | 53.4% | 56.7% | 59.1% | | | |
| | Patients waiting over 65 weeks for treatment (ICB) (% of total ICB waiting list size) | - | - | May-24 | 0.61% | 0.00% | 0.00% | | | - |
| | Patients waiting over 78 weeks for treatment (ICB) (% of total ICB waiting list size) | - | - | May-24 | 0.02% | 0.00% | 0.00% | | | - |
| | Percentage waiting six weeks or less for a diagnostic test | 99% | - | May-24 | 73.3% | 75.6% | 77.9% | | | |
| | % of patients not treated within 28 days of last minute elective cancellation (ULHT) | 0.8% | - | Q4 2023/24 | 30.3% | 25.1% | 22.7% | | | |
| Mental Health | NHS Talking Therapies access - first treatment appointment within 6 weeks (ICB) | 75% | - | May-24 | 94.8% | N/A | 92.2% | | | |
| | NHS Talking Therapies access - first treatment appointment within 18 weeks (ICB) | 95% | - | May-24 | 99.4% | N/A | 98.4% | | | |
| | People experiencing first episode psychosis waiting to start a package of care (ICB) | 60% | - | Apr-24 | 75.0% | 75.0% | 61.2% | | | |
| | CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months) | 95% | - | Mar-24 | 66.0% | N/A | 73.3% | | | |
| | CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months) | 95% | - | Mar-24 | 70.0% | N/A | 79.1% | | | |

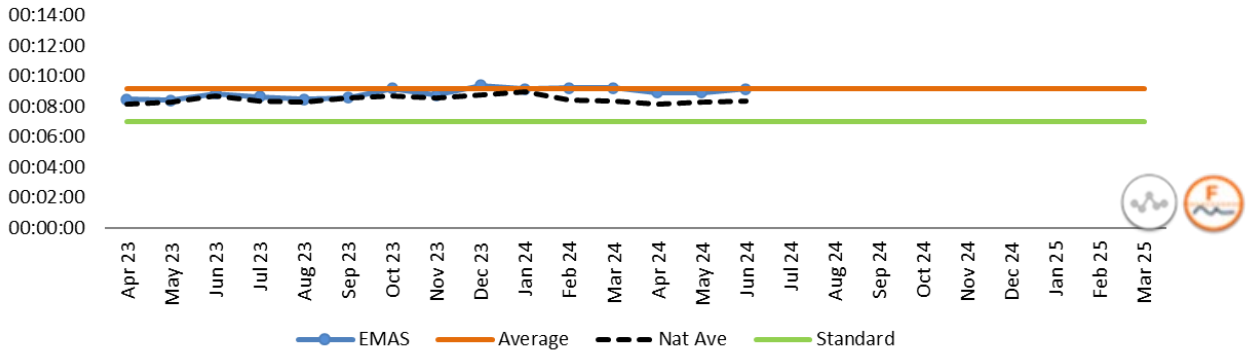
# Urgent Care

NHS Lincolnshire Integrated Care Board

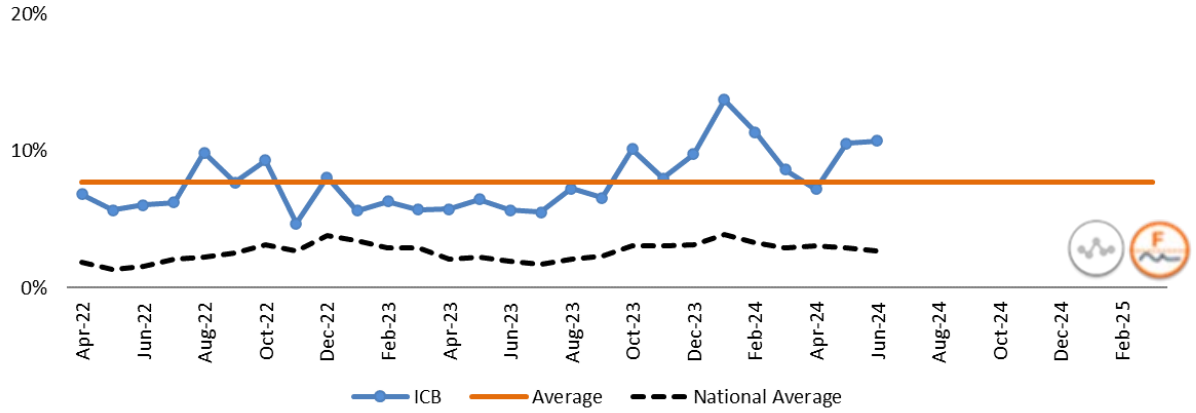
## A&E admission, transfer, discharge within 4 hours (ICB)



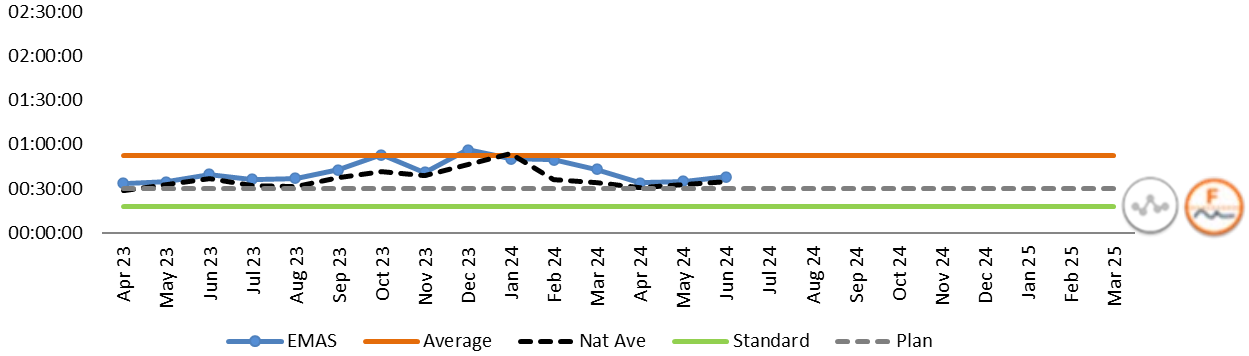

## Ambulance response times - Mean response time- Category 1 (EMAS)




## 12+ hour delays from decision to admit (ICB)



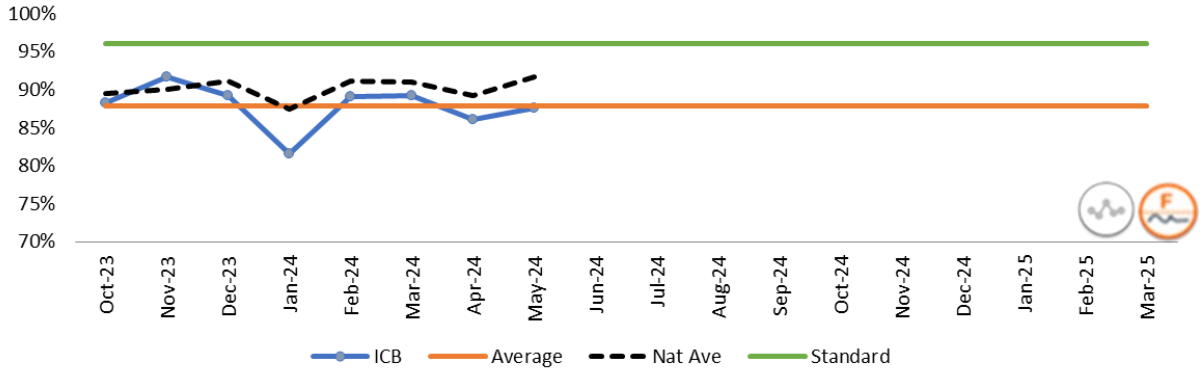

## Ambulance response times - Mean response time- Category 2 (EMAS)



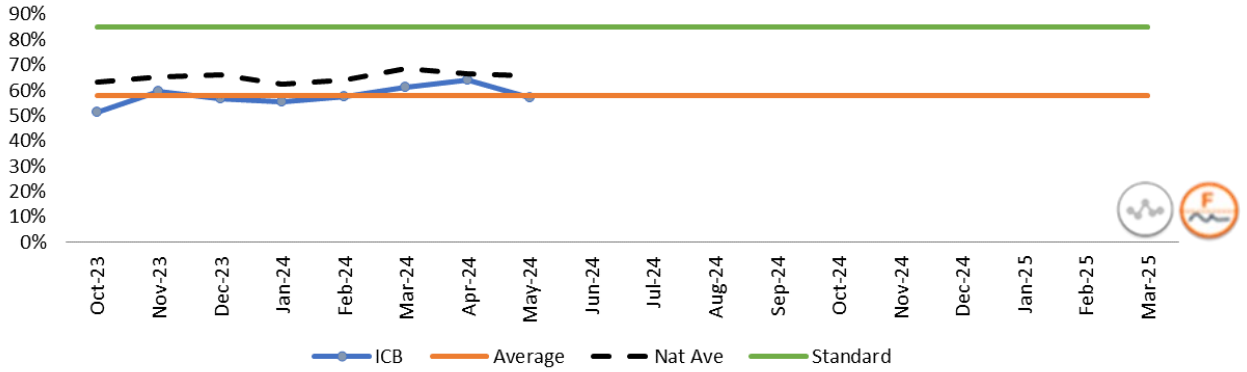
# Cancer

NHS Lincolnshire Integrated Care Board

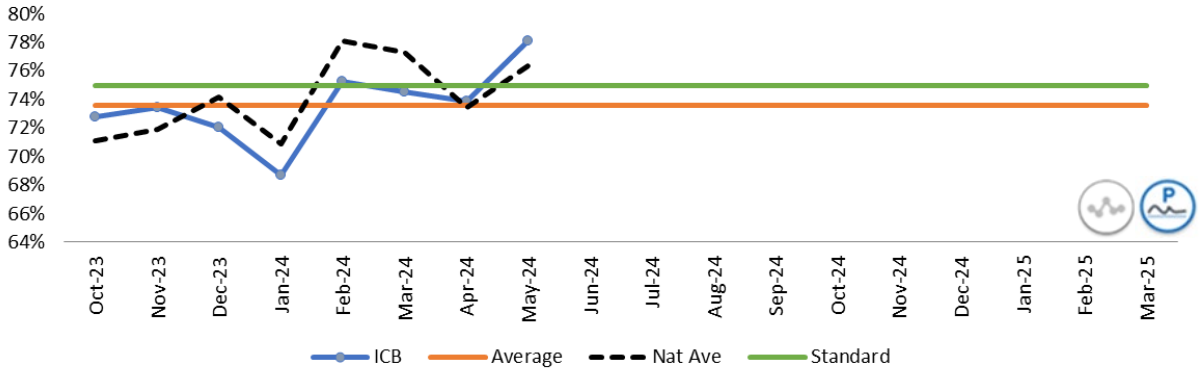
## Patients receiving treatment for cancer within 31 days of decision to treat (LICB)



