

# Public Board Meeting of the Lincolnshire Clinical Commissioning Group (CCG)

To be held on  
Wednesday, 29<sup>th</sup> June 2022 at 9.30 am

**This meeting will be held virtually**

## BOARD MEETING - PUBLIC

<b>DATE</b>	Wednesday, 29 <sup>th</sup> June 2022
<b>TIME</b>	9.30 am
<b>VENUE</b>	To be held virtually as a Live Event

### AGENDA

ITEM NUMBER	ACTION	ENCLOSURE /VERBAL	LEAD	TIME	
<b>STANDING ITEMS</b>					
1.	Welcome and Introduction from the CCG Chair <ul style="list-style-type: none"> <li>- Apologies for Absence</li> <li>- Declarations of pecuniary and non-pecuniary interests and conflict of interests</li> <li>- Questions from the Public</li> </ul>	-	Verbal	All	9.30
2.	Minutes of the previous meetings held on 25 <sup>th</sup> May 2022 and 15 <sup>th</sup> June 2022 <ul style="list-style-type: none"> <li>- Matters arising</li> <li>- Action Log</li> </ul>	Approve  Receive	Enclosures  Enclosure	All  Dr Gerry McSorley	9.35
3.	Update from the CCG Chair and Chief Executive	Note	Verbal	Dr Gerry McSorley & Mr John Turner	9.40
<b>GENERAL ISSUES</b>					
4.	<b>COVID-19 Pandemic Update</b> 4.1 Report in relation to the NHS System and CCG response to COVID-19 Pandemic 4.2 Public Health update 4.3 Healthwatch update	Note  Note Note	Enclosure  Verbal Verbal	Mrs Clair Raybould  Professor Derek Ward Mrs Sarah Fletcher	9.50  10.00 10.10
<b>QUALITY, PERFORMANCE AND PATIENT EXPERIENCE</b>					
5.	Integrated Performance Report	Note	Enclosure	Mr Martin Fahy	10.20
<b>FINANCE</b>					
6.	CCG Finance Report – Month Two	Verbal	Verbal	Mr Matt Gaunt	10.30
<b>STRATEGY AND PLANNING</b>					
7.	Update on the establishment of NHS Lincolnshire Integrated Care Board from 1 <sup>st</sup> July 2022	Note	Verbal	Mr Pete Burnett	10.40

<b>BREAK</b>					
<b>GOVERNANCE</b>					
8.	Final CCG sign-off and Due Diligence handover to the ICB, including the Risk Register	Approve	Enclosure	Mr Pete Burnett	11.00
9.	CCG documents sealed 1 <sup>st</sup> April 2022 to 30 <sup>th</sup> June 2022	Receive	Enclosure	Mrs Ellis-Fenwick	11.10
10.	CCG Final Declaration of Interest Registers 1 <sup>st</sup> April 2022 to 30 <sup>th</sup> June 2022	Receive	Enclosure	Mrs Ellis-Fenwick	11.15
<b>MINUTES FROM COMMITTEES, ESCALATION REPORTS AND TERMS OF REFERENCE</b>					
11.	Report from the Quality and Patient Experience Committee meeting held on the 7 <sup>th</sup> June 2022, including Committee handover to the ICB	Receive	Enclosure	Mrs Fenella Chambers	11.20
12.	Report from the Audit and Risk Extraordinary Committee meeting held on the 15 <sup>th</sup> June 2022, including Audit and Risk Committee Annual Report 2021/22, CCG Risk Register and Committee handover to the ICB	Receive	Enclosures	Ms Sue Liburd/ Mrs Ellis-Fenwick	11.30
13.	Report from the Primary Care Commissioning Committee held on the 15 <sup>th</sup> June 2022, including Committee handover to the ICB	Receive	Enclosure	Dr Gerry McSorley	11.40
<b>INFORMATION</b>					
14.	Reflections on the work of the CCG and advent of NHS Lincolnshire Integrated Care Board (ICB)	Note	Verbal	Dr Gerry McSorley/ Mr John Turner	11.50
15.	Close				12.00

Papers are available on the **CCG website** at [www.lincolnshireccg.nhs.uk](http://www.lincolnshireccg.nhs.uk)  
In case of difficulty accessing the papers, please contact – Jules Ellis-Fenwick, CCG Board Secretary on  
07825 938794 or via email as above

Confidential Motion: The Board will resolve 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 on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960)

**MINUTES OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP BOARD  
MEETING HELD VIRTUALLY ON WEDNESDAY, 25<sup>th</sup> MAY 2022 AT 9.00 AM**

<b>PRESENT:</b>	Dr Gerry McSorley	Acting CCG Chair
	Dr Majid Akram	GP and Clinical Lead, South Locality
	Dr Dave Baker	GP and Clinical Lead, South West Locality
	Dr David Boldy	Secondary Care Doctor
	Mrs Fenella Chambers	Non-Executive Director
	Mr Matt Gaunt	Director of Finance and Contracting
	Mr Martin Fahy	Director of Nursing and Quality
	Mrs Janet Inman	Non-Executive Director
	Ms Sue Liburd	Non-Executive Director
	Dr John Parkin	GP and Clinical Lead, West Locality
<b>IN ATTENDANCE:</b>	Mrs Jules Ellis-Fenwick	CCG Corporate Board Secretary
	Ms Charley Blyth	Director of Communications and Engagement
	Mr Pete Burnett	System Strategy and Planning Director
	Mr Peter Edwards	Capsticks (part three only)
	Mrs Sarah Fletcher	Healthwatch Representative
	Mr Andy Fox	Consultant in Public Health (part one only)
	Dr Sunil Hindocha	GP and Chair of the Primary Care Alliance (part two only)
	Mr Kester Holmes	Opinion Research Services (ONS) (part two only)
	Mrs Sarah-Jane Mills	Chief Operating Officer, West Locality
	Mrs Clair Raybould	Director of Operations (lead for South West Locality)
	Mr Andy Rix	Chief Operating Officer, South Locality
	Mrs Sandra Williamson	Chief Operating Officer, East Locality
	Mr Charlie Wilson	Opinion Research Services (ONS) (part two only)
	Mr Bruce Whitear	The Consultation Institute
<b>APOLOGIES:</b>	Mr Pete Moore	Non-Executive Director
	Dr James Howarth	GP and Clinical Lead, East Locality
	Mr Graham Felston	Non-Executive Director
	Mr John Turner	Chief Executive
	Professor Derek Ward	Director of Public Health
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board

**22/386 WELCOME AND INTRODUCTIONS**

Dr McSorley welcomed everyone to the Lincolnshire CCG Board and confirmed the meeting was quorate.

Dr McSorley advised that the agenda for the meeting was very lengthy and as such had been split into three parts: standard governance Board business in part one and parts two and three would focus on the work that has been underway in relation to the Acute Services Review (ASR).

Dr McSorley advised the meeting was being held via Microsoft Teams as a live event as has been regular practice for the last two years since the CCG was established on the 1<sup>st</sup> April 2020.

Dr McSorley emphasised that this is a meeting held in public and not a public meeting.

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

One question had been received which was in relation to parts two and three of the meeting.

**Ms Jody Clark** – If the public consultation is approved today, how long until Grantham Hospital gets the 24hr UTC?

It was noted that the question and response would be picked up under Part Two/Three of the meeting. The question and response would also be attached to the minutes of the meeting and published separately on the CCG website in line with usual practice.

The Board Members and those in attendance were asked to remain 'muted' until they wished to ask questions which will be monitored throughout the meeting and requested to ensure they introduced themselves either when presenting items or asking questions.

**22/387**

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

Declaration of Interest from Committees:  
No items declared.

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

The Board agreed to:

- **Note the interest as declared.**

**22/388**

### **MINUTES OF THE PREVIOUS MEETING**

The minutes from the previous meeting held on 27<sup>th</sup> April 2022 were presented and the Board agreed to:

- **Approve the minutes as a true record subject to the following amendment:**
  - Dr James Howarth and Mr Martin Fahy's titles were listed the wrong way round.

**22/389**

### **MATTERS ARISING**

Dr McSorley presented the Action Log from April's meeting, which included two items identified as in progress. Mr Fahy advised that the first action had been included in the latest version of the Integrated Performance Report, which was included in the pack of papers for consideration.

An update on the second item would be picked up under the presentation of the Integrated Performance Report; therefore both actions could be closed.

The Board agreed to:

- **Note the Action Log and verbal update.**

## **UPDATE FROM THE CHAIR AND CHIEF EXECUTIVE**

Mr Gaunt provided the Chief Executive update in the absence of Mr Turner and highlighted the following points:

- Operational delivery continued to be an area of concern, specifically in respect of urgent and emergency care which remained under significant pressure.
- The Lincolnshire system continued to operate at high levels of escalation and the volume and acuity of public and patient demand on services remained extremely challenging.
- This continued to be the same picture replicated across the East Midlands region and nationally.

Mr Gaunt advised that he was sure the Board would agree that a huge amount of gratitude is owed to thousands of colleagues across the health and social care system who continue to provide the best service as possible in the face of unrelenting pressure. As usual, Mrs Raybould's paper included in the pack and her supporting verbal update would provide more information.

Since the Board had last met the Health and Social Care Bill had received Royal Assent and Integrated Care Boards will be established from the 1<sup>st</sup> July 2022 and CCGs will be legally dissolved. NHS Lincolnshire CCG will continue to discharge its duties and responsibilities until the 30<sup>th</sup> June 2022. This Board meeting is the penultimate one of the CCG Board, with the last meeting taking place on the 29<sup>th</sup> June 2022.

The transition arrangements for the move to an ICB and CCG close down had been progressing for a number of months and led by the ICB Transition Programme Board with oversight, scrutiny and assurance provided through the Audit and Risk Committee. CCG staff have been kept informed of the position with regular updates provided through a range of communications, including the regular Monday morning weekly briefings, Team Talk News and staff events. A formal consultation process for all CCG staff had also been carried out during April/May 2022 and positive feedback had been received.

The Lincolnshire Financial Plan was submitted on the 28<sup>th</sup> April 2022 and included the CCG plans for elective recovery, systems improvement and financial recovery. The key headline from the plan is the elective recovery target to achieve 104% of 2019/20 activity. The Lincolnshire system in common with every other one across the East Midlands did not achieve a balanced financial position, with a £33m deficit. Since the plan was completed NHS England have announced there is a further planning round which will conclude on the 20<sup>th</sup> June 2022. Further detail will be provided under the paper on the CCG Financial Plan and Budget to be considered later in the meeting.

The Board was advised that a year has passed since the recovery support programme was launched as a successor to the previous improvement regime. On the 7<sup>th</sup> June a number of colleagues from systems who are in the recovery and support programme will attend a national face to face conference to share learning and celebrating success. The conference will also cover the impact on the recovery support programme. Mr John Turner, Chief Executive and Mr Andrew Morgan, Chief Executive, United Lincolnshire Hospitals NHS Trust (ULHT) will be attending the event to share their experiences of the Lincolnshire recovery support programme.

The previous week the latest Quarterly Review meeting took place, which was Chaired as usual by NHSE regional colleagues and led by Mr John Turner on behalf of CCG and Lincolnshire provider colleagues. It was a challenging but overall positive meeting.

On a final note, the Board will be asked to consider and approve the Decision Making Business Case in relation to the Acute Services Review later in the meeting, which is the accumulation of a vast amount of work over a significant number of years with input from the CCG and partner organisations and a wide range of stakeholders.

Dr McSorley advised that he had a few points to highlight to the Board for information:

- Dr McSorley had attended a number of meetings in respect of primary care services in recent weeks, in particular conversations in relation to the transfer of commissioning services for community pharmacy, dentistry and ophthalmology that will take place when the ICB is established in July 2022.
- Dr McSorley had also met on several occasions with Sir Andrew Cash, Interim ICB Chair Designate regarding the handover arrangements between the CCG as it comes to a close on the 30<sup>th</sup> June 2022 and the ICB when is established on the 1<sup>st</sup> July 2022.

The Board agreed to:

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

22/391

## **REPORT IN RELATION TO THE NHS SYSTEM AND CCG RESPONSE TO THE COVID-19 PANDEMIC**

Mrs Raybould presented the latest report in relation to the NHS system and CCG response to the COVID-19 pandemic and advised that she would take the report as read but wished to highlight the following points:

In Lincolnshire, as in the rest of the country, there has been a decline in the impact of COVID-19 cases on services, staff, and the population over the last month but we do still continue to see the impact from the longevity of the pandemic upon the health of the population and services.