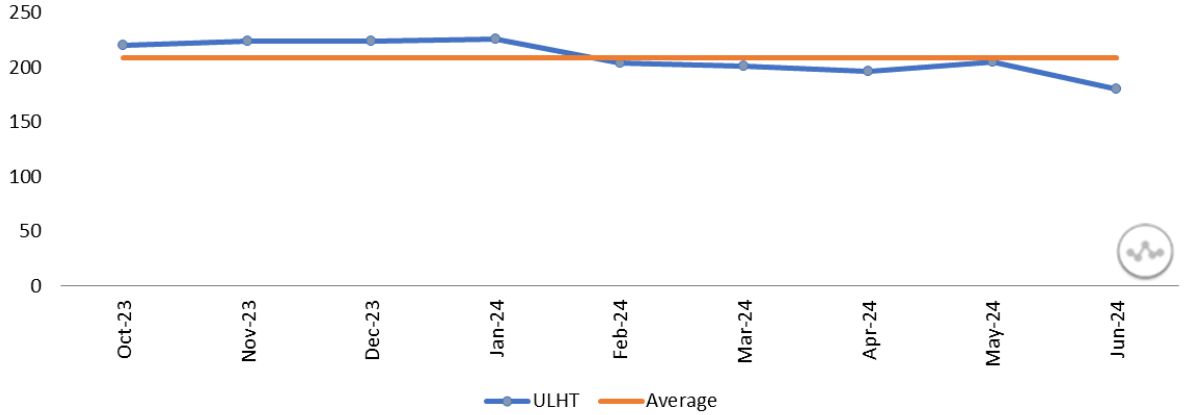

## Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade (LICB)




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



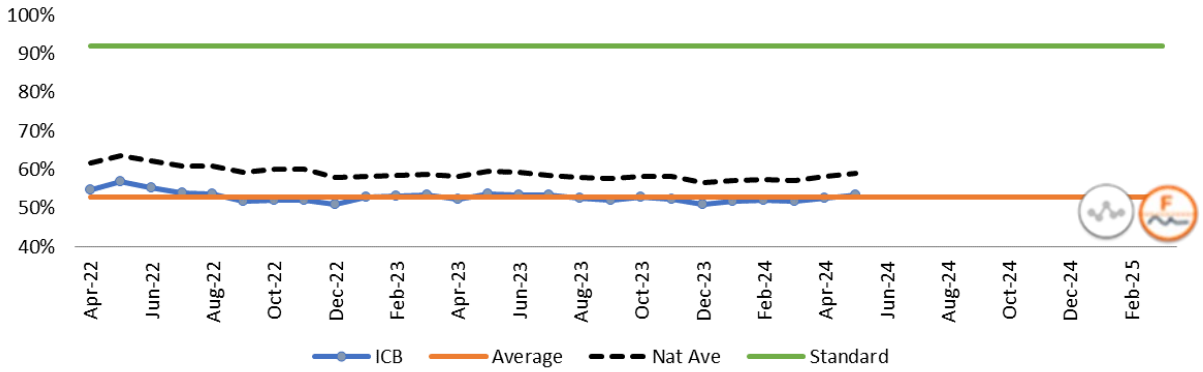

## Total 62 Day Backlog (ULHT)



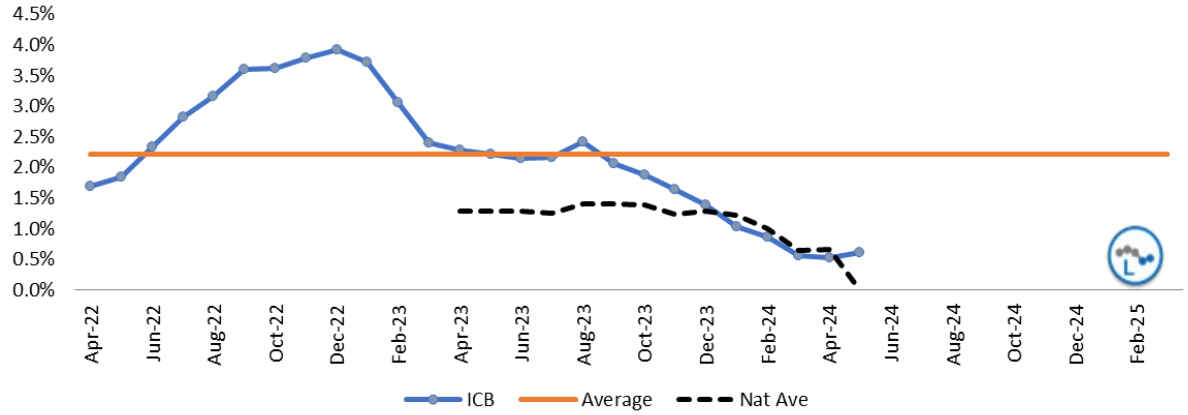
# Elective Care

NHS Lincolnshire Integrated Care Board

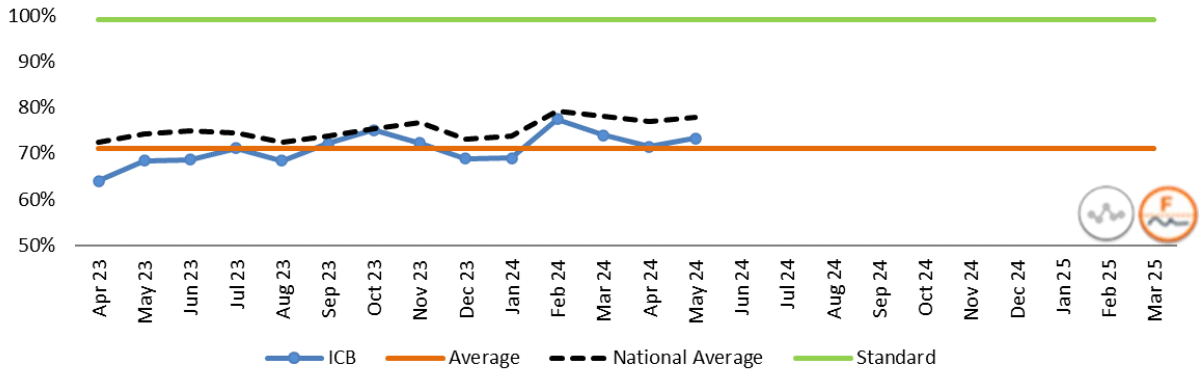
## RTT- Patients waiting 18 weeks or less from referral to hospital treatment (LICB)



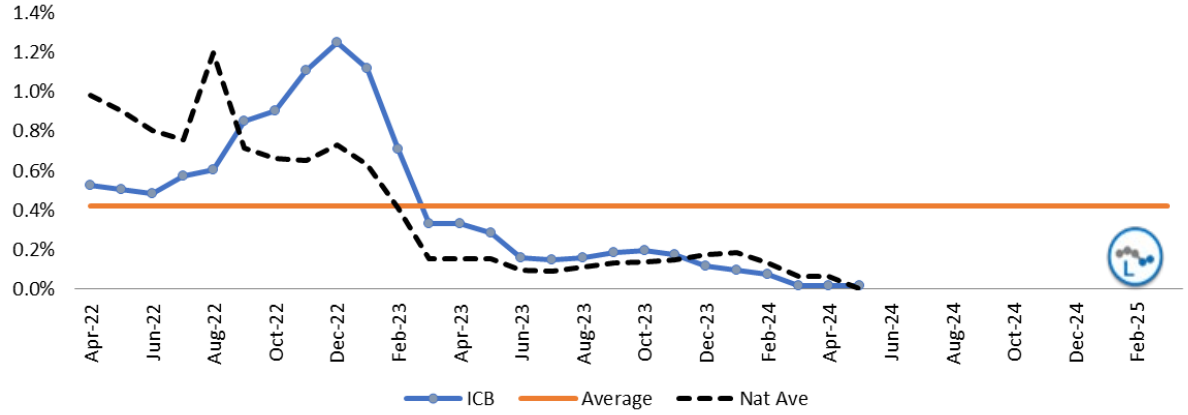

## RTT- Patients waiting over 65 weeks for treatment (LICB)




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



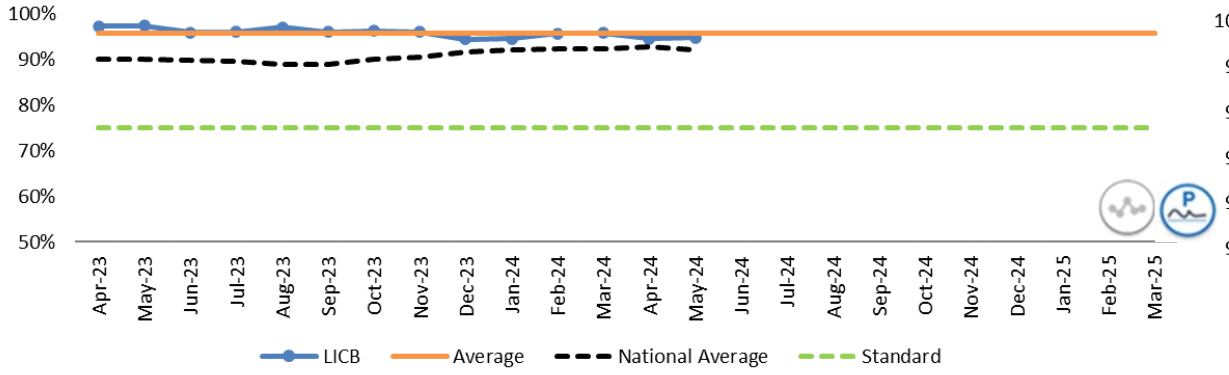

## RTT- Patients waiting over 78 weeks for treatment (LICB)



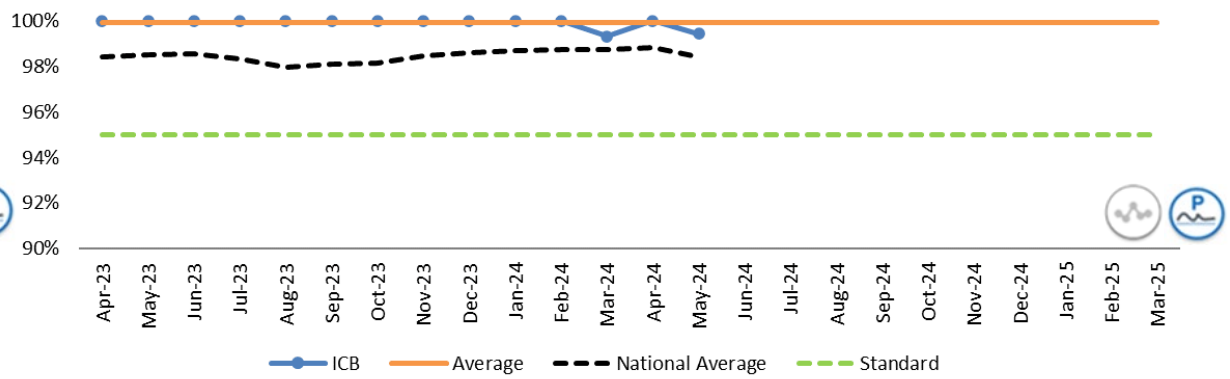
# Mental Health

NHS Lincolnshire Integrated Care Board

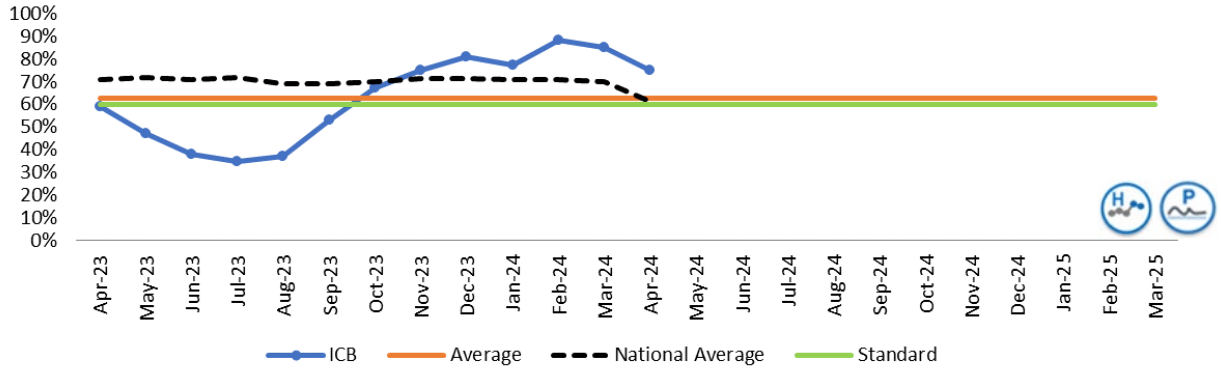
## Talking Therapies: First treatment appointment within 6 weeks of referral (ICB)



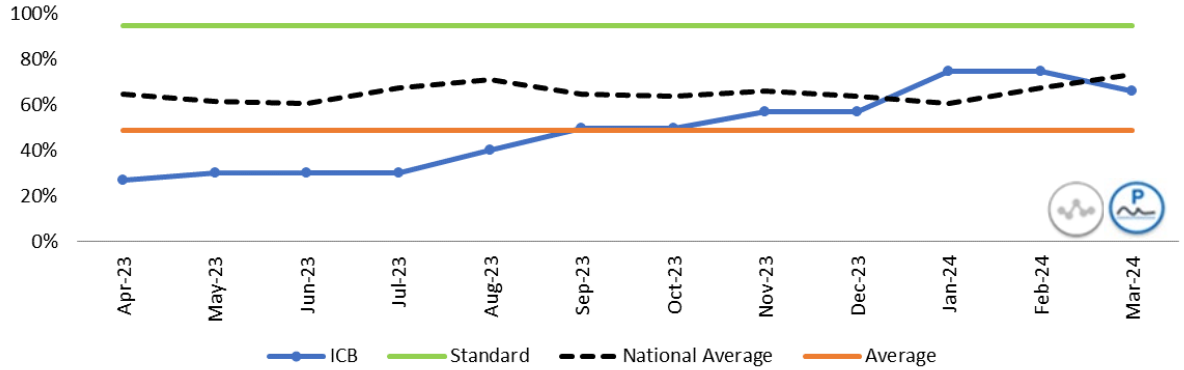

## Talking Therapies: First treatment appointment within 18 weeks of referral (ICB)




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



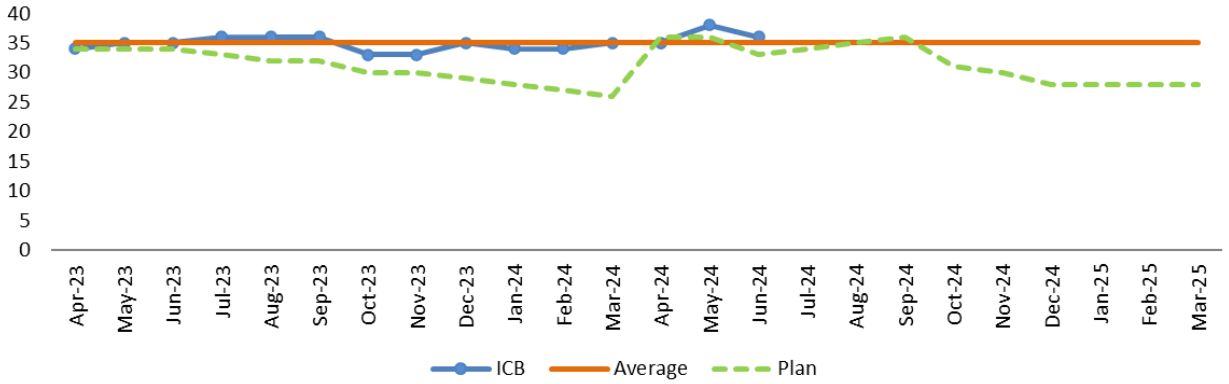

## CYP with an eating disorder (urgent) that start treatment < 1 week of referral (rolling 12 months)



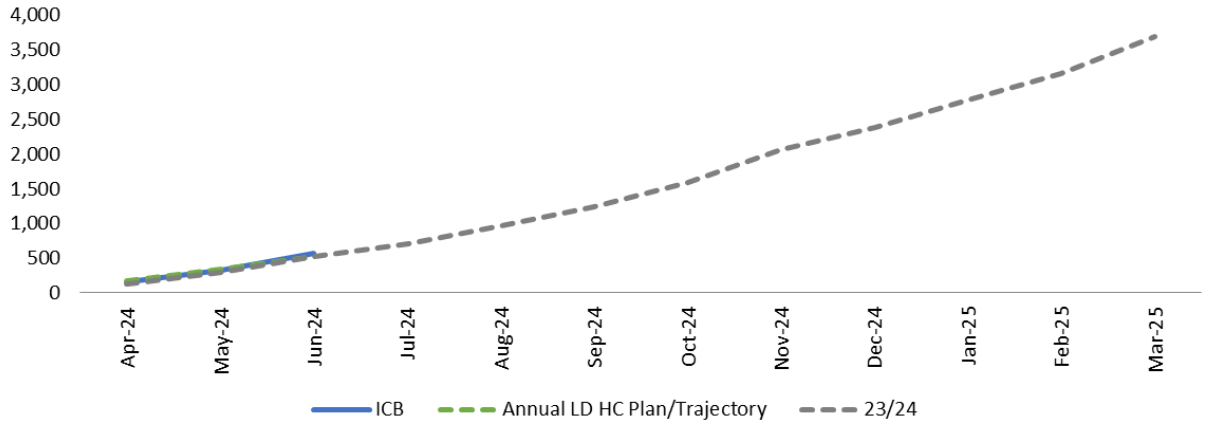
# Learning Disability & Autism

NHS Lincolnshire Integrated Care Board

## Inpatient care for adults with LD/autistic - Care commissioned by ICB. (Non Secure) and NHSE (Secure)




## Learning Disability Healthchecks




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

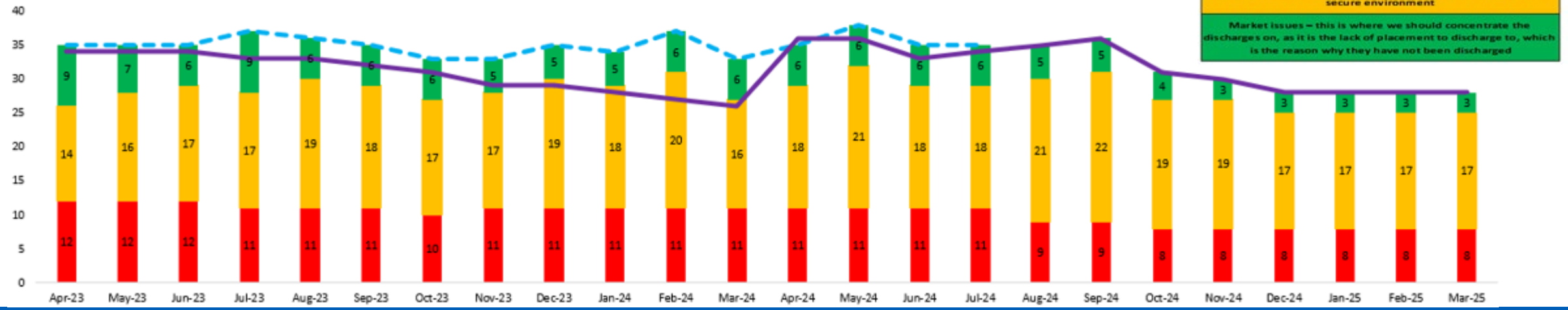
**RAG RATING Key**

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

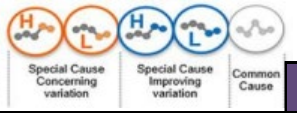
Clinical illness – Those clients where the needs are best met in a secure environment

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

## LDA ICB & IMPACT Adult Inpatient Movement 2023/24 - 2024/25



# Lincolnshire ICB Quality Dashboard




| Programme | Indicator | Standard /Plan | Period | Performance | Midlands | England | Trend | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Sparkline | Variation | Assurance |
| Incidents | Never events - YTD (ULHT) | 0 | May-24 | 0 | N/A | N/A | - | | |
| | Never events - YTD (NLAG) | 0 | May-24 | 0 | N/A | N/A | - | | |
| | Never events - YTD (NWAFT) | 0 | May-24 | 1 | N/A | N/A | - | | |
| Mortality | Summary Hospital Level Mortality Indicator (SHMI) (ULHT) | - | Mar23 to Feb24 | 1.0502 | 1.0431 | 1.0067 | | | |
| | Summary Hospital Level Mortality Indicator (SHMI) (NLAG) | - | Mar23 to Feb24 | 1.0038 | 1.0431 | 1.0067 | | | |
| | Summary Hospital Level Mortality Indicator (SHMI) (NWAFT) | - | Mar23 to Feb24 | 0.9892 | 1.0431 | 1.0067 | | | |
| Infection, Prevention, Control | MRSA Cases (ULHT 12 month rate per 100,000) | - | May-24 | 0.59 | 0.96 | 1.01 | | | |
| | C-Diff Cases (ULHT 12 month rate per 100,000) | - | May-24 | 29.66 | 30.53 | 29.55 | | | |
| | E-Coli Cases (ULHT 12 month rate per 100,000) | - | May-24 | 30.83 | 38.66 | 40.01 | | | |
| Learning Disability | Number of inpatient care for people with a learning disability and/or autism (ICB) | 36 | May-24 | 33 | N/A | N/A | | | |
| | Cumulative Learning Disability Healthchecks (ICB) | 345 | May-24 | 328 | 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 | May-24 | 2.5% | N/A | 0.9% | | | |
| | Primary Care CQC- percentage of practices rated as 'Requires Improvement' by CQC | - | May-24 | 7.4% | N/A | 7.4% | | | - |
| | GP Appointments- Total appointments in GP practice | 511,455 | May-24 | 526,975 | N/A | N/A | | | |
| | GP Appointments- time from booking to appointment same day | - | May-24 | 47.0% | N/A | 44.3% | | | - |
| | GP Appointments- time from booking to appointment < 2 Weeks | 85% | May-24 | 87.0% | N/A | 82.4% | | | |
| | Enhanced access minutes provided (ICB) (YTD) | 649,820 | Jun-24 | 636,570 | N/A | N/A | | | |
| | The percentage of available GP enhanced access appointments utilised (ICB) (YTD) | 80% | Jun-24 | 86.1% | N/A | N/A | | | |

# Insight and Signals – Quality and Patient Experience

**Urgent & Emergency Care:** A System Patient Safety and Quality of Care in Pressurised  Services meeting took place 28th June 2024 in response to the letter from NHSE 26th June 2024. 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. The Lincolnshire position was mapped against the 10 High Impact Interventions of the UEC recovery plan. Agreed next steps included consideration of clinical audit priorities as part of the assurance processes going forward.

**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. This includes clinical review of patients to ensure on correct pathway and establish impact of any potential detriment to their treatment pathway.

**Safeguarding Children Front Door:** Working Together (2018; 2023) identifies health is a statutory partner for Strategy discussions. From beginning of July 2024 LCC Childrens Health Services have withdrawn from routine health cover and will only be in attendance and sharing information for CYP open to the service, which is primarily children under 6 years of age and a relatively small proportion of cases. Current mitigations include interim arrangements for July and August through ICB and LCHG which will provide health input 3 days per week (Front Door operates Mon-Fri) and regular oversight meetings between LCC Front Door lead and health partners to monitor impact. Risks have been scoped and added to ICB risk register; remains on Lincolnshire Safeguarding Childrens Partnership risk and issues register.

**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.

**Welham House Care Home:** CQC enforcement action undertaken and managed home closure processes put in place impacting 10 residents, none of which are ICB funded. There are a further 6 services within Lincolnshire owned by the same organistion, oversight arrangements are in place through CQC and LCC to monitor quality and safety of care being delivered within these services.