Mr Fox would provide an update on the current COVID infection rates as part of the Public Health update but added that it remained vitally important for people to come forward for the Spring booster if they had not done so already. It does provide additional protection over the vaccines they have already had.

Over the last month hospital admissions have decreased from the peak in April but remain four times higher than the same time last year and with a 7-day average of 27 as of today's meeting.

Further guidance had been received across the NHS in relation to COVID-19 Infection Prevention and Control (IPC) measures at the end of April, which has been reviewed across the system in respect of the impact on all providers and staff. Many services are now able to operate at pre-pandemic levels which does increase capacity and supports recovery but there are still measures in place to protect vulnerable patients and staff such as wearing face masks in some health settings, testing where appropriate and social distancing requirements.

### **Emergency Planning, Resilience and Response (EPRR)**

Since the Board report was written all ICSs, CCGs and NHS Trusts have received a letter, dated the 19<sup>th</sup> May 2022, outlining the next steps in terms of transition from COVID-19 response to recovery.

The key points are in the letter were highlighted as follows:

- With community cases and inpatient numbers declining due primarily to the success of the winter and spring vaccine boosters the NHS Incident has been reclassified from Level Four (National Command and Control) to Level Three (Regional).
- The NHS needs to remain vigilant and local systems need to ensure their resilience capability to re-establish full incident response in the event that it is warranted. This will impact the ICB when established as it will be the Category One responder rather than CCGs as Category Two. A further update on this will be provided to the CCG Board in June. In essence the ICB will be at the core of response rather than support or undertake that as a delegation.
- Continue to offer COVID-19 vaccines and step across resources from response to recovery (UEC/DC/Elective/Cancer/patient experience and quality).

- Immediate focus for ICSs to take the lead in building on lessons of the pandemic.

The letter would be shared with the Board for information.

**Action: Mrs Raybould**

### **National, regional and system operations centres**

A framework for both national and regional operations centres has been released. These centres will not provide a routine Emergency Preparedness, Resilience and Response (EPRR) function and will instead be the single point of access for all business-as-usual communications. Although separate to EPRR, they will maintain the ability to stand up and support as incident command centres if required. There is an assumption that communications through the System Operations Centre (currently SVOC) will increase due to other lines of communication closing. We are currently reviewing the System Operations Centre capability which includes its resource requirements for Lincolnshire

On the 9<sup>th</sup> May ULHT declared a further critical incident due to extreme urgent care demand and high acuity of patients. An EPRR level One response took place which was led by ULHT in liaison with CCG commanders. The critical incident was stood down within 24hrs of declaration. During both responses, the CCG EPRR resource supported commanders to implement effective battle rhythms of system coordination.

### **COVID-19 Recovery**

All NHS services in Lincolnshire are continuing to operate under significant pressure and that is particularly noticeable in Urgent and Emergency Care (UEC) but is a feature across all service provision. This is due to a combination of acuity of patients, impact of COVID-19, demand and workforce pressures and impact of neighbouring acute providers. This has settled over the last seven days, but significant pressures remain.

As a system there is specific work being undertaken to plan for the Jubilee weekend (four day bank holiday) using the learning from recent bank holidays that gave good visibility and management of any risk across the system. A particular focus will be upon communications to visitors into the county and how they access their own health professional if they have medication supply issues.

In terms of elective care, the CCG remains on track to ensure there are no patients waiting over 104 weeks by the national target of the end of June. The system benchmarks very well regionally for elective care and the plan for 2022/23 financial year is to deliver more activity than pre-pandemic to reduce waiting times for the population.

The first Community Diagnostic Hub opened at Grantham which, given the challenges faced by radiology teams post the fire at Lincoln Hospital, is a great achievement for the population of Lincolnshire and should be noted by the Board. Further work is ongoing to develop the business case for the second site in the county and the East Coast is likely to be the preference for that, but work remained on-going.

The backlog for cancer patients has shown a slight deterioration in recent weeks due to workforce and emergency pressures. Work is being undertaken with the Cancer Alliance to support short and long-term solutions to colorectal as it is the largest backlog. Patients continue to be monitored via multiple mechanisms and are clinically prioritised as previously reported.

### **COVID Vaccination Programme**

The headline position is that in Lincolnshire 1,769,538 vaccines have been administered, with approximately 624,643 firsts, 593,466 seconds, 489,488 booster doses and 61,941 Spring Boosters (an increase of 30,000 Spring boosters since the last Board report).

Of our most vulnerable population, currently 94% of all those eligible over 80s have been vaccinated with a first, second and booster dose, 73% (of those eligible) have come forward for a Spring Booster. Strong message for all those who have not come forward for their Spring booster to do so; it is never too late.

On the 3<sup>rd</sup> May 2022 we closed the Lincolnshire Showground Vaccination Centre as the lease agreement expired. The CCG has moved the vaccination offer to walk-in pop-up services advertised through media, social media and the CCG's website to ensure the population of Lincoln and the surrounding area are able to access Spring boosters, 12-15, 5-11 and our evergreen offer. On 17<sup>th</sup> May 2022 the CCG launched a vaccination bus to supplement our mobile offer to enhance convenience for our population. The bus is further testament to the joint working across Lincolnshire, in this instance with Lincolnshire County Council, to ensure the success of our vaccination programme and to protect the public health of our people.

In conclusion the NHS in Lincolnshire whilst now not dealing with the volume of COVID patients and its associated challenges continues to feel the aftermath of the pandemic. This manifests in terms of demand, backlog and acuity of patients, fatigue in workforce along with workforce pressures who need to be looked after. It will remain operationally challenging as the recovery steps up over the coming weeks and months.

The Board considered the report. Dr Boldy referred to the 104 week waiters and asked how many patients were currently waiting to be seen. Mrs Raybould advised that at the last Board meeting it was reported there were 21 patients at United Lincolnshire Hospitals NHS Trust (ULHT) with a small number at other providers. Currently the numbers were in single figures and all of those patients have now received a date for treatment completion but there could be an impact if they contract COVID which would obviously cause a delay.

Mrs Chambers referred to the cancer backlog and the detail in the Integrated Performance report which indicated the position continued to improve but this did not appear to correlate to the information reported by Mrs Raybould. Mrs Raybould advised that the Integrated Performance Report included data from March 2022; the information provided in her report was in effect 'live' unpublished and unverified data, and reflective of the current position and there has been a deterioration due to urgent and emergency care pressures.

Dr McSorley referred to the recent announcement by the Joint Committee on Vaccination and Immunisation in relation to the potential Autumn vaccination programme in terms of planning purposes and sought clarification on the details. Mr Fahy advised that planning had commenced for an Autumn vaccine campaign for specific cohorts (as in those aged over 50) and a vast amount of material would be made available to hopefully generate a positive response. This would be run in parallel to the flu campaign.

Dr Akram sought clarification on whether the response by Mrs Raybould to Mrs Chambers' question covered other providers such as North West Anglia NHS Foundation Trust (NWAFT). Mrs Raybould advised that a track of all of the CCG's patients who go to other providers is maintained.

Dr McSorley thanked Mrs Raybould for her usual informative update.

## **Public Health Report**

Mrs Ellis-Fenwick advised that Mr Fox was having some technical difficulties and was unable to join the meeting at the current time. This item was therefore deferred and returned to at 10:11.

Mr Fox advised that there were a number of items from a Public Health perspective to brief the Board on and highlighted the following:

The impact of COVID-19 had significantly decreased over recent weeks, but nonetheless the virus was still very much out there and continuing to cause issues. In terms of numbers, these continued to be monitored. The most recent data showed 525 positive cases recorded in Lincolnshire, which is a rate of 68.5 per 100,000, which is much lower than previously but far less people are receiving tests.

In terms of trends, the positivity of the percentage of tests is a good indicator of the overall levels of prevalence, and at the end of March 2022 just above 15% of all tests were coming back positive. As of the latest data (22<sup>nd</sup> May 2022) the percentage of positive tests was 4.4%, which is indicative of a significant decrease in the amount of COVID-19 circulating.

In respect of ONS estimates, they model data based on the prevalence survey as well and there has been a significant decrease in the numbers of positive tests reported in March 2022, although there had been a slight increase towards the end of March and into April. However, the numbers had since decreased again during May so there is a declining picture.

In terms of the COVID-19 variants currently circulating in Lincolnshire over the last four weeks, there was approximately a 50:50% split between the two Omicron lineages. Looking back to January 2022 the vast majority of cases were the original Omicron variant.

In terms of modelling going forward and looking at the future, the Joint Committee on Vaccination and Immunisation (JCVI) had recently announced there will be an Autumn booster campaign for vaccinations. That would be the next point when an increase in the numbers of cases was likely to be seen based on previous knowledge of flu and respiratory diseases but that is predicated on the COVID-19 variants remaining pretty much the same and Omicron has remained the primary one globally for some time now.

The Board considered the update. Ms Liburd sought clarification on what factors might trigger another variant of COVID-19. Mr Fox advised that new variants tend to be triggered usually by someone who is possibly immuno-compromised or an individual where the virus stays in their system for a long time and mutates, develops, then grows with a competitive advantage and takes hold and spreads. It is not possible to say whether this could be more severe than other variants.

Dr McSorley thanked Mr Fox for his attendance and update.

## **Healthwatch Report**

Mrs Fletcher provided a verbal briefing on the key headlines of topics reported to Healthwatch over the last month and highlighted the following:

- NHS dental services and access – this is now being raised on a national level, with local MPs raising issues and Lincolnshire and Greater Lincolnshire identified as having particular issues. This had been reported to Healthwatch as a key issue for a number of years now with an impact on health inequalities. Healthwatch was happy to share any of their work around this with the CCG.
- Autism services and diagnosis for younger children – some families have reported there is not enough support in place after diagnosis; no issue with the staff – just not enough to provide the level of support and information required.
- Long Term Conditions – some people are reporting they need more help in managing their conditions.
- A Community Pharmacist in Grantham has apparently stopped the provision of Dosette boxes which for vulnerable patients, such as those with visual impairment, is quite a significant issue. The information given by the provider is that this is an NHS directive.

- Care Quality Commission (CQC) integrated care brief being supported by Healthwatch – key headlines coming out of that work are around communications which needed in some respects to be improved, waiting times, out of county support for some people who felt this did not link back to local services and being listened to in terms of their conditions and interventions being received in a timely fashion.

The Board agreed to:

- **Note the COVID-19 report.**
- **Note the verbal update from Public Health.**
- **Note the verbal update from Healthwatch.**

22/392

## **INTEGRATED PERFORMANCE REPORT**

Mr Fahy presented the latest version of the Integrated Performance Report and advised that he would focus on areas for potential patient harm and poor outcomes. Areas such as urgent care pathways, cancer, elective treatment backlog, and long waiters have already been covered by Mrs Raybould and would not be revisited unless the Board had any specific questions in relation to those areas.

**Mental Health:** Whilst there had been some improvement in the early intervention in psychosis (EIP) waiting times towards the end of 2021, the performance fell in March to a low of 20% seen within two weeks, which was much lower than the 60% standard. The Board asked for the detail at the last meeting in terms of when patients were being seen and the current backlog is 31 with an average of 40 referrals each month. Currently the service is seeing patients within three weeks as opposed to two; the detail is set out in slide 20 in the paper. There is a service improvement plan in place to address the staffing shortages and this is being closely monitored. Mr Fahy was confident an improved position would be reported at next months' meeting.

There was an improved position for Severe Mental Illness (SMI) health checks. Against the national target of 60% current performance was at 46% and above the national average, however, there is still a way to go.

**Learning Disability, Autism and Transforming Care Partnerships (LD&A TC) inpatients:** Currently, the CCG has 31 adult patients and work was underway to reduce this to 26 by year end. The position was over by five patients. Of those 31 Adult inpatients - 17 were in CCG commissioned beds, 14 impact beds commissioned by NHSE and two Children and Young People (CYP) – with 33 in total. Work is underway to get that cohort number down 24 adult beds in 2022/23, which is a further reduction of seven patients. A monthly update would be provided to the CCG and ICB moving forward.