**Nottingham University Hospitals Early recommendations from Ockenden:** These have been benchmarked against local services and required improvement areas are already in progress as these align to compliance plans for the 3 Year delivery Plan.

# Insight and Signals – Primary Care

| Type of Provision | Practice | CQC Rating | Information to note |
|---|---|---|---|
| GP | Caskgate Surgery | Inadequate | CQC report published August 2023 rated Practice Inadequate and placed into special measures, following issuing of section 29 warning notices June 2023. A further inspection was undertaken by CQC 24th May 2024, awaiting outcome. |
| GP | Sutterton Surgery | Good (2015; reviewed July 2023) | ICB led Quality Review meeting undertaken 26th June 2024 to monitor progress with patient reviews that are being undertaken following identification of concerns relating to QOF. Practice is under new Partnership, progress with required patient reviews is satisfactory and will continue to be monitored. |
| GP | Cleveland Surgery | Good (2021; reviewed July 2023) | ICB led Quality Review meeting undertaken 5th June 2024 and assurance received regarding actions taken by the Practice to maintain patient safety in response to an identified incident. |

# Quality Improvement

**CHC:** Process has commenced for procurement of care and nursing home CHC placements. Draft care tiers and service specification have been drafted and the first round of engagement is underway, having completed 3 engagement days with providers focusing on the care tiers and the specification. The process includes a public and wider system stakeholder survey. Feedback has been generally positive with the tiers well received. Next steps are to review care tiers and specification following review of the feedback and to work through the costings for the tiers. Further engagement days planned for September which will focus on how providers apply.

**Health Protection:** Lincolnshire has been identified as an examples of good public health practice in the Faculty of Public Health publication *Public health good practice in ICSs and ICBs* Good practice in ICSs and ICBs - Faculty of Public Health (fph.org.uk). 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.

**Lincolnshire Community & Hospitals NHS Group:**

- ULHT achieved significant improvements in the **2023 Staff Survey** results. The trust has presented through its internal governance processes detail of the achievements and where there remain areas for improvement. This has included confirmation that in relation to recognising and rewarding; safe and healthy; always learning; and working flexibly People Promise elements and the Theme of morale, results are statistically significantly higher when compared to 2022.
- ULHT has demonstrated great improvement in position in the **Midlands Maternity Heat Map** which began with ULHT in amber, now Green and one of the best performing on the Heat Map metrics
- ULHT **falls risk reduction** due to extensive improvement programme of work undertaken over the last couple of years.
- **Cardio-Diabetic Pathway** is a service that commenced in September 2021 seeing 468 patients to date. This was a clinically led service redesign, adopting an evidence based, data driven approach to holistic care. Patient outcome data has shown a significant reduction in acute kidney injury, myocardial infarction, hospitalisation for heart failure and death which has resulted in the service winning the HSJ Silver Award.
- **Health Service Journal Awards:** LCHS Skegness and Mablethorpe Community Nursing Teams have been shortlisted for a project with Health Innovation East Midlands transforming wound care. ULHT Patient Safety Partners have been shortlisted due to the successful implementation across the trust and has included improvement programmes, recruitment panels, ward assurance visits and much more.

**Lincolnshire Partnership Foundation Trust:**

- **Ash Villa** CQC inspection report was published 14th June 2024. The inspection was as a consequence of the CQC receiving concerns about medicines management, however following the inspection, the CQC found these claims to be unsubstantiated and the trust overall rating remains as Good.
- **PICU** (Hartsholme Centre) has reopened following full assurance on water quality
- There are known **Consultant vacancy** levels which are mitigated and there is innovative work to address through different initiatives e.g. CESR fellows; and multi-professional approved clinicians.

# Quality and Patient Experience Thematic Update – Children and Young People

**Insights & Signals:**

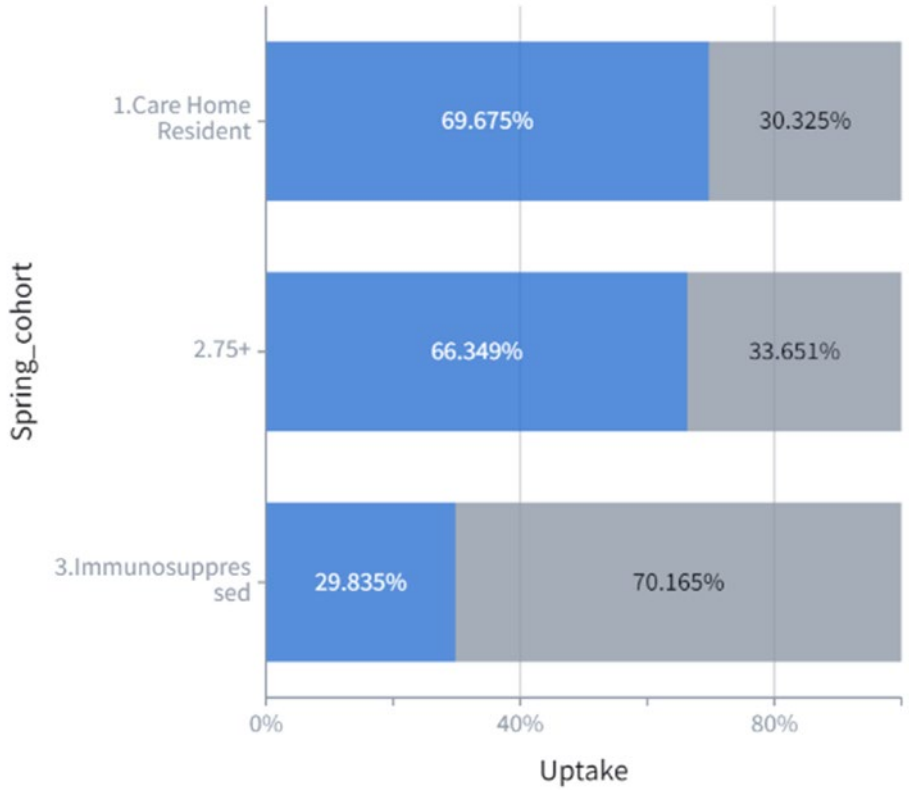
There are a number of challenged areas of service provision for CYP which are currently being worked through. Oversight of the programmes of work is through the CYP Integrated Transformation Board; MHDLDA Transformation Programme; and/or the Lincolnshire Safeguarding Childrens Partnership. There is recognition of pathway redesign and resource implications required to address the presenting areas of concern which include:

- **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 referral pathway to focus on complex cases this has only had an initial positive effect which has not been sustained. 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 and autism. MHDLDA Transformation Team are working with system partners and experts by experience to develop an improved, effective pathway. In the interim risk mitigation plan will be overseen through the CYP Integrated Transformation Board.
- **Clinical Interventions in Special Schools (ULHT; LCC)** - ULHT provide clinical support through a school nursing team based at St Francis School in Lincoln. In line with the LCC led Special Schools programme, which will lead to more children with complex health needs being able to attend a school closer to home, the staffing model for clinical support is currently being worked up. However, whilst this is being undertaken concern has been raised by schools regarding the current complexity of needs being cared for in schools and availability of support to meet the increase in complexities of care required. Collaboration with SEND and the Education Team at LCC is currently taking place to understand associated risk and any immediate mitigations that can be put in place while waiting for the redesigned model to be ready.
- **Initial and Review Health Assessments of Looked after children (LCHS)** - There has been an 18% increase in children in care in Lincolnshire over the last few years and a 28% increase in children been placed into care in Lincolnshire from external Local Authorities, this has resulted in a significant increase in the number of statutory Initial and Review Health Assessments which now exceeds the capacity of the service. Current review is being undertaken within LCHS which will include assessment of risk, mitigating actions and options appraisal.

**Quality Improvement:**

- **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
- **Transition (across all providers)** – Transition network has been launched, ICB led but with buy in across all providers. Face to face development session held May 2024 which will inform priorities and next steps.
- **CYP Diabetes Getting it Right First Time (GIRFT)** – Lincolnshire is one of 2 pilot ICS. Review meeting held with national team in May 2024 and report received which is largely positive. Action plan is in process being developed to address areas for improvement

# Covid-19 Vaccinations




## Update

- The Spring vaccination programme ended 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 following groups are eligible for a Spring covid vaccination
  - Residents in older adult carehomes
  - Anyone aged 75+
  - those aged 6 months and over with a weakened immune system

## Performance

- Lincolnshire officially finished the programme with 60.1% uptake (we have open queries about one PCN and the number of vaccinations recorded in the national system and we think we are closer to 63%), this is against a National uptake position of 56.5% and Regional uptake of 55.8%.

Item 5 (ii)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 5 (ii) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | System Financial Management Report June 2024 (Month Three) |
| **Report Author:** | Rebecca McCauley, Senior Finance Business Partner |
| **Presenter:** | Matt Gaunt, Director of Finance |
| **Appendices:** | Appendix 1: Lincolnshire Integrated Care System Financial Position<br>Appendix 2: Lincolnshire Integrated Care System Income & Expenditure Summary<br>Appendix 3: Lincolnshire Integrated Care Board Income & Expenditure Analysis |

| 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 members of the Board are asked to consider and note the reported financial position of the Lincolnshire Integrated Care System (ICS), the risks presenting along with the mitigations and the actions that are in progress within NHS Lincolnshire Integrated Care Board (ICB) and system Provider executive teams.

## Summary


Summary Financial Position

The report presents 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.

Year To Date Financial Position

The ICS' plan was to deliver a £14.0m deficit at month 3 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.

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 3 is to achieve plan.

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

Risks and mitigations

The ICS overall plan reflects a level of net risk of £21.1m. This is comprised of gross risks of £54.5m that are offset by £33.4m of mitigations.

This net risk includes a planning round gap of £16.0m relating to system investments and cost pressures. These are being mitigated through a system wide 'four corners' rapid bridging the gap exercise comprising Executive Directors from 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 by the end of July.

Cost Improvement Plan

At Month 3 the ICS has reported £8.9m cost improvements against a plan of £8.3m equating to a £0.6m favourable 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 £37.2m capital allocation for the full year and is expected to utilize this in full by the financial year-end.

Mental Health Investment Standard (MHIS)

At the 30th of June, the ICS is expecting to achieve its 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 NHS England.

Better Payment Practice Code

The ICB has delivered the Better Payment Practice Code, to pay 95% of suppliers within 30 days. It has achieved a rate more than 98% both in month and on a year-to-date cumulative bases on both value and volume of invoices received.

ICB Financial Duties

The ICB, as a statutory organisation, must fulfil certain financial duties. The ICB is expecting to meet its statutory financial performance targets.