**Learning Disability Health checks:** Year-end delivery is 3,513 delivered, 80% of the total learning disabilities register against the national target of 75%. The intention was to maintain that level of performance going forward.

**Safeguarding:** the report included an update on the CCG safeguarding activity with CCG partners. Mr Fahy drew the Board's attention to the draft Mental Capacity Act (MCA) Code of Practice, which was published on 17<sup>th</sup> March 2022. A consultation period has since commenced for a period of 16 weeks up to 7<sup>th</sup> July 2022. The report contained a link to the consultation.

**Overview of response to Ockenden report:** This will be a regular feature in the report going forward. A detailed update was provided at the last Board meeting, however the latest report provided detail in respect of system assurance for NWAFT and Northern Lincolnshire and Goole Hospitals NHS Trust (NLAG). Both Trusts have provided assurance on the initial seven Immediate and Essential Actions (IEAs) via their respective Trust Boards in April 2022. A further benchmarking exercise as per national requirements for assurance against 15 IEAs from the most recent Ockenden report is underway at both Trusts.

**Serious Incidents & Never events:** There were no new never events to report this month. There have been a total of 42 serious incidents reported between 6<sup>th</sup> April 2022 – 10<sup>th</sup> May 2022, this represents an increase when compared to the previous two months, where the level of serious incidents reported was recorded as 26 and 29 respectively. **Mortality metrics:** All Summary Hospital-Level Mortality Indicators (SHMI) were now on trend for all of the CCG providers, ULHT, NLAG & NWAFT, which was very good news.

**Elective recovery:** The Board was asked to note the continued good performance for elective recovery. The details of trends was set out on slide 19 of the report.

**Primary care quality:** nothing new to report by exception but to note Lakeside Healthcare were still awaiting final report publication of the report following their recent CQC inspection.

The Board considered the report. Dr McSorley referred to the total waiting list size for Lincolnshire patients at all hospitals detailed in the report which had increased and was now 11,000 above plan and sought clarification on the reasons for this. Mrs Raybould advised there were a couple of reasons for this, and one which was being looked into. Firstly, when the Half Year Two Plan was written a number of planning assumptions were made and at that point the level of urgent and emergency care pressures was not anticipated and the impact that would have on elective care, and also the emergence of the Omicron variant – this was the same position across the country. When the phasing of activity for Half Two was carried out, usually by March as the country is moving out of winter you would normally expect to see significantly more activity going through elective care, which clearly did not happen related to the two pressures previously mentioned. For the last few months the waiting list has been increasing by approximately 2,500 patients each month over the winter/Omicron period, but there had clearly been a large jump in March which was partly as a result of planned activity levels, which was not achieved and then due to the additional pressures.

Having looked into the data and to provide some assurance to the Board, the increase in numbers at ULHT had remained relatively static in March compared to January and February. NWAFT had also been relatively static but then had an increase of almost 400 patients in March as they had greater urgent and emergency care pressures than Lincolnshire with several critical incidents, which impacted on their ability to deliver elective care. NLAG was also hit particularly hard in March with urgent and emergency care pressures and was not able to deliver a number of operations.

The biggest impact had been with the independent sector providers who do not generally get impacted with urgent and emergency care issues in the same way the acute providers tend to. The Performance Team are carrying out a piece of work on this to understand the issues, although initial findings appeared to indicate this was a data issue. It was proposed and agreed that an update be brought back to the Board at its next meeting.

**Action: Mrs Raybould**

Mrs Chambers referred to the data taken into account in the recovery (page 47 of the report), where it referred to the backlog numbers being numbers affected due to bank holidays and school holidays and asked why this was not taken into account as part of the initial planning when establishing the recovery plan.

Mrs Raybould advised that bank holidays and school holidays are taken into account as part of the planning process and usually higher levels of agency staff are but used, but what has been seen post COVID is a significant drop in agency rates across all providers which has been discussed in considerable detail as part of the bank holiday planning and mitigations are being looked at. In summary, normal staffing levels are planned for appropriately, it is the agency fill rate which has caused issues.

Mr Fahy added that from a workforce point of view he is the CCG lead and sits on the People Board and there is clear evidence of a high level of fatigue across the workforce and the reality is that a lot of staff do not want to, or are not in a position to, work additional hours in the way they did previously during COVID. Moving out of COVID work is now underway in terms of reset and restore and it is hoped that the situation might improve as go forward into Summer and Autumn.

In reality, it is hangover effect of the last two years and the additional work requirements associated with the COVID-19 pandemic.

Mrs Fletcher asked how many elective patients from the waiting list are referred to private provider partners with NHS contracts. Mrs Raybould added that the numbers are less than 10% for the two main providers (Ramsey Healthcare and Fitzwilliam) and hence the backlog referred to previously did not add up and was being looked into.

The Board agreed to:

- **Note the Integrated Performance Report.**

**22/393**

### **CCG AND ICB FINANCIAL PLAN AND BUDGET UPDATE**

Mr Gaunt advised that at the April meeting he had advised that an update paper would be presented to today's meeting which would include details on the Financial Plan and to seek Board approval for the CCG budget. At that stage Mr Gaunt also anticipated that the Board would review the full year plan with the knowledge that from 1<sup>st</sup> July 2022, with the passage of legislation, the budgets would novate from that point to the ICB.

The position is now that a further planning around is going to be undertaken and will be subject to a further iteration and approval. The next planning round had already commenced the previous week with a deadline date of the 20<sup>th</sup> June 2022. The logistics on how the CCG Board would have the opportunity to have sight of that proposal was currently being considered.

All of that aside, the focus for the Board at today's meeting, as detailed in section seven of the report, was essentially to approve the CCG expenditure budget for the period April-June 2022.

The CCG plans to spend £377.2m for the period April-June 2022. The allocation will be matched to expenditure and therefore the CCG will operate at a breakeven position.

The Board had previously been made aware, and the detail was contained in the report, that at the point of submission there was a predicted deficit to the CCG/ICB Financial Plan of £27.1 million. The responsibility for the deficit and any issues associated with that would fall under the remit of the ICB going forward.

The CCG/ICB Financial Plan had been considered and supported by the Finance and Performance Committee at its May meeting.

The Board was requested to note the CCG/ICB Financial Plan and approve the planned expenditure for the period April-June 2022.

The Board considered the report and agreed to

- **Note the Financial Plan update for April 2022 to March 2023**
- **Approve planned expenditure for Quarter One.**

**22/394**

### **UPDATE ON THE DEVELOPMENT OF THE INTEGRATED CARE SYSTEM (ICS)**

Mr Burnett advised that at the last Board meeting there were some concerns reported that the Health and Social Care Bill may not receive Royal Assent in time for ICBs to be established on the 1<sup>st</sup> July 2022 and CCGs to be legally dissolved.

As the Board was aware, the Health and Care Bill received Royal Assent on 28<sup>th</sup> April 2022 and the Health and Care Act 2022 (the Act) has now been passed into law. The final part of the process to establish the ICB from the 1<sup>st</sup> July 2022 and close down the CCG was now being worked through with NHSEI regional colleagues. An updated version of the ICB Constitution template had been issued and the draft NHS Lincolnshire ICB Constitution was the next item on the agenda for consideration by the CCG Board.

This version of the ICB Constitution had been submitted to NHSEI the previous week with some minor amendments, along with the Readiness to Operate Statement (ROS) to ensure the CCG is adhering to all the requirements to become an ICB.

The next stage in that process is a review meeting with NHSEI and CCG colleagues to go through the ROS on the 6<sup>th</sup> June and there will be a letter of confirmation written by Mr John Turner, Chief Executive to the NHSE Regional Director to confirm that everything is in place for the ICB to be established on the 1<sup>st</sup> July 2022. No major issues were anticipated at this time to prevent that from happening.

The ICB Board will be expected to hold its first meeting on Friday, 1<sup>st</sup> July 2022 to consider and approve a number of governance documents, including the ICB Constitution. Consideration was currently being given as to how to advertise the meeting and publish the papers in light of the new ICB website not being launched until 12:01 am on the morning of the 1<sup>st</sup> July 2022. Guidance along with expectations around communication of the meeting was anticipated to be provided by NHSEI in the next few weeks.

In summary, everything was on track for the establishment of the NHS Lincolnshire ICB on the 1<sup>st</sup> July 2022.

The Board agreed to:

- **Note the verbal update.**

**22/395**

## **DRAFT NHS LINCOLNSHIRE ICB CONSTITUTION**

Mrs Ellis-Fenwick advised that, as the Board was aware, NHS Lincolnshire Integrated Care Board (ICB) is a new statutory organisation that will be established on 1<sup>st</sup> July 2022. All Integrated Care Boards are required to have a Constitution and to support the emergent ICBs NHS England developed a Model Constitution Template as a starting point. This was accompanied by a set of Supporting Notes and Transcript Numbers.

The Model Constitution Template has been updated on several occasions in recent months to reflect the latest changes to legislation as it has passed through the Parliamentary process. As part of the Readiness to Operate Statement process, the CCG has been required to submit several iterations of its proposed ICB Constitution to NHSE, which have been considered and feedback provided.

The latest version of the NHS Lincolnshire ICB Constitution was submitted as part of the next stage of the Readiness to Operate Statement process on the 20<sup>th</sup> May 2022 and feedback is awaited. Once received this will be incorporated into the final version which must be submitted to NHSE on the 10<sup>th</sup> June.

As part of the final stage in the process, NHSE have requested that the CCG provides evidence that its Board has endorsed the ICB Constitution. On that basis the CCG Board is asked to endorse the draft NHS Lincolnshire ICB Constitution to NHSE who will be responsible for approval of the final version. As referred to by Mr Burnett under the previous item, the final version will be presented to the NHS Lincolnshire Integrated Care Board for noting at its first meeting to be held on the 1<sup>st</sup> July 2022.

Dr McSorley advised that Sir Andrew Cash, Interim ICB Chair and Mr John Turner, Chief Executive have both confirmed verbally that the draft ICB Constitution is acceptable to those individuals in their designate roles for the incoming ICB.

Mrs Chambers referred to 3.18.4 which refers to assessing Executive roles in terms of equality and diversity and whether that should apply to all Board roles. Mrs Ellis-Fenwick advised that this applied to all roles on the ICB Board but would check the wording in the draft ICB Constitution to ensure this was reflected.

**Action: Mrs Ellis-Fenwick**

The Board agreed to:

- **Endorse the Draft NHS Lincolnshire ICB Constitution.**

**22/396 REPORT FROM THE MEMBERS' FORUM**

Mrs Ellis-Fenwick presented the report from the Members' Forum meeting held on the 12<sup>th</sup> May 2022 and outlined the contents.

It was noted that the Members' Forum had covered the following items:

- Review and update of NHS service challenges and next steps
- Update and discussion regarding the establishment of the statutory Integrated Care System (ICS) in Lincolnshire from the 1<sup>st</sup> July 2022.

The Board agreed to:

- **Note the report.**

**22/397 REPORT FROM THE EXTRAORDINARY QUALITY AND PATIENT EXPERIENCE COMMITTEE**

Mrs Chambers presented the report from the extraordinary Quality and Patient Experience Committee meeting held on the 12<sup>th</sup> May 2022, which had focused on receiving a report in relation to the assessment of the quality; clear clinical evidence base; and access elements of the Acute Services Review (ASR).

The report to the Board will be covered in further detail under Part Two of the meeting as part of item 12a.

**22/398 REPORT FROM THE AUDIT AND RISK COMMITTEE**

Ms Liburd presented the report from the Audit and Risk Committee meeting held on 18<sup>th</sup> May 2022 which had focused on a number of areas, all of which were summarised in the document.

There were no items to escalate to the Board but Ms Liburd wanted to add that the finalisation of the Annual Report and Accounts for 2021/22 was on track to be presented to the Board for approval at its extraordinary meeting on the 15<sup>th</sup> June.

The Board agreed to:

- **Note the report.**

**Dr McSorley advised that this now concluded Part One of the meeting and there would be a 15 minute break.**

## **PUBLIC CONSULTATION ON THE REVIEW OF FOUR OF NHS LINCOLNSHIRE'S SERVICES**

### **Part Two**

Mr Pete Burnett advised that there was one report for this part of the meeting included in the pack of papers, but this contained several different sections. Individuals from outside organisations who had supported the whole public consultation and review of the feedback process would be joining the meeting at various stages to cover off and support their relevant areas. These individuals would be introduced as and when they joined, and Mr Burnett expressed his appreciation for their support and attendance.

Mr Burnett advised that following the Board's approval of the Pre-Consultation Business Case in September 2021, a significant work programme has been undertaken. From 30<sup>th</sup> September 2021 through to 23<sup>rd</sup> December 2021 a Public Consultation took place on each of the four proposals. Listening to the views of those that responded to the consultation and working with partners across the Lincolnshire health system has been invaluable. This feedback and the further consideration and evidence compiled following the public consultation in response to it, together with the evidence contained within the PCBC, have been brought together into a Decision Making Business Case (DMBC).

The outputs from this extensive work programme have enabled the Decision Making Business Case (DMBC) to be developed in line with the legal duties of the CCG, which will be presented in the next section of this item.

Mr Burnett advised that the purpose of the report is to:

- Confirm the work undertaken to develop the proposals that were outlined in the Pre-Consultation Business Case.
- Outline the approach and activities undertaken to deliver the public consultation exercise in 2021.
- Review the Consultation Institute (tCI) Quality Assurance of the public consultation undertaken by NHS Lincolnshire CCG and briefing from tCI on the role of the Board in considering the feedback when making a final decision on the Decision Making Business Case.
- Provide a summary presentation on the independent consultation report detailing the responses received throughout the public consultation on four of Lincolnshire's NHS services. This will be presented by an independent company, Opinion Research Services (ORS), who analysed the feedback received and produced the report.
- Confirm the approach taken to involve the public in the decision making process following the consultation formally closing.
- Outline the approach taken across the NHS in Lincolnshire to respond to the feedback identified in the independent consultation report.
- Inform the Board on the role of the Clinical Directorate and the CCG Clinical Polices Sub-Group in reviewing the response to the consultation feedback, evaluating the four proposals as presented in the Decision Making Business Case and reviewing the Equality Impact Assessments and Quality Impact Assessments.
- Present the findings from the Quality and Patient Experience Committee's review of the response to the public feedback, Equality Impact Assessments and Quality Impact Assessments.

In doing this, the Board is asked to note and provide feedback on:

- The work undertaken following the approval of the Pre-Consultation Business Case to inform the development of the Decision Making Business Case.
- The information and advice provided by the Consultation Institute when considering and taking the final decision on the DMBC.
- The key findings identified in the public feedback and the information provided by ORS.

- The approach taken to respond to the feedback identified in the Independent Consultation Report, including public involvement and input from across the NHS in Lincolnshire.
- The clinical assessment that has been undertaken.

Mr Burnett advised that by way of some background information before moving into a summary of the consultation activities, the reconfiguration of acute hospital services has always formed a key part of the Lincolnshire health and care system's transformation plans, including in the most recent articulation through the *Lincolnshire's NHS Long Term Plan 2019-24*.

To support this the Pre Consultation Business Case (PCBC) was prepared by system partners to provide assurance to local governance Boards and NHS England and Improvement that the system has thoroughly considered a range of requirements before deciding to move to public consultation on the proposed service changes. The four NHS service proposals that went out to public consultation are as follows:

Change Proposals	Description
Orthopaedics	Consolidate planned orthopaedic surgery at Grantham and District Hospital, to establish a 'centre of excellence' in Lincolnshire.  Establish a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery.
Urgent & Emergency Care	Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC).
Acute Medicine	Develop integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.
Stroke Services	Consolidate hyper-acute and acute stroke services on the Lincoln County hospital site, supported by an enhanced community stroke rehabilitation team.

The four service change proposals contained within the PCBC successfully passed through rigorous regional and national assurance processes.

From a clinical perspective, on the 11<sup>th</sup> July 2018, the East Midland Clinical Senate was asked to consider whether there is a clear clinical evidence base underpinning Lincolnshire STP's proposals.

The review focussed on the clinical interdependencies and the totality of the changes proposed, as opposed to a more in-depth review of each clinical specialty. Specifically, the clinical review team was asked whether it supported Lincolnshire STP's proposals based on clinical sustainability, workforce and clinical outcomes.

Following this meeting the panel recommended that the Lincolnshire STP proceeds with its proposals for Orthopaedics and Stroke, and the use of the word 'Plus' in UTC was dropped (which was agreed by the Lincolnshire system on the day at the end of the session.). The panel was of the opinion further work needed to be completed for the acute medical beds at Grantham and District Hospital.

Further to that, a supplementary clinical review took place on 12<sup>th</sup> September 2018 in relation to the acute medical beds at Grantham and District Hospital.

The panel were left with the impression that all system partners are joined up on the future of medicine for Grantham, and that the proposal had changed significantly in a short period. All previous concerns were adequately addressed, and the proposal was considered by the panel to be not only clinically acceptable but to represent an excellent example of the value of a team approach to finding solutions to the inevitable issues that result from service redesign.

This then led to the Pre-Consultation Business Case (PCBC) being submitted to NHSE regional and national colleagues which was provided in 2021. The PCBC was then presented to the NHS Lincolnshire CCG Board on the 29<sup>th</sup> September 2021. The Board were asked to:

- Approve the Acute Services Review (ASR) Pre-Consultation Business Case (PCBC), which underpins four Lincolnshire NHS service change proposals relating to Orthopaedics, Urgent & Emergency Care, Acute Medicine and Stroke Services; and
- Agree to proceed to a period of public consultation on the four Lincolnshire NHS service change proposals set out within the PCBC.

The NHS Lincolnshire CCG Board approved the ASR PCBC and agreed to proceed to a period of public consultation. The public consultation on the four Lincolnshire NHS services launched on the 30<sup>th</sup> September 2021 and closed on the 23<sup>rd</sup> December 2021.

Mr Burnett introduced Ms Charley Blyth, Director of Communications and Engagement at this stage to run through the consultation process. There would then be a short pause for any questions by the Board to be considered on the PCBC and consultation process.

Ms Blyth introduced herself and advised that her role at today's meeting was to brief the Board on the work and process of delivering the public consultation, which was carried out by the Communications and Engagement Team.

Ms Blyth advised that she would be outlining the practical delivery of the public consultation and also the communication and promotional work that went alongside that to raise awareness as broadly and widely as possible that the public consultation was taking place and inform stakeholders about the service proposals within it and the review work that had been undertaken to date. It was absolutely key to involve stakeholders, experts and general public and broaden and deepen their access to the public consultation to enable the team to gather meaningful information that would lead to today's decision making process. The CCG was also required to comply with the Health and Social Care Act 2006 in respect of public consultation and also the Equality Duty, which was outlined in the report presented.

All of this throughout was applied with a sense of realism in that it is not possible to reach everyone in a public consultation or that everyone will engage with it. The prime goal therefore was to enable everyone in Lincolnshire to engage if they wished to and feed back if they chose to do so.

The overview of activities would be broken down into two parts:

- a) Communications activities (page eight of the report)
- b) Consultation activities (page six of the report)

**Summary of communications activities:**

- Launch day cascade – briefings through staff, stakeholders, public, and then press/media release (see list as per page 15 of the report for cascade and full stakeholder list) - all of which has been clinically led and supported.
- Consultation materials – wide breadth utilised and as diverse as possible.
- Door drop – 375k leaflets commissioned.
- Press office management – routine briefings to press and stakeholders.
- Social media and 'next door' activity throughout the 12 weeks consultation.

- Paid for advertising to capture those who we are not organically reached through the PR process.
- Display of posters at NHS and non NHS sites.
- Flyering – as above (including translated materials).
- Partner communications support – e.g. Lincolnshire County Council reaching their audiences on the CCG's behalf.

**Summary of consultation activities:**

- Events – ours: on and offline. Ever available. Clinically led. COVID controls to allow access safely and assurance
- Events – others: accepted all invites (e.g. Skegness Town Council). Attended Health and Overview Scrutiny Committee (HOSC).
- Parish councils were encouraged to agenda. PPG updates/ULHT patient panel etc – all incorporated.
- Survey – available at events, online, handed out and left in community locations.
- Telephone surveys – ORS delivered
- Independently facilitated online focus groups and 1:1 in depth interviews supplemented this broader public activity.
- Seldom heard groups reached via local partner organisations, and large employers/factories/ specialist stores as examples.
- Involvement champions out and about reaching as many local community groups as possible.
- Staff engagement incredibly important throughout the 12 weeks – manager briefings conducted, staff comms updates throughout, e.g. ULHT Clinical services groups.
- Stakeholders briefed and asked to share information (MPs, LCC, District councils, Non-Executive Directors and HOSC).

**Preparatory phase:**

Materials and consultation activity and delivery plans were tested and assured via the following groups:

- System NHS Chief Executive leads
- Acute Services Review (ASR) Steering Group
- Lincolnshire system-wide Non-Executive Directors (NEDs) scrutiny group
- Healthwatch Readers Panel
- Healthwatch Steering Group
- NHSE/I midlands and national teams
- HOSC (giving rise to the door drop suggestion)
- Involvement champions (and the communities they represent)
- PPGs

The public consultation was a self-correcting/dynamic programme of work and there were a number of times when suggestions or concerns raised were factored into the programme. Some examples include:

- Patient Participation Groups (PPGs) and Health and Overview Scrutiny Committee (HOSC) – suggested a meeting in Louth which was scheduled.
- HOSC requested door drops, which was commissioned.
- Skegness Town Council requested representation for a dedicated agenda item, which occurred.

**Results:**

- Page 21 of the report detailed the attendance numbers at the events, including those reached by external groups

- Page seven of the report detailed the communications reach – this is direct only. The cascade of partners delivered a vast indirect, but immeasurable reach.
- Page 29 detailed the seldom heard groups.

In summary, the scale of the consultation was significant and sustained.

Mr Burnett came back in at this stage and asked if there were any questions from the Board in relation to the PCBC or consultation process before moving forward. No questions were received in relation to this item.

Mr Burnett advised that he would be inviting Mr Bruce Whitear from the Consultation Institute (tCI) to join the meeting for the next stage to provide an update on the work they had undertaken and advice to the Board. As a way of a short background, the Board was advised that prior to the Pre-Consultation Business Case being presented to the CCG Board the Consultation Institute were commissioned to undertake a six-stage Quality Assurance (QA) process. The tCI is a UK-based not-for-profit organisation founded in 2003, which has been setting the standards for best practice in public engagement and consultation across the UK, although they do go outside to other countries as well.

The Consultation Institute QA six-stage methodology is listed below:

- Scoping documents sign-off (now expanded to include aspects of governance)
- Project Plan sign-off
- Documentation approval
- Mid-consultation Review
- Closing date Review, Analysis & Feedback plan approval
- Analysis & Report sign-off

The Institute QA services have now been used extensively throughout the NHS, to help:

- Conduct a best practice consultation that will enable safe decision making.
- Design a consultation process that is fit for purpose and withstand external scrutiny.
- Mitigate for risks associated with legal challenge.

The tCI has now signed off all of the first five stages of the QA process for the public consultation. The final Gateway Review focuses on the reporting of findings from the consultation. The aim is to ensure that the report of findings is a balanced and true representation of the views which have been received and is suitable to inform and influence the decision-makers and meet the requirements of the Public Sector Equality Duty.

As part of this process the tCI agreed to provide an overview of the consultation process following the QA process and provide advice to the CCG Board on its role when considering the Public Consultation findings and in making a final decision on the DMBC.

This was to ensure the CCG Board are aware of:

- The law regarding consultation; case law
- The Court's view of equality analysis
- Risks of legal challenge and risk mitigations

Mr Burnett handed over to Mr Bruce Whitear at this stage. Mr Whitear thanked the Board for inviting him to attend the meeting and advised adding to Mr Burnett's comments, that the tCI do look at quite closely the legal cases that go through courts in terms of challenges in relation to public consultation and this informs the support that they provide to health organisations but emphasised that they are not legal experts and are not able to provide advice around the CCG's legal processes. The CCG also has its own legal advisors in place for that element.

Mr Whitear advised that in the first instance he wished to pay tribute to the CCG team he had been working with, namely Mr Burnett, Mr Diamond, Ms Steph King and Ms Charley Blyth who had been fantastic to work with and had been very responsive and open to making sure some of the recommendations put forward have been acted on to ensure the public consultation and engagement has been as robust as possible.