The table below demonstrates delivery against the key financial duties as at month 3.

| Delivery of Statutory Targets | Duty Achieved | |
|---|---|---|
| | Year to Date | Outturn |
| Expenditure not to exceed income | No | Yes |
| Capital resource use does not exceed the amount specified in Directions | Yes | Yes |
| Revenue resource use does not exceed the amount specified in Directions | No | Yes |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | Yes | Yes |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | Yes | No |
| Revenue administration resource use does not exceed the amount specified in Directions | Yes | No |

| Other Financial Targets | Duty Achieved | |
|---|---|---|
| | Year to Date | Plan |
| Better Payment Practice Code (BPPC) | Yes | Yes |
| To manage cash payments within the Annual Cash Drawdown Requirement (ACDR) | No | Yes |
| Period end cash balance (less than 1.25% of monthly drawdown value) | Yes | Yes |

| How does this paper support the ICB's core aims to: | |
|---|---|
| Aim 1: Improve outcomes in population health and healthcare. | Provides assurance on the effective use of financial resources and delivery of the financial plan, which is fully aligned to improving outcomes in population health. |
| Aim 2: Tackle inequalities in outcomes, experience and access. | Provides assurance on the effective use of financial resources and delivery of the financial plan, which is fully aligned to tackling inequalities. |
| Aim 3: Enhance productivity and value for money. | Provides direct assurance on the effective use of financial resources. |
| Aim 4: Help the NHS support broader social and economic development. | Provides assurance on the effective use of financial resources and delivery of the financial plan, which is aligned to broader social and economic development. |

| Conflicts of Interest | Summary of conflicts |
|---|---|
| No conflict identified | Not applicable |

| Risk and Assurance |
|---|
| As detailed in the main body of the report. |

| Implications (legal, policy and regulatory requirements) | |
|---|---|
| Does the report highlight any resource and financial implications? | Yes |
| Does the report highlight any quality and patient safety implications? | Not Applicable |
| Does the report highlight any health inequalities implications? | Not Applicable |
| 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: |
|---|
| The month seven and full year financial position was discussed in detail at the ICB Finance and Resource Committee. |

| Is the report confidential or not? |
|---|
| Yes ☐ No ☒ |

## Appendix 1 – Lincolnshire Integrated Care System Financial Position

| Organisation | Surplus / (Deficit) - Adjusted Financial Position | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Year To Date | | | | Full Year | | | |
| | Plan | Actual | Variance | | Plan | Outturn | Variance | |
| | £m | £m | £m | % | £m | £m | £m | % |
| United Lincolnshire Hospitals NHS Trust | (9.8) | (11.7) | (1.8) | (0.9%) | (6.9) | (6.9) | - | 0.0% |
| Lincolnshire Partnership NHS Foundation Trust | 0.5 | 0.5 | - | 0.0% | 2.2 | 2.2 | - | 0.0% |
| Lincolnshire Community Health Services NHS Trust | (0.6) | (0.9) | (0.3) | (1.0%) | 0.0 | (0.0) | (0.0) | (0.0%) |
| Lincolnshire ICB | (4.1) | (4.1) | (0.0) | (0.0%) | 4.7 | 4.7 | 0.0 | 0.0% |
| **ICS Total Surplus/(Deficit)** | (14.0) | (16.2) | (2.2) | (0.4%) | 0.0 | 0.0 | (0.0) | (0.0%) |

## Appendix 2 – Lincolnshire Integrated Care System Income & Expenditure Summary

| | Plan | Actual | Variance | | Plan | Outturn | Variance | |
|---|---|---|---|---|---|---|---|---|
| | YTD | YTD | YTD | YTD | Year Ending | Year Ending | Year Ending | Year Ending |
| | £m | £m | £m | % | £m | £m | £m | % |
| **System Revenue Resource Limit** | (486.9) | | | | (1,797.7) | | | |
| **ICB Net Expenditure** | | | | | | | | |
| Acute Services | 228.4 | 231.2 | (2.8) | (1.2%) | 920.3 | 927.0 | (6.8) | (0.7%) |
| Mental Health Services | 56.6 | 55.8 | 0.9 | 1.5% | 221.3 | 224.1 | (2.8) | (1.3%) |
| Community Health Services | 49.8 | 50.2 | (0.4) | (0.8%) | 200.4 | 201.6 | (1.2) | (0.6%) |
| Continuing Care Services | 17.1 | 18.7 | (1.6) | (9.3%) | 70.5 | 75.3 | (4.8) | (6.7%) |
| Primary Care Services | 49.5 | 50.9 | (1.4) | (2.8%) | 187.3 | 194.5 | (7.2) | (3.8%) |
| *Memo: Prescribing* | 43.2 | 44.6 | (1.4) | (3.3%) | 162.0 | 168.4 | (6.3) | (3.9%) |
| Other Commissioned Services | 1.8 | 2.2 | (0.4) | (24.0%) | 7.1 | 9.2 | (2.1) | (29.8%) |
| Other Programme Services | 1.3 | 1.2 | 0.1 | 7.6% | 6.6 | 6.4 | 0.2 | 3.4% |
| Reserves / Contingencies | (7.8) | (9.3) | 1.5 | (19.2%) | (54.0) | (76.2) | 22.2 | (41.2%) |
| Delegated Specialised Commissioning | 34.0 | 34.0 | - | 0.0% | 143.3 | 143.3 | - | 0.0% |
| Delegated Primary Care Commissioning | 57.2 | 53.1 | 4.1 | 7.2% | 226.1 | 223.5 | 2.6 | 1.2% |
| ICB Running Costs | 3.0 | 2.9 | 0.1 | 2.8% | 12.2 | 12.4 | (0.2) | (1.8%) |
| **Total ICB Net Expenditure** | **490.9** | **490.9** | - | **0.0%** | **1,941.2** | **1,941.2** | - | **0.0%** |
| **ICS Providers I&E - Adjusted Financial Performance** | | | | | | | | |
| Income | (276.4) | (279.2) | 2.8 | (1.0%) | (1,104.4) | (1,106.1) | 1.7 | (0.2%) |
| Pay | 197.4 | 200.5 | (3.1) | (1.6%) | 749.9 | 749.9 | (0.1) | (0.0%) |
| Non-Pay | 87.2 | 89.3 | (2.1) | (2.4%) | 350.7 | 352.7 | (1.9) | (0.5%) |
| Non Operating Items | 1.8 | 1.6 | 0.2 | 13.7% | 8.5 | 8.2 | 0.3 | 3.0% |
| **TOTAL Provider Surplus/(Deficit)** | (10.0) | (12.1) | (2.2) | 0.8% | (4.7) | (4.7) | (0.0) | 0.0% |
| **TOTAL ICS Surplus/(Deficit)** | (14.0) | (16.2) | (2.2) | 0.4% | 0.0 | 0.0 | (0.0) | 0.0% |

## Appendix 3 – Lincolnshire Integrated Care Board Income & Expenditure Analysis

| System I&E Analysis | Year to Date | | | | Full Year | | | |
|---|---|---|---|---|---|---|---|---|
| | Net Expenditure Plan £m | Net Expenditure Actual £m | Net Expenditure Variance £m | Net Expenditure Variance % | Net Expenditure Plan £m | Net Expenditure Outturn £m | Net Expenditure Variance £m | Net Expenditure Variance % |
| **System Revenue Resource Limit** | 486.9 | | | | 1,945.9 | | | |
| **ICB Net Expenditure** | | | | | | | | |
| **Acute Services** | 228.4 | 231.2 | (2.8) | (1.2%) | 920.3 | 927.0 | (6.8) | (0.7%) |
| Acute services - NHS | 221.8 | 222.2 | (0.4) | (0.2%) | 894.2 | 897.9 | (3.6) | (0.4%) |
| Acute services - Independent/commercial sector | 6.6 | 6.6 | (0.0) | (0.3%) | 25.7 | 25.7 | 0.1 | 0.2% |
| Acute services - Other non-NHS | (0.5) | 1.0 | (1.6) | 287.6% | (2.2) | (3.0) | 0.9 | (39.1%) |
| Acute Services - Other Net Expenditure | 0.6 | 1.4 | (0.8) | (125.9%) | 2.5 | 6.5 | (4.0) | (160.4%) |
| **Mental Health Services** | 56.6 | 55.8 | 0.9 | 1.5% | 221.3 | 224.1 | (2.8) | (1.3%) |
| MH Services - NHS | 32.2 | 31.6 | 0.6 | 1.9% | 128.9 | 128.8 | 0.1 | 0.1% |
| MH Services - Independent / Commercial Sector | 11.0 | 10.5 | 0.4 | 4.1% | 38.9 | 41.8 | (2.9) | (7.4%) |
| MH Services - Other non-NHS | 13.0 | 13.2 | (0.3) | (2.1%) | 51.6 | 51.6 | - | 0.0% |
| MH Services - Other net expenditure | 0.5 | 0.4 | 0.1 | 16.7% | 1.8 | 1.8 | (0.0) | (1.1%) |
| **Community Health Services** | 49.8 | 50.2 | (0.4) | (0.8%) | 200.4 | 201.6 | (1.2) | (0.6%) |
| **Continuing Care Services** | 17.1 | 18.7 | (1.6) | (9.3%) | 70.5 | 75.3 | (4.8) | (6.7%) |
| **Primary Care Services** | 49.5 | 50.9 | (1.4) | (2.8%) | 187.3 | 194.5 | (7.2) | (3.8%) |
| Prescribing | 43.2 | 44.6 | (1.4) | (3.3%) | 162.0 | 168.4 | (6.3) | (3.9%) |
| Other Primary Care Services | 6.3 | 6.3 | 0.0 | 0.6% | 25.3 | 26.1 | (0.9) | 0.1% |
| **Other Commissioned Services** | 1.8 | 2.2 | (0.4) | (24.0%) | 7.1 | 9.2 | (2.1) | (29.8%) |
| **Other Programme Services** | 1.3 | 1.2 | 0.1 | 7.6% | 6.6 | 6.4 | 0.2 | 3.4% |
| **Reserves / Contingencies** | (7.8) | (9.3) | 1.5 | (19.2%) | (54.0) | (76.2) | 22.2 | (41.2%) |
| **Delegated Specialised Commissioning** | 34.0 | 34.0 | - | 0.0% | 143.3 | 143.3 | - | 0.0% |
| **Delegated Primary Care Commissioning** | 57.2 | 53.1 | 4.1 | 7.2% | 226.1 | 223.5 | 2.6 | 1.2% |
| Primary Medical Services | 40.6 | 39.4 | 1.2 | 3.1% | 162.5 | 159.8 | 2.6 | 1.6% |
| Delegated Dental, Ophthalmic and Pharmacy Services | 16.5 | 13.7 | 2.8 | 17.2% | 63.7 | 63.7 | - | 0.0% |
| Dental Services | 10.4 | 7.4 | 3.0 | 28.9% | 37.7 | 37.7 | - | 0.0% |
| Ophthalmic Services | 2.0 | 2.0 | 0.0 | 1.8% | 7.8 | 7.8 | - | 0.0% |
| Pharmacy Services | 4.1 | 4.3 | (0.2) | (5.1%) | 18.1 | 18.1 | - | 0.0% |
| **ICB Running Costs** | 3.0 | 2.9 | 0.1 | 2.8% | 12.2 | 12.4 | (0.2) | (1.8%) |
| **Total ICB Net Expenditure** | 490.9 | 490.9 | - | 0.0% | 1,941.2 | 1,941.2 | - | 0.0% |
| **TOTAL ICB Surplus/(Deficit)** | (4.1) | (4.1) | (0.0) | (0.0%) | 4.7 | 4.7 | 0.0 | 0.0% |

Item 5 (iv)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 5 (iv) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | Update on Cyber Assurance |
| **Report Author:** | Kathy Fulloway, Chief Digital and Information Officer, Lincolnshire Integrated Care System |
| **Presenter:** | Kathy Fulloway, Chief Digital and Information Officer, Lincolnshire Integrated Care System |
| **Appendices:** | |

| 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

This report is brought to the Board for information and to note the work happening in respect of Cyber Assurance across the NHS organisations in the Lincolnshire Integrated Care System.

It is recommended that the Board consider their role in creating the right environment and culture that supports good cyber security, and their role and responsibilities in supporting decision making and managing risk.

It is suggested that the Board consider holding a dedicated Board Development session to ensure a fuller understanding of this vital subject, to discuss roles and responsibilities in more detail and to provide the opportunity for more detailed considerations..

## Summary

**Scope**

The Lincolnshire Integrated Care System consists of all the organisations involved in delivering health and care services, however, this report focuses specifically on NHS organisations (NHS Lincolnshire Integrated Care Board, Primary Care GP practices that are serviced by Arden and GEM Commissioning Support Unit, United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust and Lincolnshire Partnership NHS Foundation Trust).