Mr Whitear advised that he wanted to highlight a series of principles that tCI use to guide decision making and the role of the Board in terms of governance and which are set out in law. The first related to the legal framework under which the NHS operates, and which is enshrined in the NHS Act which is around the duty to involve the public in decision making, which is backed up by a whole series of guidance from the Department of Health. There is also then a set of common law principles which are called the Gunning Principles which, if followed, are designed to make consultation fair and lawful:

**Gunning 1** – Consultation must be at a time when proposals are still at a formative stage.

**Gunning 2** – Sufficient reasons must be put forward for any proposal to permit “intelligent consideration” and response.

**Gunning 3** – Adequate time is given for consideration and response.

**Gunning 4** – The product of consultation is conscientiously taken into account by the decision maker(s).

In terms of the first principle, it is really important to understand where the public is making an influence and the CCG is able to demonstrate that, through the scrutiny and process, where they have been able to influence the proposals. Also that the Board has an open mind up to the very last moment on the options and can make the decision not to adopt those proposals.

The second principle is around intelligent consideration which means that enough information is being provided to the public for them to provide an appropriate consultation response – which is effectively about transparency. The CCG has been encouraged all the way through the process to publish as much information as possible; some people will just scan it but there will be those who go through it in great detail; hence that level of transparency is encouraged.

A further element to this is whereby people have requested additional information through the consultation process that the CCG has access to, and that this has also been published.

The third principle is that the CCG has given adequate time for consultees to respond. The CCG carried out the consultation over a three month (12 week period) which would be considered sufficient time for responses, although extra time could have been permitted should anyone have identified that they did not feel this was adequate.

The final principle, which is the most important one for the CCG at this stage, relates to ‘conscientious consideration’ which in summary is that the CCG Board are conscientiously considering all the responses that have been received and being seen to do that, which is the point of today’s meeting.

The other area of focus for the tCI is to make sure organisations are cognisant of their equality duties and take account of people who are most likely to be affected by the changes, least likely to respond to the consultation or most seldom heard and has the impact from an equalities point of view been considered. This information was included in the papers presented to the Board at today’s meeting in terms of the Quality Impact Assessment (QIA) and EIA (Equality Impact Assessment).

Lastly, tCI has made its final assessment and they are content the CCG has met good practice standards for public consultation, and this will be confirmed in writing in the next few days.

Mr Burnett thanked Mr Whitear for his valuable contribution today and also for his work over the last 12 months which has been invaluable to ensure the CCG has carried out a thorough and robust consultation.

Mr Whitear left the meeting at this point.

Mr Burnett introduced Mr Charlie Wilson and Mr Kester Holmes from the Opinion Research Services (ORS) who are a company that grew out of Swansea University, and now have a UK-wide reputation for social research and major statutory consultations. They were appointed by NHS Lincolnshire CCG to support some consultation activities, and to analyse and report the outcomes of this public consultation programme with members of the public, clinicians and other NHS staff, and other stakeholders.

Mr Wilson and Mr Holmes introduced themselves and thanked the Board for giving them the opportunity to attend the meeting and present the key findings (a high level summary) from the consultation feedback. Mr Wilson added that the presentation should be considered alongside both the Executive Summary and also the main body of the report.

The presentation covered the following:

- Summary of consultation reporting and activities (some of which were addition to those summarised by Ms Blyth) and questionnaire response by closest hospital.
- Views on the four proposals (Orthopaedic Surgery, Urgent and Emergency Care, Acute Medical Beds and Stroke).

Ms Blyth had helpfully already summarised some of the different consultation activities undertaken by the CCG. In terms of the feedback being reported by the ORS, this had been obtained through a number of those activities, including a telephone survey and consultation questionnaire. A number of in-depth focus groups and interviews were facilitated by the ORS to get into some of the depth of the feedback and comments raised and to understand some of the concerns raised.

A large number of additional engagement activities had been undertaken by the CCG to promote the consultation and direct people to feedback channels. The feedback received from some of those had also been included along with written correspondence received from some organisations and residents and two petitions received.

Mr Wilson emphasised that it was important to note that there is a key difference between the telephone survey and the consultation questionnaire. A telephone survey is controlled by a sample and it is designed to be a statistically robust summary that is representative of the general population as a whole. It was guided with information coming from the documents as referred to by Ms Blyth. However, that a telephone survey does not do is to give a real opportunity for a lot of detailed feedback. To ensure that feedback was received from people disagreeing or expressing concern with the proposals, then an on-line and paper questionnaire was made available. All of those avenues ensured the views of those who wanted to respond were captured. This was not therefore representative of the whole population as typically those people who are the most motivated to respond are often those not unhappy with the proposals. The reasons why some people were not happy with the proposals had been included in the report.

In terms of views on the four proposals, the findings were summarised as follows:

**Orthopaedic Surgery (broad agreement with the proposal):**

- 68% of NHS staff (consultation questionnaire)
- 61% of other individuals (consultation questionnaire)
- 78% of residents (telephone survey)

Feedback on the proposal for orthopaedic surgery in terms of the support and disagreement was summarised, including key themes arising across all feedback:

- Concerns about residents who might have to travel further to reach the orthopaedic services that they require particularly:
  - Older and frail people; those with lower incomes and/or without access to private transport; people with disabilities; residents of rural areas
  - Availability of patient transport services a significant concern
- Rehabilitation services and good communication between healthcare providers.

**Urgent and Emergency Care (Overall agreement with the proposal for Grantham and District Hospital Urgent Treatment Centre but strong local concerns from some respondents):**

- 61% of NHS staff (consultation questionnaire)
- 50% of other individuals (consultation questionnaire)
- 81% of residents (telephone survey)

The difference was highlighted between the outcome of the residents survey and the questionnaire survey.

Feedback on the proposal for urgent and emergency care in terms of the support and disagreement was summarised, including key themes arising across all feedback:

- Travel and access to, and from (discharge), emergency departments in Lincoln or elsewhere.
  - Older and frail people; those with lower incomes and/or without access to private transport; people with disabilities; residents of rural areas
  - Availability of patient transport services a significant concern
- Alternative suggestions - full A&E department 24/7 or retain current service with overnight UTC.

**Acute/Community Medical Beds (broad agreement):**

- 62% of NHS staff
- 53% of other individuals
- 78% of residents

Feedback on the proposal for acute/community medical beds in terms of the support and disagreement was summarised, including key themes arising across all feedback.

- Broader concerns about hospital bed numbers and staff shortages.
- Concern about the capacity of primary healthcare and community social care services to meet the needs of those most likely to need access to acute medical beds.
- Suggestions in feedback:
  - Establishing separate 'acute' and 'rehabilitation' pathways
  - Using 'halfway house' care services and integrated multi-disciplinary teams

**Stroke (broad agreement but strong local concerns from some respondents):**

- 53% of NHS staff
- 51% of other individuals
- 72% of residents

Feedback on the proposal for stroke in terms of the support and disagreement was summarised, including key themes arising from all feedback.

- Implications for access to specialist stroke rehabilitation services.
- Health inequalities for older residents and people living in local deprived communities.
- Travel for elderly family members - impacting patients' mental health and recovery.
- Mitigations and alternatives:
  - Specialist stroke services should therefore be located at Pilgrim Hospital, Boston
  - Air ambulance provision; increased community care to speed up discharge times
  - Improve recruitment and retention of staff; increase bed numbers
  - Telemedicine – junior clinicians to deliver services locally with input from consultants.

Mr Burnett came back into the meeting and asked whether the Board had any questions on the presentation and feedback on the consultation process. Mr Fahy asked about seldom heard groups in terms of the efforts made to try and reach out to those and what measures what used. Mr Wilson advised that a two prong approach was adopted to ensure people in those groups hear about the consultation and are able to take part appropriately, firstly by ensuring accessible versions of documents are available. The resident survey sample was designed to ensure, within reason, that different groups were adequately represented and that their feedback could be broken down to look at and consider their views and also potential impacts on those individuals/groups with protected characteristics. In doing all of that t the review of the feedback/responses by those individuals/group demonstrated that they were primarily the same concerns as raised by others who disagreed or had concerns about the proposals, such as travel and access. The full detail was contained in the full report produced by the ORS.

Mr Burnett expressed his appreciation to Mr Wilson and Mr Holmes for all their hard work and efforts in supporting this process and thanked them for attending the meeting.

Mr Wilson and Mr Holmes left the meeting at this stage.

Ms Blyth came back in to the meeting as this stage to summarise the public involvement since the consultation had closed. The Board was advised that there is a legal requirement for NHS Clinical Commissioning Groups to involve the public during the decision-making process and for this purpose the NHS Lincolnshire CCG Involvement Champions and Healthwatch were engaged.

### **Healthwatch Lincolnshire**

Healthwatch Lincolnshire Readers Panel were heavily involved in the consultation process as previously referred to earlier in the meeting and also in reviewing the full draft independent report on the consultation findings from ORS. Healthwatch circulated this to their volunteers to undertake a readability and 'plain English' review of the document and to their steering group to gain an organisational perspective on the draft findings.

All feedback was taken into consideration during discussions with ORS and development of the final report.

### **Involvement Champions**

The CCG Involvement Champions are individuals from a variety of backgrounds who wish to work with the NHS to support their community / groups' voices to be heard. There are currently representatives from a breadth of the county's diverse population, such as a young person, military and mental health, East Coast, carer, cancer service user, campaigner and GP receptionist as well as others.

During the consultation they supported the CCG by reviewing the consultation plan and identifying any gaps, promoting the opportunities to get involved, putting posters up in their local area, sharing emails with their groups and encouraging people to complete the questionnaire etc.

As well as supporting the CCG with activities such as displaying posters and sharing the consultation information with their networks, the CCG Involvement Champions were integral to the review of the consultation findings and emerging themes. In order for them to undertake a confidential review, they were provided with the full draft independent report on the consultation findings from ORS together with the themed feedback.

A subsequent meeting was held to enable the Involvement Champions to share their thoughts on whether the feedback theming included everything in the report that they would expect to see, identified all of the key pieces of feedback or information that they would expect to be responded to and if there was anything they felt had been missed. Discussions also included their thoughts on the consultation report in general and suggestions for how we could communicate the findings of the consultation and CCG Board decision extensively.

Mr Burnett thanked Ms Blyth for her further contribution.

Mr Burnett moved on to the approach to review of the services change proposals following consultation and advised that following the end of the public consultation there has been an extensive programme of work to review the findings of the public consultation and ensure conscientious consideration of the feedback, ahead of final decision-making on the change proposals.

Central to this review process has been the theming of the feedback received through the public consultation for each of the four change proposals and the establishment of subject matter expert working groups to consider and respond to each theme. An example of the themes around the Grantham UTC proposal was included in the report.

Subsequently feedback consideration documents were developed for each of the themes by the relevant subject matter experts as summarised in Chapter five of the DMBC and detailed in DMBC Appendix F. These were developed jointly from colleagues across the Lincolnshire NHS including United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Community Health Services NHS Trust (LCHS) General Practice and East Midlands Ambulance Service NHS Trust (EMAS).

This process was overseen by the Consultation Steering Group and chaired by Mr Pete Burnett, with weekly meetings being held with the key organisational leads to review progress, assess the depth of response and ensure collaboration was undertaken in the consideration of the feedback.

Responses relating directly to the four clinical directorates (orthopaedics, urgent and emergency care, stroke and acute medicine) were signed off by steering group for each proposal and the Trust Leadership Teams at ULHT and LCHS.

This ensured significant rigour through those organisations and to ensure they were in agreement with the feedback and response to those proposals.

The next stage in that process was to then put that information to the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group which was established to co-ordinate the clinical consideration and ensure quoracy of the CCG Clinical Policies Sub-Group was maintained, whilst facilitating appropriate engagement of clinical leaders within the Lincolnshire system.

A series of three meetings took place in April 2022 which focused on the process (14<sup>th</sup> April 2022) and each of the proposed changes to the four service areas (UEC and Acute Medicine, 21<sup>st</sup> April 2022; Orthopaedics and Stroke Services, 28<sup>th</sup> April 2022).

The ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group were asked to assess the change proposals, in light of the feedback received through the public consultation that took place September to December 2021 and subsequent consideration given to this, against the following criterion:

- Quality
- Clear clinical evidence base
- Access

Mr Burnett advised that Dr Sunil Hindocha, GP and Chair of the Primary Care Alliance had chaired those meetings and invited him to join the Board at this stage to provide a more detailed summary of the debate and work that took place at those meetings.

Dr McSorley advised that prior to Dr Hindocha joining the meeting, Mrs Chambers had a question relation to the previous section in terms of the public involvement following completion of the consultation. Mrs Chambers advised that as a Board and a CCG Non-Executive Director she had been assured throughout by Ms Blyth and her team about the level of communication and engagement involved in this process and the team has carried out an incredible amount of work and that was to be commended. Mrs Chambers asked whether Ms Blyth could provide some assurance that the excellent high level of communication and engagement with the public would continue should the Board approve the Decision Making Business Case. Ms Blyth provided a summary of what had been taking place in recent weeks in terms of communication and what will happen in the forthcoming weeks. In short it is essential to be able to brief staff, stakeholders and the media as much as possible and a wide range of materials and both verbal and written communications were being considered in preparation for the outcome of any decision. This would be provided through a cascade process.

It was emphasised that all of this was dependent on the decision of the Board later in the meeting under Part Three.

### **ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group**

Dr Hindocha came into the meeting at this point. As highlighted by Mr Burnett, the Joint Committee of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group had met on three occasions to discuss the specific areas of the four proposals. The Committee consisted of a wide range of clinicians, not just medical but also allied health professionals, some with nursing backgrounds and others along with the specialist clinical leads for each of the four areas of the proposals.

In those meetings the Committee had access to all of the consultation documentation and feedback, the report from the Clinical Senate and previous clinical feedback. In turn the Committee/Group was fully aware of the whole background and process that has been conducted as outlined this morning.

Dr Hindocha advised that each of the proposals was clinically stress tested in turn having had a broad overview of the process and the Committee/Group was confident that the requirements involved had been met. For example a detailed assessment was carried out on changes to the SBC which is referred to in the information on the use of drugs particularly associated with stroke, current models of care and how they compared to any future proposed models. Feedback was also considered from local, regional and particularly national teams, in particular in relation to the orthopaedic model and previous reviews around the care and modelling of bed services at Grantham and District Hospital. Feedback was also provided from local colleagues who have been heavily involved in delivery of the process.

Some clinical changes were also made through the COVID-19 pandemic and the feedback from those assisted with the conclusions reached by the Committee as they highlighted any issues positively or otherwise which might impact on these proposals.

The three meetings held were very lengthy on each of the proposals and the Committee was very clear that no decision could be made until each of those had been sense checked from a clinical perspective and in particular in respect of trying to improve outcomes for the residents of Lincolnshire or at best maintaining the status quo.

The conclusions from those meetings and the outcome of the assessment against the criteria is outlined in chapters six, seven, eight and nine of the Decision Making Business Case (DMBC).

Mr Burnett thanked Dr Hindocha for his briefing and asked if the Board had any questions. Mr Fahy asked whether there were any concerns or objections raised by any of the senior clinicians involved in the process and discussion. Dr Hindocha advised that in summary there was very broad consensus with unanimous agreement that patients are able to ask for help and when they do so they can access the right care and treatment at the appropriate time which will in turn improve services.

Mr Gaunt asked whether, reflecting on the consultation feedback, the clinical group assessed the extension of drive times for services and what their assessment of that perception of risk was. Dr Hindocha advised that this was considered at length for all of the models, but specifically in respect of stroke. It was agreed that when you have a specialised unit those teams are ready and waiting to see patients far more quickly which overall mitigates any impact there might be on travel. Also, there is clear evidence that where there are centres of excellence in place people are prepared to travel further because the outcomes are so much better, adding that he has patients who will go out of county because the service offer is so much better. As a clinical body it is not appropriate to be advising patients to go out of county to access specialised care and the clinicians felt very strongly about this being their responsibility. The stroke consultant who participated in the meetings and process was very clear that the time to treatment was much better by this change, not worse.

Dr McSorley advised that there is significant feedback throughout the consultation process in respect of rehabilitation care and community based care and asked that Dr Hindocha provided some information about the extent of the debate in respect of those aspects of service provision. Dr Hindocha advised that this related particularly to two elements of the proposals - orthopaedics and stroke. Colleagues were very confident that the community based stroke model, which has been developed over approximately the last ten years, is of a quality that would help repatriate patients to their local towns and areas with good enough support. The important aspect of this is that the package of care and support has to absolutely be in place and carried out by staff with the right skills and capabilities. The clinicians were confident about the on-going support in place for stroke. In respect of orthopaedics it was agreed that the support is good but currently prehabilitation services are being developed so that patients are having their rehabilitation before they access their surgery and then only stay in hospital for the minimum length of time.

Dr Parkin sought Dr Hindocha's views on the definition of a Centre of Excellence and particularly in relation to the Medical School that is now in place at the University of Lincoln. Dr Hindocha advised that the focus and direction taken by the group was very much about patient outcomes and patient experience is very much part of that. Excellence is about being the best we can be in the county in that respect.

The Medical School was touched on by the group and the impact it would have on the service changes proposed. The group was reassured by the clinical leads that this would be a positive move, not otherwise.

The Clinical Directorate intends to look at a number of areas going forward, one of which will be working with the Lincoln Academy of Clinical Excellence and looking to set up through the Medical School and the University of Lincoln the best form of research that is clinical evidence based and that informs this type of work.

There were no further questions, and Mr Burnett thanked Dr Hindocha for his attendance.

Mr Burnett handed over to Mrs Chambers to present the final section of Part Two.

### **CCG Quality and Patient Experience Committee (QPEC)**

Mrs Chambers advised that as referred to under Part One, the Extraordinary QPEC meeting on 12<sup>th</sup> May 2022 focused on receiving a report in relation to the assessment of the quality; clear clinical evidence base; and access elements of the Acute Services Review (ASR).

Members were asked to endorse the process undertaken by the Joint ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group to consider the quality; clear clinical evidence base; and access elements of the ASR proposed changes to the four service areas, following feedback from the public consultation. This process included consideration of the Equality Impact Assessments (EIA) and Quality Impact Assessments (QIA) that were revised following the public consultation.

Members were also asked to endorse the outcome of the assessment of the ASR proposed changes to the four service areas, undertaken by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group.

Members considered each proposal and the feedback from the ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group meeting and agreed to:

- Endorse the process undertaken.
- Endorse the outcome of the assessment of the ASR proposed changes to the four service areas.

Dr Boldy advised that he had been involved in this process, both as a Board member and a member of QPEC and advised that he had some comments to make, the first of which related to the population growth in and around Grantham, which he had previously sought clarification on and was pleased to see this data was detailed on page 80 of the report. It was evident that the population growth in Grantham would not make an A&E in the town a logical step at any stage in the future. It was also important to note that Grantham and District Hospital does not have paediatrics, obstetrics, gynaecology or acute general surgery on the site either. The proposal to move to an Urgent Treatment Centre (UTC) is a very sensible one.

The second point related to stroke services and Dr Boldy made it clear that he has always been in favour of moving this service to one site to improve outcomes and provide an excellent service. He had previously been concerned about moving hyper-acute services to Lincoln rather than Boston but had now been reassured by the evidence that has been provided that this proposal will improve outcomes and he was particularly reassured and impressed by the improvement with thrombectomy which was happening already.

Dr Boldy added that he remained concerned about the pressures on services at Peterborough City Hospital but was hopeful that the outcomes there will mirror the outcomes at Lincoln and consideration may need to be given in the future as to whether patients in the south of the county may need to be seen in Lincoln.

In summary, overall he was really impressed with the work by everyone involved in this whole process, which had clearly been well examined by a whole range of individuals and expressed his appreciation to everyone for their efforts.

Dr McSorley thanked all those individuals and colleagues who had contributed to Part Two of the meeting. That section was now concluded and there would be a 15 minute break and then Part Three would commence.

**22/400**

### **Part Three**

Dr McSorley welcomed everyone present to Part Three of the meeting which would focus on the Decision Making Business Case on four of Lincolnshire's NHS services and followed on from the detailed presentation and discussion which took place under Part Two and focused on the work that had been undertaken since the Pre-Consultation Business Case (PCBC) was approved by the CCG Board back in September 2021.

There had been a number of extensive presentations from individuals representing the various workstreams that had been progressed since that time and following completion of the public consultation process.

The next stage of the meeting would focus on the conclusion of that work and the decision to be considered on the four proposals and supporting recommendations that had been put forward before the Board and were available in the pack of papers uploaded to the CCG website the previous week.

Dr McSorley handed over to Mr Gaunt at this point who was representing Mr Turner as Deputy Chief Executive.

Mr Gaunt advised that the CCG has a legal duty is to make arrangements to inform, involve and consult with the public in relation to the planning of commissioning arrangements and to fulfil the development and consideration of proposals and the decisions affecting those.

The purpose of this report is to seek **approval** for changes to four of Lincolnshire's NHS services as presented in the Decision Making Business Case (DMBC). These changes have been developed under the Lincolnshire Acute Services Review (ASR) Programme and are recommended by the Chief Executive of the NHS Lincolnshire CCG, with the support of the CCG Executive Team.

As the Consulting Authority, the NHS Lincolnshire CCG Board is asked to **approve** key changes to the configuration of four NHS services.

Mr Gaunt advised that Mr Burnett would go through the DMBC itself but prior to that invited Mr Peter Edwards from Capsticks. Mr Edwards and his colleagues had been supporting the CCG throughout the whole process with legal advice and specifically in terms of the CCG's legal duties and how the CCG has discharged them.

Mr Edwards thanked the Board for the invitation to join the meeting and then referred to page 22 of the report (item 12c) which detailed the legal content relating to this item. Mr Edwards would pick up some of the themes from that section of the paper and amplify those to some extent.

The Board was advised that as referred to by Mr Gaunt the presentation of this documentation was the culmination of a long process in relation to the development of these proposals under the ASR programme, the public consultation and the consideration of the feedback from that consultation and the development of the DMBC. Capsticks have been engaged by the CCG throughout the whole programme to provide assurance that the process followed has been legally robust.

In order to do that Mr Edwards, in particular, has carried out detailed legal reviews of both the PCBC and also the DMBC that is being considered today. In addition to that, Mr Edwards has provided ad-hoc advice to the ASR programme throughout the process and has included advice on the legal duties in respect of public consultation and the Gunning Principles of lawful consultation of which the Board had been briefed on some of the detail under Part Two of the meeting by the Consultation Institute.

On the basis of that advice Mr Edwards advised that he was able provide assurance to the Board that appropriate legal considerations were taken on board by the ASR programme throughout the process leading up to the presentation of the DMBC at today's meeting.

The main focus is therefore on the legal considerations that the Board need to have in mind in making their decision on the proposals that are presented within the DMBC.

Mr Edwards referred to the box included in the paper (page 22) which set out the detail of the main legal duties that the CCG is subject to when it is making decisions in respect of the ASR proposals.

Alongside each of those legal duties there is a summary of the evidence from the DMBC and its appendices that demonstrates compliance with those duties.

In addition to those duties that are documented in the paper and as the Board had already been briefing on earlier in the meeting, the CCG is subject to the Public Sector Equality Duty which is contained within the Equality Act 2010. This is addressed both in terms of what the Public Sector Equality Duty actually provides for and also how it has been addressed in the process in relation to the DMBC and particularly the Equality Impact Assessment (legal section in page 799 of the paper – Item 12c).

In summary the Public Sector Equality Duty states that due regard should be given to three main aims:

1. Eliminate discrimination, harassment and victimisation.
2. Advance equality of opportunity between those who share a protected characteristic and those who do not.
3. Foster good relations across all protected characteristics – between people who share a protected characteristic and people who do not share it.

The Board needs to be cognisant of all of these points when making its decision.

Mr Edwards added that the duties are expressed in slightly different terms – some duties must be done and are self-explanatory, some which should exercised with a view to doing something, and some, such as the duties in respect of equalities and inequalities have regard duties.

In respect of the last category, this is described as a procedural duty rather than one to achieve a particular outcome and what the law says is that the decision maker must carry out a rigorous consideration of the duty, although ultimately it is for the decision maker to decide how much weight to give to that consideration. In simple language this means that the decision maker should properly and seriously take into account the subject of that duty.