**Context**

Boards should seek assurance for both cyber security (preventing hackers from getting into online systems) and cyber resilience (ensuring we have the ability to detect, respond to and recover from a cyber-attack) across their own organisation. As we move to models of care supported by Integrated Care Systems and Community Primary Partnerships, how systems interact, are organised and how information is shared across multiple organisations adds a level of complexity.

In a modern healthcare system cyber incidents threaten our electronic systems which increasingly underpin and are business critical to everything we do such as healthcare delivery to patients and our population, operational mobilisation, communications, electronic storage, and business functions such as payroll, finance, recruitment, and so forth.

Cyber attacks occur because criminal gangs, individuals, or nation states attack our systems, or those of our suppliers or partner organisations. They do this for financial gain, state secrets and intelligence, or for the kudos or challenge.

It is evident that globally there is an increased threat of cyber-attack. To protect our patients, our staff and the continuity of our services we must give due consideration to ensuring we have appropriate controls in place for the associated risks.

**Risk**

There are several ways that cyber attackers seek to breach systems. The most common root cause are phishing attacks in which there is an attempt to trick our staff to download malware or divulge their login credentials, which can then be used to gain access or cause disruption. Sometimes SMS text messages are also used in a similar way which is called smishing. Other attack vectors include but are not limited to:

- exploiting vulnerabilities in the code of websites or applications.
- brute force attacks where passwords are ‘guessed’ by repetitive tries at possible combinations.
- stolen information is used (if other attackers publish it on the dark web, or if written information is mislaid for example).
- more sophisticated social engineering can be used to befriend, coerce or trick individuals into sharing information that will support an attack.
- with the rise of AI and deep fake there are emerging threats around impersonated authorisation that supports scams.

**Impact**

Whatever the reason, the impact of losing or having our systems disrupted, losing or suffering corrupted data, or being the victim of a scam results in operational disruption such as:

- being unable to effectively deliver or suffer delays in delivering healthcare services.
- being unable to operate or function as an organisation.
- being able to work alongside system partners, which impacts on their operations.
- stolen information can be used for identity theft and fraud.
- individuals’ confidentiality is breached.
- information on our systems can be corrupted or missing which has significant implications for healthcare delivery.

As a result the resulting harm can be:

- patients are harmed, distressed or suffer financially.
- organisations suffer significant costs of recovery (noting that the NHS does not pay ransom requests) (the recent Irish Health Authority cyber-attack is reported to have cost over 100m Euros to date).
- we suffer reputational damage and lose public confidence.
- staff find incidents upsetting, tiring and frustrating.
- the Information Commissioner's Office can fine organisations up to £17m if it deems that they have not managed risk appropriately or taken appropriate mitigations.
- furthermore, we put professionals in a position of risk as they make decisions relating to patient outcomes with incorrect or missing data.

**Responsibilities**

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. These regulations are intended to establish a common level of security for network and information systems, which play a vital role in the economy and wider society. NIS aims to address the threats posed to them from a range of areas, most notably cyber-attacks. Although NIS primarily concerns cybersecurity measures, it also covers physical and environmental factors. GP practices are not considered in scope of the regulations, but the ICB is.

NHS Providers recommend in a recent publication:

- Understand that every board member and senior leader has a role in keeping your system safer.
- Invest time in understanding your supply chain.
- Share skills and expertise system-wide, share your assets system-wide.
- Challenge your system to share learning openly.
- Don't underestimate the importance of building trusted relationships, support and collaboration.

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 (this is based upon the Cyber Assurance Framework outlined by National Cyber Security Centre). Typically, Committees/Sub-Committee work through detail to be assured on, such as:

- DSPT compliance
- Risks
- Responses (e.g. High Severity Alerts and patching)
- Multi Factor Authentication rollout
- Penetration test results
- Business continuity plan status
- Process (e.g. movers having rights provided/redacted as appropriate)
- Policy status
- Horizon scanning (emerging threats/opportunities for example how to safely use Artificial Intelligence)

There is support and resources available to Boards such as training and the National Cyber Security Centre provide a Cyber Security Toolkit for Boards to help them:

- Create the right environment
- Get the right information to support decision making
- Take steps to manage risks

**Preparedness and controls**

It should be recognised that cyber attacks **will** be attempted and are highly unlikely to be completely preventable. However, we can move from safe to safer; there are four key areas that we can consider our response and preparedness and where effort is well-spent.

1. **National support**

We should and do use the support of a national team at NHSE that provide monitoring and early threat warnings.
Cyber Security Operations Centre (CSOC) is part of the central cyber security team for the NHS in the Cyber Operations function of NHSE aiming to protect healthcare systems from cyber-attacks. CSOC is not a regulator. It acts as an enabler, helping leaders and employees across the system to deliver better cyber security within their health and care organisations. CSOC provides monitoring 24 hours, 7 days of the week, 365 days of the year. They provide support appropriately in incident management.
Local organisations are asked to locally deploy Microsoft Defender for Endpoints (MDE) and Secure Boundary as key to this work and elevates the protection CSOC can offer. We have done this in Lincolnshire. These tools enhance the visibility CSOC needs to help protect organisations locally as well as the NHS system as a whole.

2. **Legacy infrastructure and software**

As infrastructure and software gets older, suppliers choose a point in time to stop providing security updates. This means we cannot address vulnerabilities and mitigate risk of breached systems. Extended support can sometimes by bought from other companies but is time-limited as parts become more scarce or compatibility is no longer possible.

Replacing ageing and unsupported infrastructure and software reduces our cyber risk, which is why replacement schedules for telephony, IT equipment such as laptops and for servers and Wi-Fi devices seem like costs which can be deferred for short term savings but could have longer term implications. Data Security Protection Toolkit requires 95% of servers to be supported and 98% of end point devices (laptops, smartphones, etc) to be supported. Unsupported software can be embedded in other software or products and digital teams work to reduce and eliminate unsupported software. There is a small risk of 'Shadow IT' where electronic systems have been put in place without engaging digital teams although monitoring will often highlight where this is happening.

3. **Control measures such as Multi Factor Authentication (MFA)**

There are various technical controls we can implement to help reduce risk of attack, but the most effective is Multi Factor Authentication (MFA). All Lincolnshire organisations have implemented MFA wherever possible. It is most crucial on remote access systems, and those where there are privileged permissions (e.g. administrators who can change and configure systems). This is also essential for our suppliers.. There is a risk profile associated with this depending on the level of access and the information/data within a system or the business criticality of the system.

Other technical controls we use or are implementing are:

- Patching (applying updates to reduce opportunity for exploitation).
- Segmentation (so infections are ring fenced).
- Immutable backups (more secure from corruption once created if the source data was clean).
- Web and email filters (stop what looks malicious coming in or going out).
- Antivirus software (to spot and neutralise threats).

- Network Access Control (reducing the opportunity for connections to our network to create problems – connections may be valid such as printers, medical devices, but can also be malicious).

When implementing technical controls there will always be a balance to be found between how strong the technical controls are, versus operational ease and tolerable risk.

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 our systems. What our staff do can make a big difference to how much we can reduce our risk. Staff need training to have confidence in how to spot warning signs, how to keep safe and how to respond in an incident. Well-trained staff who report phishing emails that make it through our filters, who create strong passwords and keep these confidential, and remain vigilant to unusual activity, reduce the opportunity for attacks. They are vital in recognising early warnings if something is wrong, and this can help us limit damage and recover as quickly as possible.

**4. Resilience**

Business Continuity Plans outline how we will respond to incidents. We need to ensure we have these in place for all services and organisations, but also that they are practiced because in a real incident a response will be better coordinated and faster if staff know what they are doing and are well-prepared. All organisations aim to test BCPs annually and from time to time they are tested through genuine incidents (e.g. the global Crowdstrike incident).

BCPs need to account for long enough downtime. Cyber incidents duration is sometimes months. It can take days to establish the root cause, then systems often need to be rebuilt which takes time, clean backups found, and all the while contingency measures will need to be enacted. The process of recovery and retrospective data capture can understandably take time.

In addition to these areas, we also need in line with national guidance to develop an ICS cyber strategy and plan. This would support us considering and implementing:

- Opportunities for greater collaborative working at a system level which is not yet in place. Organisations are giving their own response due consideration, but we know from recent incidents that connectedness of organisations and how resilient we are in different scenarios is something we need to consider prior to an event. We need to agree as a system how we would use our resources together for greatest overall impact. As a system we need to test our plans through an ICS desktop exercise.

- We also need to better understand our supply chain in its fullest sense. We need to better understand our resilience and the impact of disruption if it were outside our control. Single suppliers provide us opportunity for economies of scale, for simpler third-party management, consistency and operational ease, however, this can also be a single point of failure and so as a system we should give due consideration to our approach and any principles we might want to adopt.

**Summary**

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.

The NHS in Lincolnshire is working closely in line with NHS E and CSOC guidance. Our IT teams across our organisations are continuously striving to keep our infrastructure safe and protected from cyber attacks in line with the national guidance. This requires continuous vigilance and updating not just from our IT teams, but also by our NHS workforce across the county.

The purpose of this paper is to provide the Board with assurance that the ICB and our NHS partners are working in line with national requirements.

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.

| **How does this paper support the ICB's core aims to:** | |
|---|---|
| Aim 1: Improve outcomes in population health and healthcare. | Defence against cyber-attack reduces risk of loss or disruption of our services and allows us to continue to provide health and care services which improves outcomes for the population. |
| Aim 2: Tackle inequalities in outcomes, experience and access. | Digital solutions underpin how we deliver services and address health inequalities. |
| Aim 3: Enhance productivity and value for money. | The cost of cyber attack is considerable (the recent Irish Health Authority cyber attack is reported to have cost over 100m Euros to date)<br>Productivity is significantly impacted by business continuity and workarounds after cyber incidents for months.<br>Recovery costs are significant. |
| Aim 4: Help the NHS support broader social and economic development. | Interactions with suppliers and system partners are affected if we suffer a cyber incident. |
| **Conflicts of Interest** | **Summary of conflicts** |
| No conflict identified | |

**Risk and Assurance**

Corporate Risk Register ref LICB 1.27 refers to Lincolnshire ICB risk of cyber-attack. Each NHS organisation in the Lincolnshire Integrated Care System has equivalent risks on their risk registers.

| **Implications (legal, policy and regulatory requirements)** | |
|---|---|
| Does the report highlight any resource and financial implications? | Not Applicable |
| Does the report highlight any quality and patient safety implications? | Yes |

| | |
|---|---|
| Does the report highlight any health inequalities implications? | Not Applicable |
| 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 ☒

Appendix One

**LINCOLNSHIRE HEALTH, CARE AND EDUCATION PARTNERSHIP**

**"OUR AMBITION"**

1. Background

   i) The Lincolnshire Health & Care and Colleges/Universities leaders have committed to building a strategic partnership which will maximise the opportunities of working together for the benefit of the population we serve. The purpose of this statement is to describe the shared five-year ambition that we are all driving towards.

   ii) There are approximately 35,000 jobs within health and care in Lincolnshire – 15,000 in the NHS and 20,000 in care.

2. "Our Ambition"

   i) For the people of Lincolnshire to be receiving great health and care services provided by a fully staffed and high-quality workforce who have received excellent advice and guidance, education and training for these roles.

   ii) For Lincolnshire to be as 'self-sufficient' as possible in 'growing our own' high quality health and care workforce.

   iii) For people across the county to be fully aware of, and engaged with, the prospect of having rewarding and meaningful jobs and careers in health and care in the county and being enabled and informed to join our health and care workforce.

   iv) For our partnership and approach to be recognised as one of the best in the country supporting rural and coastal communities which attracts the necessary funding to thrive.

   v) For people to be fully informed of and able to easily access excellent education and training through co-ordinated career pathways and programmes across the county.