Mr Edwards advised that the information provided should provide the Board with clear legal grounding on the actions it needs to take in the next part of the meeting.

On a final note, Mr Edwards advised that he wanted to address the decision making process itself in the sense that having been presented with a number of different legal duties, how they are all taken into account in reaching the decision, particularly if not all of those duties are aligned. On that issue the High Court expressed a view approximately 18 months ago involving another CCG in a different part of the country that was making changes to its acute stroke services in a similar way to the one of the Lincolnshire CCG's proposals, that there is a suite of high level duties under the NHS Act which relate to a wide range of factors and that reflects the complexity of decision making in an advanced healthcare system like the NHS. Therefore the decisions the Board will be making will be multi-factual and may involve the allocation of limited resources between competing needs. It is recognised that not all of the factors may necessarily pull in the same direction so the Board as the decision makers have substantial discretion as to the weight that they choose to attach to each factor.

Mr Edwards advised that he was happy to take any questions at this point in terms of the legal obligations in respect of what the Board is being asked to do.

Mr Burnett thanked Mr Edwards for his comprehensive and informative briefing and for his support throughout the whole process and potentially going forward.

Mr Burnett advised that he would now go through the DMBC in detail for any members of the public who had just joined the meeting, and which would cover some of the elements the Board had already been briefed on in Part Two.

Mr Burnett advised that the purpose of this report is to seek **approval** for changes to four of Lincolnshire's NHS services as presented in the Decision Making Business Case (DMBC). These changes have been developed under the Lincolnshire Acute Services Review (ASR) Programme and are recommended by the Chief Executive of the NHS Lincolnshire CCG, with the support of the CCG Executive Team.

As the Consulting Authority, the NHS Lincolnshire CCG Board is asked to **approve** key changes to the configuration of four NHS services.

Mr Burnett advised that the Lincolnshire population is served by a number of acute hospital Trusts. However, ULHT is by far the largest provider in terms of the number of residents covered. The viability and long-term sustainability of services within ULHT is therefore critical to the provision of acute care services to the residents of Lincolnshire. ULHT provides services from hospital sites located in Lincoln, Boston and Grantham plus a fourth smaller site at Louth.

The geographical distance is considerable between these hospital sites, and the acute services provided at each have evolved over many years to try to best meet the needs of their local population. However, this has led to a number of services becoming increasingly 'fragile' and struggling to be sustainable over a lengthy period of time with no obvious solution in the short to medium term, which has a consequence for service failure.

Key factors underpinning services becoming increasingly unstable and more challenging to sustain are:

- Vacancies and reliance on agency and locum staff
- Rota duplication across two or three sites
- Traditional workforce dependent on Doctors versus Advanced Care Practitioners (ACPs)

Which in turn results in:

- Poorer quality care and patient outcomes
- Longer waiting times for patients to be seen
- Delays for patients to receive treatment
- Clinical staff being over-stretched
- Higher financial costs incurred in an attempt to sustain clinical care

Acute service provision across Lincolnshire therefore needs to find the optimal configuration across the county to maximise clinical, operational and financial sustainability.

In August 2017 the leaders of the Lincolnshire health system agreed the need for a review of the current configuration of acute health services in the county. The full scope of this review, known locally as the Acute Services Review (ASR), covered eight services; Acute Medicine, Breast, General Surgery, Haematology & Oncology, Orthopaedics, Stroke, Urgent & Emergency Care, Women's and Children's.

The aim of the ASR Programme was defined as a programme to develop a set of recommendations on the optimal configuration of acute hospital services across Lincolnshire to maximise clinical, operational and financial sustainability.

In November 2018 a Pre Consultation Business Case (PCBC) was submitted to NHS England for assurance, which set out a preferred option for the future configuration of all eight services within the scope of the ASR Programme. The business case identified a capital requirement of c.£52m (priced in 2018) to enable the proposed changes.

Through the first half of 2019 the availability of capital to enable the proposed service changes set out in the business case submitted to NHS England looked evermore unlikely to be achieved. In light of this, in November 2019 the Lincolnshire health system agreed to go into a 'production line' approach to progress the proposed service changes identified through the ASR Programme. This approach was adopted to minimise delays to the delivery of patient benefits for those service change proposals that, if agreed, could be progressed with no or minimal capital or where sufficient capital could be secured for specific service changes.

Following consideration of the eight services within the scope of the ASR Programme, four services were agreed as the focus for a revised Pre Consultation Business Case (PCBC), as detailed below:

- Orthopaedics
- Urgent & Emergency Care
- Acute Medicine
- Stroke

The PCBC detailed the work completed by the Acute Services Review (ASR) Programme and sets out its recommendations on the proposed options for service change in the four areas set out above, including the identification of a preferred option.

Since the establishment of the ASR Programme, key elements around evidence development and assurance have been carried out including:

- Development of a case for change, new clinical models and potential solutions for review and consideration.
- Patient, public and stakeholder engagement
  - The NHS in Lincolnshire has undertaken a wide variety of engagement programmes across the county, with a diverse range of staff, public and stakeholders.
  - This dialogue has been continuous since prior to the publication of the first Sustainability Transformation and Partnership (STP) five-year plan in 2016 and has played a pivotal role in developing the case for change, guiding and shaping the vision and underpinning the ASR planning process.
  - Engagement on the ASR Programme falls into three phases:
    - Broad engagement (2018)
    - Options engagement (2018)
    - Pre-consultation engagement (2019)
  - In March 2019 'Healthy Conversation 2019' was launched, which was an open engagement exercise to shape how the NHS in Lincolnshire takes health care forward in the years ahead. This included pre-consultation engagement on the emerging options for all eight services in the Acute Services Review and ran through to October 2019.
  - Discussions of proposals with the Health Scrutiny Committee for Lincolnshire.
- Development and ongoing refinement of a Pre Consultation Business Case (PCBC) exploring the options for change. 7
- An assessment of the options for change, including a clinically-led stakeholder workshop and four workshops with members of the public.
- Regulatory and best practice assurance, including:
  - Two reviews of proposals by the East Midlands Clinical Senate.
  - Submission of the PCBC for regional regulatory assurance.
  - Independent assurance process by the Consultation Institute.
- National assurance approval of the PCBC.

The PCBC was approved by the CCG Governing Body on 29<sup>th</sup> September 2021, and it was agreed to proceed to a period of public consultation on the proposals as set out in the PCBC. Part Two of the meeting concentrated on the work that has taken place since that process had completed.

The DMBC is a technical document that follows the PCBC and completion of the public consultation exercise, which ran from 30<sup>th</sup> September to 23<sup>rd</sup> December 2021.

As described under Part Two of the meeting, the overarching conclusion of this independent analysis was there is broad support across all elements of the consultation for the need for change, and overall agreement with each of the four proposals. There were however, two proposals where slightly more concerns were raised, and there was evidence of differing views between those living in different areas of Lincolnshire as detailed below:

- A slight majority of consultation questionnaire respondents living nearest to Grantham and District Hospital disagreed with the urgent and emergency care proposal
- A majority of consultation questionnaire respondents living nearest to Pilgrim Hospital, Boston disagreed with the proposal relating to stroke services

Some equalities concerns were raised about or by particular groups or communities. They focused on travel and transport, particularly for those with limited access to private transport. Specific groups mentioned in this regard included: older people; people with disabilities and long-term conditions and co-morbidities; people living in rural and isolated communities, areas of deprivation or with low incomes; people living with disabilities and neurodiverse people.

Listening to the views of those that responded to the consultation and working with partners across the Lincolnshire health system to consider the feedback has enabled the Chief Executive of the NHS Lincolnshire CCG, supported by the CCG Executive, to recommend proposals that:

- Deliver better outcomes and quality of care for patients
- Reduce waiting times to receive care
- Make it easier for staff to provide the best possible care to patients
- Make services more attractive so they can recruit and retain great staff dedicated to high quality care.
- Better use NHS funds, reducing spend on temporary staff

This feedback and the further consideration and evidence compiled following the public consultation in response to it, together with the evidence contained within the PCBC, have been brought together into a DMBC which is put before the Board for decision.

## **Recommendations**

Specifically, the DMBC document sets out the ask for the NHS Lincolnshire CCG Board, as the Consulting Authority, to approve key changes to the configuration of four NHS commissioned services across Lincolnshire.

The document and the recommendations within it have been underpinned by a clinically led review and evaluation process which considered the evidence collated in the Pre Consultation Business Case (PCBC), feedback received through the public consultation and the considerations of subject matter expert working groups to the consultation feedback received.

The NHS Lincolnshire CCG is grateful for all the feedback and fully acknowledges both the support and concerns of the four change proposals. Following the extensive programme of work to review the findings of the public consultation and ensure conscientious consideration of the feedback, the overarching conclusions of the subject matter expert groups and wider clinical leaders from across the county were the change proposals consulted on were still supported.

However, as set out in detail in the DMBC and highlighted here, through the review and consideration of the feedback a number of actions have been identified for implementation across all four services if the change proposals are agreed.

Mr Burnett advised that he would go through the four recommendations but before doing so it was important to note the following:

- The CCG Board is not bound by the recommendations or conditions put forward in this Decision Making Business Case. The CCG Board can choose to support, reject or amend the recommendations as members see fit.
- The proposals have been built on a solid base of clinical evidence and have been through rigorous clinical testing throughout the duration of the programme.
- The proposals have heard, considered and responded to the themes that emerged from public consultation.
- The proposals are assured by the East Midlands Clinical Senate.
- The proposals are recommended in order to improve patient outcomes and deliver against national clinical guidance.

The recommendations for each of the four services is set out below, together with an overview of key areas of consultation feedback, considerations given and identified actions if the change proposals are agreed. The full extent of consultation feedback, the consideration given and resulting conclusions and actions of the subject matter expert working groups should be read in full and can be found in the DMBC and its appendices.

### **Recommendation 1: Orthopaedics**

Consolidate planned orthopaedic surgery at Grantham and District Hospital, to establish a 'centre of excellence' in Lincolnshire and establish a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery. This reflects the orthopaedics pilot arrangements:

- Outpatients clinics would be unaffected.
- This would mean Grantham and District Hospital would not provide unplanned orthopaedic surgery.
- Lincoln County Hospital and Pilgrim Hospital, Boston would continue to provide unplanned orthopaedic surgery, and some planned orthopaedic surgery for high risk patients with multiple health problems, which is comparatively small in volume.

The CCG Executive have confirmed this proposal results in improved care (as demonstrated through the orthopaedics pilot evaluation) through:

- Reduced waiting times for planned orthopaedic surgery, which mean patients get seen quicker
- Reduced cancellations on the day of planned surgery due to a lack of beds
- Reduced length of stay following planned orthopaedic procedures (including United Hospitals Lincolnshire NHS Trust (ULHT) outperforming many other hospitals)
- Reduced numbers of Lincolnshire patients going to the private sector (often out of county) for planned orthopaedics procedures, funded by the local NHS Improvements in overall patient experience and satisfaction
- Removal of need for temporary staff to cover vacancies and services are more attractive to staff which supports long term sustainability

This has been evidenced further by ULHT currently being one of the best performing trusts in the midlands region in relation to waiting times for orthopaedics and providing 'mutual aid' to neighbouring trusts to support delivery of elective orthopaedic waiting lists.

The concerns raised by the public during the consultation in relation to unforeseen emergencies during planned procedures and the negative impacts on the quality and timeliness of emergency orthopaedic care are acknowledged and were considered and reviewed by orthopaedic service leads as well as wider system clinical leads.

From an elective procedure perspective clinical review and discussions confirmed that since the pilot started in 2018 there has been only one patient who required transfer due to a post operation complication to Lincoln County Hospital, due to a suspected thrombolism, which demonstrated how robust the selection criteria for patients is.

With regards to emergency orthopaedic care it was confirmed by orthopaedic service leads that at the start of the pilot trauma lists were kept at Grantham and District Hospital as part of the model, however it was evidenced over time that these were not being utilised. Minor trauma cases that can be appropriately discharged home to have a semi-planned operative procedure on a later day at Grantham are, thereby keeping orthopaedic trauma patient transfers to a minimum.

The concerns raised by the public during the consultation regarding increased travel and equity of access in a large rural county (particularly for groups such as older people, people on low incomes, those without access to private vehicles and people with disabilities) for planned orthopaedic procedures are acknowledged and were considered and reviewed by orthopaedic service leads as well as wider system clinical leads.