3. To Achieve This We Will:

   i) Develop a strong, dynamic and innovative partnership which all partners will build, share, and contribute to. This will be underpinned by our Partnership Commitment.

   ii) Develop a five-year strategy which will describe how our partnership will achieve our ambition. This strategy will describe the key areas we will address.

   iii) Create and review an annual action plan, which will describe the actions we commit to delivering in the forthcoming 12 months, and how they will build year on year to achieving our five-year ambition.

   iv) The above work will be underpinned by our commitment to work together to service the people of Lincolnshire by supporting each partner to succeed to play their part to the fullest, and ensuring that 'the sum of the parts' is maximised. We have considerable experience, insights, perspectives, talented staff, networks and resources at our disposal – we will support and enable each other, our teams and organisations to work together to deliver our ambition.

**Health, Care & Education Partnership**

**Dated Jun 24**

# LINCOLNSHIRE ICS AND EDUCATION PARTNERSHIP PROPOSAL

## Statement of Purpose

1. Leaders across Lincolnshire's Health & Care and Further and Higher Education sectors are 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.

2. Our intent is to create an integrated and proactive trusted partnership between us which empowers communities across Lincolnshire to access skills, education and experiences and in doing so to equip and enable individuals in the county to become members of our health and care workforce into the future.

3. In doing so, our partnership will aim to match training and education with the dynamic needs of the health and care sector in Lincolnshire across the broad range of skills including both direct care and the many essential support functions.

4. Every member of our partnership has an important contribution to make and as such will have a vital part to play. By working in partnership, we aim to maximise the potential contribution everyone can make, and in doing so that the 'sum of the parts' is as comprehensive as possible to meet the needs of the county.

5. There are already many strong foundations in place with our growing partnership and much to be proud of and to build on as we create and deliver a programme of change in the years ahead. Our partnership and work programme will evolve as it moves forward, and we will work together to innovate, take necessary risks, remove barriers to change, and grow our collective work for the benefit of people across the county, our health and care system, and our institutions.



Bishop Grosseteste University

Boston College

Grantham College

Inspire education group (Peterborough & Stamford College)

Lincoln College

Lincolnshire Care Association (LinCA)

Lincolnshire Community & Hospitals Group

Lincolnshire Partnership NHS Foundation Trust

Lincolnshire Voluntary Engagement Team (LVET)

NHS Lincolnshire Integrated Care Board

University of Lincoln

Item 6 (i)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 6 (i) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | Board Forward Plan 2024/25 |
| **Report Author:** | Gerry McSorley, Acting ICB Chair<br>Jules Ellis-Fenwick, ICB Board Secretary |
| **Presenter:** | Dr Gerry McSorley, Acting ICB Chair |
| **Appendices:** | Appendix 1 - Board Forward Plan |

| 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:

- Consider the Board Forward Plan for 2024/25 and identify any amendments/comments.
- Note any amendments will be incorporate as appropriate with the updated version circulated to the Board for information.

## Summary

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, specifically identifying the reports which will be regularly presented for consideration.

The Forward Plan is one of the key components in ensuring that the Board is effectively carrying out its role in leading the organisation and has plans in place to deliver its strategy and achieve a balanced budget position. It is also a key mechanism by which appropriately timed governance oversight, scrutiny and transparency can be maintained in a way that does not place an onerous burden on those in executive roles or create unnecessary or bureaucratic governance processes.

The Board Forward Plan has been prepared based on the Board meeting dates agreed for 2024/25 and reflects good practice.

The Board is asked to consider the document and identify any amendments/comments which will be incorporated as appropriate. The final document will be then circulated to the Board for information.

**Development Session**

The following sessions have been arranged to date:

| DATE AND TIME | TOPIC |
|---|---|
| Tuesday, 27th August 2024 (subject to confirmation) | To be confirmed. |
| Tuesday, 29th October 2024 | Safeguarding Training<br>Board Development |
| Tuesday, 17th December 2024 | To be confirmed. |
| Tuesday, 25th February 2025 | To be confirmed. |

| 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 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

# DRAFT BOARD FORWARD PLAN
# 2024/25

| ITEM | 28/05/24 | 30/07/24 | 24/09/24 | 26/11/24 | 28/01/25 | 25/03/25 |
|---|---|---|---|---|---|---|
| 1. INTRODUCTION | | | | | | |
| i) Welcome and apologies | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ii) Confirmation of Quoracy | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| iii) Declarations of Interest | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| iv) Minutes of the previous meeting (for approval) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| v) Action Log (Matters Arising) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2. CHAIR AND CHIEF EXECUTIVE UPDATES | | | | | | |
| i) Chair update | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ii) Chief Executive update | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3. KEY UPDATES | | | | | | |
| i) Public Health | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ii) Healthwatch | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4. POPULATION HEALTH PLANNING | | | | | | |
| i) Supporting the CORE20Plus 5 Children and Young People – Oral Health | ✓ | | | | | |
| ii) Update on the Primary Care Access Recovery Plan | ✓ | | | | | |
| iii) Draft Research and Innovation Strategy | | ✓ | | | | |
| iv) Health Inequalities Annual Report 2023/24 | | ✓ | | | | |
| v) Health Inequalities Update (standing item) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 5. SYSTEM OVERSIGHT AND ASSURANCE | | | | | | |
| i) Integrated Quality and Performance Report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ii) System Financial Report | | ✓ | ✓ | ✓ | ✓ | ✓ |
| iii) ICB Budget 2025/26 | | | | | | ✓ |
| iv) Operational and Financial Planning 2025/26 | | | | | | ✓ |
| v) GP Collective Action | | ✓ | | | | |
| vi) Update on Cyber Assurance | | ✓ | | | | |
| vii) Lincolnshire Health, Care and Education Partnership “Our Ambition” | | ✓ | | | | |
| viii) Winter Planning | | | ✓ | | | |
| 6. GOVERNANCE | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| i) | ICB Annual Report and Accounts 2023/24 | | | ✓ | | | |
| ii) | Board Assurance Framework | | | ✓ | | | |
| iii) | ICB Constitution - amended | | | ✓ | | | |
| iv) | Amendments to the ICB Governance Handbook | ✓ | | | ✓ | | |
| v) | Briefing Summary of the East Midlands Joint Committee Meetings | ✓ | ✓ | | | | |
| vi) | Draft Board Forward Plan 2024/25 | | ✓ | | | | |
| **7. COMMITTEE HIGHLIGHT REPORTS** | | | | | | | |
| i) | Report from the System Quality and Patient Experience Committee (QPEC) | ✓ | | | | | |
| ii) | Report from the Service Delivery and Performance Committee | ✓ | | | | | |
| iii) | Report from Audit and Risk Committee | | | ✓ | ✓ | ✓ | ✓ |
| iv) | Report from the Primary Care Commissioning and Delegated Functions Committee | | | ✓ | | ✓ | |
| v) | Audit and Risk Committee Annual Report 2023/24 | ✓ | | | | | |
| **8. INFORMATION / CLOSING ITEMS** | | | | | | | |
| i) | Register of Documents Sealed 1st April 2023 to 31st March 2024 | ✓ | | | | | |
| ii) | Declaration of Interest Registers as at May 2024 | ✓ | | | | | |
| iii) | Risks identified during the course of the meeting | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

Item 07 (i)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 7 (i) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | Update from the Service Delivery & Performance Committee – May and June 2024 |
| **Report Author:** | Dawn Kenson, Non-Executive Director and Chair of Service Delivery & Performance Committee |
| **Presenter:** | Clair Raybould, Executive Director for System Delivery |
| **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

**<u>May 2024</u>**

**Home Visiting Report**

The Committee received on update report regarding Home Visiting following a deep dive requested at the UEC Programme Delivery Group.

The data demonstrated an improvement in responsiveness in January and February, with a slight dip in March 2024 when there was an increase in demand across the entirety of UEC. It was reported that additional staff continue to be onboarded within the service and additional clinical working hours and shift changes to match demand have been implemented. Closer working between home visiting and community nursing (as part of unplanned care clinical response) would continue improving responsiveness within the home visiting service. Operational oversight continues on a daily basis to ensure grip and rigor over performance.

**Winter Wash Up**

The Committee received a presentation on the Winter 23/24 comparison with 22/23.

Overall, demand across the system increased and improvement in performance was evidenced towards the end of winter.

Although impacted by industrial action, ambulance category 2 mean response times were more stable in 23/24, the previous year saw significant deterioration from mid-December to early January and then improvement throughout March. Similarly, with the handover position, the increase in delays in December 22 was not experienced in December 23. However, the post-handover times trended significantly above last year – improvement of this metric is a priority in this year's contract planning.

Type 1 demand was lower than last year, as would be expected due to the shift of work to the Grantham UTC. However, the performance on average worsened, partly due to the acuity of the resultant case mix. The focus to achieve the 4-hour target of 76% in March 24 saw improvement and this continues into 24/25.

Type 3 activity was consistently above plan, performance reduced overall and was quite variable at Grantham. The standalone sites generally performed better than those co-located. As with Tier 1, the focused work in March 24 provided evidence of improvements in performance.

Acute bed occupancy remained in line with the previous year though there were periods in 23/24 when it was lower, making occupancy more challenging but also reflecting that the increased demand was managed with a lower level of capacity. There were 20 extra non-acute beds (in addition to core Community Hospital beds) open in 23/24 over 22/23 levels.

Important metrics looking forward would be average length of stay, the number of discharges per day and the number of admissions, and assurance was given re the Group's work on this.

It was confirmed that the impact of capacity in social care was considered in the planning, it was very much a combined approach between health and social care and the associated costs for care at home, in the community and in an acute setting were fully accounted for.

This year's winter planning process has already started in the form of initial discussions and has been included within the system plan.

**Children and Young People (CYP) Neurodiversity Services**

A report regarding Neurodiversity Services for CYP in Lincolnshire was presented to the Committee, highlighting the current challenges in meeting demand for, in particular, the autism diagnostic pathway, ADHD and Speech and Therapy Services (SALT).

Nationally there has been significant increases in demand over the last two years and this is reflected in Lincolnshire where referrals numbers have risen steadily post pandemic and are now averaging over 100 per month, with growing waiting lists and wait times.

There are capacity/resource issues to be considered in tackling this and work on options for new cross system pathways is to be completed to provide options for improving service delivery.

**Performance Report 23/24**

The Committee reviewed the dashboard for the 2023/24 outturn and April's data for UEC and ambulance performance.

The new targets for 2024/25 were also highlighted in the monthly report.

**Statistical Process Control**

A presentation was given regarding SPC and the Committee discussed its potential use for future reporting.

**June 2024**

**Palliative/End Of Life/Primary Care**

The report presented was to update the Committee on the detailed analysis and insights into palliative and end of life care delivery and performance across Lincolnshire and the progress of the plans to implement a new model of PEOL care.

The model was co-designed with partners and stakeholders and, focusing on the needs of individual patients, will be coordinated and delivered within Primary Care Networks, supported by local, integrated multi-disciplinary health and social care teams.

Agreement to support the implementation of a strategic commissioning arrangement for PEOL is in place and work is now under way on a full business case.

**Key Targets**

The three key areas of focus at the moment are Elective, Cancer and A&E.

The Elective 65-week trajectory was impacted by the recent industrial action with June expected to have 473 waiting against an original target of 418. The September target of zero remains in place.

Cancer performance remains stable and overall positive, though some funding risks exist and a number of bids have been submitted to the national team.

In relation to emergency care, May's performance dipped but June so far is showing some improvement to 73% against a trajectory of 75%. Tier 1 has been challenged across all of the system providers in relation to the 4-hour target, hand over delays and 12 hour ED waits. The UTCs have performed well, reaching 98% on 4 hours on some days.

The Psychiatric Intensive Care Unit (PICU) has reopened and resulted in a welcome reduction of out of area placements.

The potential collective action by GPs being called for by the BMA was noted.

**2024/25 Operational Planning**

The Committee considered and supported the latest version of the 2024/25 Operational Plan, noting it reflects the investment decisions that the system has made, including achieving a balanced financial plan.

**Dashboard**

The updated dashboard report was presented to the Committee to provide oversight on progress for the key deliverables within the 2024/25 Operational Plan. The report has been formatted into the planning domains detailed in the planning guidance and accompanied with monthly updated narrative from system programme leads for each planning domain.

| **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 ☒

Item 7 (i)

NHS
Lincolnshire
Integrated Care Board

# PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

| | |
|---|---|
| **Agenda Number:** | 7 (i) |
| **Meeting Date:** | Tuesday, 30th July 2024 |
| **Title of Report:** | System QPEC (Quality and Patient Experience) Committee |
| **Report Author:** | Sharon Robson, Non-Executive Director (Chair)<br>Martin Fahy, Director of Nursing<br>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 2nd July 2024 and focused on the following agenda items:

- **System Quality Strategy:** it was noted that work is ongoing in aligning the Strategy to the various quality priorities and that the Strategy will be shared with members at a later date for review and comment.

- **HealthWatch Update:** it was reported that two main areas of concern have been highlighted that relate to the wheelchair service and access and diagnosis to the autism service. Examples of case studies were shared with members. It was noted that work is taking place to mitigate the issues and concerns raised and that an update would be provided at the next meeting. In addition, a patient communications message providing clarity and expectations regarding the provision of autism services would be developed and shared.

- **EDI (Equality, Diversity and Inclusion) Update:** it was noted that an update had been provided at the February 2024 Board Development session and subsequent to this four objectives had been published:-

  1. ***Objective 1***: ICB Leaders to drive the EDI agenda and create a sense of belonging through the delivery of measurable objectives.
  2. ***Objective 2***: Strive to create a compassionate, diverse and inclusive culture by fostering an ethos across the ICS of wellbeing, inclusion and belonging.

3. ***Objective 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.
4. ***Objective 4***: To 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.

It was noted that a forward plan is in place for each of these areas and that an Equality, Diversity and inclusion Strategy will be formulated. Engagement events with stakeholders and patients and the public to help inform and shape the Strategy will take place.

- **Parliamentary and Health Service Ombudsman Recommendations:** an update was provided in relation to the publication of the recommendations and the requirement to review the case of the individual and the requirement for the Individual Funding Request and Prior Approval Policy to have a clear exceptions policy which is more sensitive to the needs of individuals. It was reported that work has commenced on reviewing the Policy of which is due to draw to a conclusion in mid November.

- **FTSU (Freedom to Speak Up) Themes 2023/24:** it was reported that the FTSU process was launched within the ICB in December 2022 and a Guardian and Champions appointed. It was noted that the number of contacts for the ICB were low and predominantly cases that had been reported related to primary care. Work is taking place to establish freedom to speak up arrangements for primary care, pharmacy, optometry and dental reporting and that the learning from Lincolnshire is being shared regionally as a blueprint for implementation within other systems.

- **Enhanced Health in Care Homes Programme Deep Dive:** a presentation was provided on the Enhanced Health in Care Homes project. It was noted that national guidance had been re-launched in November 2023 of which the main focus had been to ensure that Care Homes have a supportive network within the Community and GP teams.

  It was reported that work has been taking place with the Lincolnshire PCN's on the framework which focusses on personalisation, health and wellbeing, proactive care, teamworking across boundaries, multi-disciplinary team meetings and being the voice between residents and staff.

  An annual review is undertaken against the key areas. An update was provided on the comprehensive support provided in relation to the ReSPECT forms, falls prevention and roll out of Whzan. Discussions took place regarding the initiatives that have been put in place and the impact that these have had. It was suggested that a future Board Development session receive a presentation in relation to this area.

- **Lincolnshire Community and Hospitals NHS Group Highlight Report:** an emerging risk was reported in relation to the management of pressure ulcers and the number of Section 42's. It was noted that an in-depth review has been undertaken and that oversight will remain in place until improvements are seen. Discussions took place regarding the United Lincolnshire Hospitals NHS Trust mortality unit and the refurbishment work that is currently taking place and the security processes in place. An update was given on the work taking place to reduce the backlog with Echo's. Progress was noted with the Regional Maternity Heat Map and that this had moved from an amber to a green rating. It was noted that the Trust has been shortlisted for two Health Service Journal Awards with the Skegness and Mablethorpe Community Nursing Teams being shortlisted for a project with Health Innovation East Midlands transforming wound care and ULHT Patient Safety Partners shortlisted due to the successful implementation across the Trust and has included improvement programmes, recruitment panels, ward assurance visits and much more.

- **LPfT Highlight Report:** an update was provided in relation to the previously reported risk for the Front Door capacity issues and that funding for two posts has been approved and an Interim Head of Safeguarding has been put in place to cover short term sickness. It was reported that the CQC visit to Ash Villa had concluded that a rating of Good was received with no required actions.

It was noted that the PICU unit had re-opened. In terms of learning from experience it has been highlighted that work is required on the transfer of care from the Trust to ULHT to reduce the risk of miss treatments.

- **EMAS Highlight Report:** an update was provided on the recruitment processes that have been undertaken and the improvements in the workforce trajectory. In terms of performance against the Category 2 (30 minute) target, improvements are being made. It was noted that there had been some issues reported with the clinical quality metrics and that specific training had been provided particularly in relation to patients suffering a cardiac arrest and following this 100% compliance has been reported. It was noted that work is also taking place with the Ministry of Defence and the utilisation of paramedics with EMAS at a reduced cost which benefits both organisations in developing the skill mix and additional workforce.

- **Primary Care Update including Primary Care Commissioning Committee Update:** an update was provided in relation to the Sidings Practice and that steady progress is being made against the CQC Action Plan with the ICB Quality and Primary Care Teams are continuing to provide support. In terms of the Sutterton Practice the issues previously reported have now been resolved the issues previously reported are being reviewed and the individual is no longer working at the Practice. A final highlight report will be produced. An emerging risk has been highlighted in the delay with the timeliness of reporting on clinical systems and those used within community pharmacies. An incident at Cleveland Surgery resulted in the need for a rapid quality review to be established to check for risks to patient safety. The review concluded that sufficient quality and safety oversight was place and patient safety was not compromised. The Caskgate Practice has recently been re-inspected by the CQC and the outcome of the report awaited.

- **Operational Quality Assurance Group Update**: it was reported that there are four areas of concern for providers that relate to:-

    1. LCHS (Lincolnshire Community Health Services NHS Trust) and the Lymphoedema Service; Children & Young People (CYP) Speech & Language Therapy (SLT); Community Nursing; Pressure Damage; Continence Service; and Looked After Children (LAC)
    2. North West Anglia Foundation Trust – Compliance with Boarding policy/guidance
    3. NRS Healthcare – wheelchair waiting list backlog
    4. LIVES and the previous quality concerns raised and recent media interest.

    It was noted that two new risks have been added to the Operational Quality and Assurance Group risk log - complaints and ability to report through ICB governance due to a backlog in logging complaints activity; and increase in LCHS Section 42 enquiries.

- **System Quality Group Update:** an update was provided in relation to the Children and Young Peoples Continence Service that has been challenged and that additional recruitment has recently been put in place to mitigate the risk. It was noted that an update from Public Health had been provided on assurance visits to Funeral Homes and that United Lincolnshire Hospitals NHS Trust had shared their mortality information. In terms of thematic reviews an update had been provided on pressure ulcers and tissue viability, homelessness services, specialised commissioning for mental health and transforming care.

- **System Quality Priorities Register:** it was noted that a new risk has been added in relation to TB and hematology with these being fragile services. Discussions took place regarding communicable diseases and that there has been two measles cases recently reported of which does not present an issue at present, both cases have been isolated and from the same family.

**Items for escalation to the ICB Board:-**

- The intelligence received from HealthWatch in relation to the concerns raised regarding the autism and neuro-diversity pathways.
- Progress with the Equality, Diversity and Inclusion update against the workplan.

- Parliamentary and Health Service Ombudsman Recommendations to develop an exceptions policy for unique conditions.
- Strengthened arrangements with the Freedom to Speak up arrangements for primary care and Pharmacy, Optometry and Dental.
- Enhanced Health in Care Homes and uptake in use of the Raizer Chairs and Whzan and an update to be presented at a future Board Development session.
- United Lincolnshire Hospitals NHS Trust Maternity Heat Map and the progress made.
- Health Service Journal Awards and the Skegness and Mablethorpe Community Nursing Teams that have been shortlisted for a project with Health Innovation East Midlands transforming wound care and ULHT Patient Safety Partners have been shortlisted due to the successful implementation across the Trust and has included improvement programmes, recruitment panels, ward assurance visits and much more.
- East Midlands Ambulance Service quality improvements that are being made with the Category 2 (30 minute) target.

| **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 ☒ | | | |

# Briefing Summary of the East Midlands Joint Committee Meeting held on Tuesday 18 June 2024

## 1. Purpose

1.1. This **ADVISORY** report is presented to provide a summary of the East Midlands Joint Committee meeting held on Tuesday 18 June 2024.

1.2. Specialised Commissioning Integrated Assurance Report and Directors Report

Through the presentation of this paper the committee received assurance on the current status on matters relating to the 59 delegated services. Specific discussions centred on the 2024/25 financial plan and current performance against plan, the treatment of reserves and, the composition of month 2 ICB allocations and anticipated position for month 3. It was confirmed that contingences would be held by NHS England (NHSE). Confirmation of alignment between clinical / quality oversight and the Joint Committee was received alongside a commitment of focus on quality improvement and shared learning.

The committee supported the establishment of a Midlands Executive Leadership Group consisting of lead ICBs and NHSE representatives, and for this group to jointly oversee the delivery of the current delegated arrangements and the mobilisation of future specialised services delegation and staff transferring in 2024/25.

1.3. Primary Care Finance and Assurance Report

Through the presentation of this paper the committee received assurance on the current status of delegated Dental, Community Pharmacy and Optometric services. The committee approved the recommended opening recurrent balance transfer for 2024/25 reflective of the same action undertaken in 2023/24, noting the undertaking of this negated any need for risk share arrangements.

1.4. Dental Services Commissioning Plans Briefing

The committee received an update on overall work being undertaken by the hosted team, the national guidance with regard to dental services planning, progress made on the Oral Health Needs Assessment, and the actions underway/ planned to develop the 2024/25 Dental Plan. The committee agreed draft dental plans need to be developed through local engagement within each ICB area, having taken into account locally determining factors and engagement with key local partners. The committee considered the timeframes for development, concluding these need to be challenging but realistic when balancing the engagement required and need to conclude as soon into the year as possible. The committee set an expectation for local engagement to be undertaken in the coming months to enable plan sign off in October.

1.5. Update 111/999 Governance Arrangements

The committee received an updated proposal on the future governance arrangements for the commissioning of NHS 111 and 999 services, agreeing that each ICB Board should receive a paper sponsored by its Chief Executive Officer seeking:

- Delegation of strategic decision making to the East and West Joint Committee for NHS111, and Emergency Ambulance (East) including the lead commissioner arrangements.

• Delegation of operational leadership to Derby and Derbyshire ICB as lead commissioner for both NHS111 and 999 commissioning.

## 2. Recommendation

2.1. This briefing summary is provided for information to be noted.