It was recognised that for a small proportion of people who provided feedback through the consultation that the timeliness of ambulance response was a concern. East Midlands Ambulance Service (EMAS) has been fully engaged in the work and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. The DMBC provides resource to EMAS to mitigate the impact of the proposed changes on current ambulance response times.

Mr Burnett advised that was a section later on in the report on transport which was a consideration across all four proposals and would be covered in more detail later on in the meeting.

The change proposal for orthopaedics is supported by the NHS Lincolnshire CCG clinical leads, who also identified a number of actions relating to implementation if the change proposal is agreed:

- A roadmap needs to be developed to ensure the vision of a 'centre of excellence' is fully realised.
- Opportunities should be identified to increase the volume of planned orthopaedic activity at Grantham and District Hospital as this will further support the development of a 'centre of excellence'.
- Need to make sure there is not a distillation of orthopaedic skills at different sites in Lincolnshire.

## **Recommendation 2: Urgent and Emergency Care**

Establish a 24/7 walk-in Urgent Treatment Centre (UTC) at Grantham and District Hospital:

- This would be in place of the current Accident & Emergency (A&E) department.

The CCG Executive have confirmed this proposal results in improved care through:

- 24/7 walk in urgent care would return to Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term.

- The vast majority of patients seen at Grantham and District Hospital A&E department would continue to be treated at the 24/7 Urgent Treatment Centre (UTC).
- The UTC would provide greater accessibility due to increased opening hours compared to the current A&E arrangements (currently closed between 6.30pm and 8.00am).
- The UTC would support better integration with primary care and community services and the provision of care closer to home.
- For a small number of patients (estimated to be around two patients a day on average) currently attending the Grantham and District Hospital A&E who would not be able to have their care needs met by the UTC, care would be received at an alternative site with the right facilities and expertise to ensure better clinical care outcomes.
- Making sure patients get to the definitive treatment, first time whether that be Grantham and District Hospital or an alternative site.
- Reducing the number of intra hospital transfers from Grantham and District Hospital to another site, so demonstrating that the patient was getting to the definitive treatment site, first time.

The concerns raised by the public during the consultation in relation to the conditions that would be treated at a 24/7 UTC and that Grantham and District Hospital should have a 'full' Type 1 A&E and supporting hospital service provision area are acknowledged. These have been considered and reviewed by urgent and emergency care service leads as well as wider system clinical leads.

In relation to the conditions that would be treated at a 24/7 UTC, clinical leads identified and agreed a number of key conclusions and actions for implementation if the change proposal is agreed, and which were set out in the paper.

A comprehensive communication plan would be rolled out for members of the public to make sure local residents are made fully aware of what services the 24/7 UTC would be able to provide. This will include a public facing document that clearly lists conditions that can be managed at the proposed 24/7 UTC and be explicit about the red flags that should prompt 999 and includes information about diagnostics.

With regards to Grantham and District Hospital having a 'full' Type 1 A&E and supporting hospital service provision, following a thorough review (of national guidelines and standards, independent clinical advice, current service provision, population growth data and the experiences of other health systems) the clinicians reaffirmed that a number of combining factors lead to the conclusion that a type 1 A&E department at Grantham and District Hospital that provides a full range of 'unselected' care and is supported by the required core set of specialties is not feasible. The reasons for that were set out in the report.

It is acknowledged that there are concerns about ambulance conveyance, including risk to life as a result of increased travel time. Clinicians have carefully considered this issue and identified:

- Under the current exclusion criteria, patients from Grantham and the surrounding areas with serious conditions such as heart attack, acute cardiology and suspected stroke and already taken straight to neighbouring hospitals where more specialised services are located. This exclusion criteria is well understood by the local healthcare system including primary care, community providers and the ambulance service.
- Under the proposed model of a 24/7 UTC at Grantham and District Hospital the exclusion criterion for the Grantham Hospital site would be refined, meaning a relatively small number of patients (2 a day on average) currently attending the A&E, would not in the future.

As highlighted under the recommendation on orthopaedics, EMAS have been engaged in the work and the DMBC presented provides resource to mitigate the impact of the proposed changes on current ambulance response times.

The concerns raised by the public during the consultation regarding travel and transport (particularly older people, people with disabilities, those from more deprived communities or living in rural areas) are acknowledged and were considered and reviewed by urgent and emergency care service leads as well as wider system clinical leads.

As also identified previously, transport would be addressed later in the report.

The change proposal for urgent and emergency care is supported by the NHS Lincolnshire CCG clinical leads, who also identified a number of actions relating to implementation if the change proposal is agreed which were set out in the report.

### **Recommendation 3: Acute Medicine**

Establish integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.

- The CCG Executive have confirmed this proposal results in improved care through:
- Delivering a balance between access and sustainable long term outcomes for acute medicine services at Grantham and District Hospital.
- Supporting the majority of patients that currently receive Acute Medicine care at Grantham Hospital to do so in future, only c.10% of high complexity patients would be cared for at another hospital with the right facilities and expertise to ensure the best outcomes.
- Enabling Grantham Hospital to offer services which may not be offered elsewhere and build a centre of excellence for integrated multi-disciplinary care, particularly for frail patients.
- Delivers a more comprehensive service provision at Grantham Hospital, specifically in relation to the 'frail' population, thereby reducing pressure on acute sites in Lincoln & Boston.
- Grantham Hospital acts as a hub for supporting community teams and community services across the county, and improves accessibility to specialist advice for primary care and community-based teams.
- Supports improved community-based management of long term conditions and reduced length of stay in hospital beds.
- Supports a more sustainable medical and nursing workforce through new and innovative care models that offer sustainability, role variety and greater integration across pathways.

Key concerns raised by the public during the consultation that are acknowledged include:

- Placing elderly needs out of a secure hospital environment supported by specialist consultants or moving them to alternative hospital sites requiring considerable journeys with associated risk
- Adequate staffing, cost of implementing the changes and increased workload required
- Negative impacts on the quality of care provided, and the potential for increased pressure on other hospitals.
- Grantham and District Hospital should be a fully serviced hospital with acute medical beds.

These were considered and reviewed by the acute medicine service leads and wider system clinical leads as they were in the other proposals.

The integrated community/acute medical beds would be delivered through a partnership model between a community health care provider and United Lincolnshire Hospitals NHS Trust. The care of patients would still be led by consultants (senior doctors) and their team of doctors, practitioners, therapists and nursing staff.

Workforce modelling for the Pre Consultation Business case identified an increased workforce requirement to deliver the proposed model of care.

It is anticipated this change would affect around 10% of those patients currently receiving care in the acute medical beds at Grantham and District Hospital. This is equivalent to 1 patient a day, on average. These patients would receive care at an alternative hospital with the right skills and facilities to ensure the best possible outcome.

It should be noted that there are no changes in the beds available on the site for medical inpatients. Retaining current provision is essential to supporting stabilisation of the wider health system. The proposed integrated community/acute medical beds would continue to be supported by a Level 1 bed function on the Grantham and District Hospital site that would support medical patients requiring escalation.

The East Midlands Clinical Senate strongly supported the proposed model – identifying it delivers a balance between access and sustainable long term outcomes for acute medicine services - and there is a strong clinical evidence base for it.

As referred to previously it was recognised that there are some concerns about an additional impact on East Midlands Ambulance Service (EMAS) to transfer people to the nearest hospital with an acute bed, and it was confirmed EMAS has been fully engaged in the work and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models.

It is acknowledged that in the public consultation feedback there were few comments related to potential impacts on any specific demographic groups, with the exception of a small number of comments reiterating concerns about travel and access for groups without access to private transport. Again, as referred to previously, this would be picked up later in the report.

It is also acknowledged that several respondents, including some NHS staff members, felt that the proposed move to integrated community/acute medical beds would benefit older and more frail patients by better integrating acute and community care for those patients who need the latter.

In terms of access, the clinical leads identified a distinction needs to be drawn between these proposals and those for urgent and emergency care as these are based on admitted patients, so access would be straight forward in that regard.

The change proposal for acute medicine is supported by the NHS Lincolnshire CCG clinical leads, who also identified a number of actions relating to implementation if the change proposal is agreed, which were documented in the report.

#### **Recommendation 4: Stroke Services**

Establish a 'centre of excellence' for hyper-acute and acute stroke services at Lincoln County Hospital site. This would be supported by increasing the capacity and capability of the community stroke rehabilitation service:

- This would mean hyper-acute and acute stroke services are no longer provided from Pilgrim Hospital, Boston.
- Transient ischaemic attack (TIA) clinics would be unaffected at Pilgrim Hospital, Boston.

The CCG Executive have confirmed (which has been informed through the temporary service change to consolidate hyper-acute stroke services on the Lincoln County Hospital site in light of COVID-19) the proposal result in improved care through:

- Tackling significant workforce shortages and challenges in stroke by concentrating specialist stroke and multi-disciplinary skills and expertise.

- Reducing heavy reliance on locums by increasing chances of recruiting to substantive roles and having to spread staff across two sites.
- Improved achievement against national stroke standards.
- Enabling a critical mass for a stroke unit well above recommended levels.
- Improved alignment with clinical interdependencies – Lincolnshire Heart Centre and Mechanical Thrombectomy services at Queens Medical Centre (QMC) in Nottingham.

Key concerns raised by the public during the consultation that are acknowledged, and were considered and reviewed by the stroke service leads and wider system clinical leads relate to:

- Increased travel times to Lincoln County Hospital for emergency stroke care
- Concerns the proposal could widen health inequalities and negatively impact patients access as services would be removed from a deprived area.

Following thorough consideration by clinical leads from across the health system it was confirmed that it is the overall time from event to treatment by a skilled and dedicated workforce that can provide high-level Consultant led 7-day provision that has the greatest impact on quality of care and outcomes, not travel time. Faster access to high quality diagnosis and treatment at the acute site can offset longer travel times.

It was also confirmed that time spent in an ambulance can still be used to support the treatment of patients. Since the start of the temporary service change, a good joint working model has been established between ambulance paramedics and stroke Advanced Care Practitioners (ACPs) at Lincoln Hospital to review previous medical history and decision for treatment commences as soon as patients arrives at hospital.

It was acknowledged that East Midlands Ambulance Service (EMAS) has been fully engaged in the work and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. The business case provides resource to EMAS to mitigate the impact of the proposed changes on current ambulance response times. It was also noted that the Lincolnshire division of EMAS has the most efficient on scene time of all East Midlands divisions/counties helping to reduce overall call to definitive treatment timescales.

Through the clinical consideration it was also acknowledged that the consolidation of cardiology services on the Lincoln County Hospital site to concentrate capacity, skills and expertise, in a similar way proposed for stroke, has demonstrated improvements in outcomes for all Lincolnshire residents.

Using the experience of the temporary service change of consolidating hyper-acute services on the Lincoln County Hospital site clinical leads have given thorough consideration to the impact this has had on the quality of care received by patients. This confirmed that:

- In 2021 Lincoln County hospital was one of the highest performing sites nationally in terms of national stroke performance standards.
- Patients from the Boston Hospital catchment area have been seen and scanned quicker, had more access to thrombectomy and were, on average, discharged sooner (compared to before the temporary change).

A conclusion of the clinical considerations was the temporary change to consolidate hyper-acute stroke care on the Lincoln County Hospital site has shown thrombolysis can be achieved providing a first-class service to stroke patients in the County regardless of where they live and that this is predicated on having the best expertise on one site that is clinically supported based on the evidence.

Through the clinical discussions it was confirmed that key factors contributing to the performance at Lincoln County Hospital was the stroke service on-call Advanced Care Practitioner workforce and co-location with cardiology services.

Co-location with the heart unit also has the benefit of using the Cath lab facilities to directly access acute imaging thus bypassing A&E and further reducing door to needle time/angiogram time.

The stroke team at Lincoln Hospital has also developed an excellent working relationship with the Queens Medical Centre (QMC) Nottingham thrombectomy team and became one of the best referring sites in the region.

The clinical discussions confirmed the public's concerns about patients travelling further need to be recognised and, if the change is agreed, a communication and education strategy on the proposals, how to recognise stroke symptoms and how to access care needs to be put in place. This should include a targeted, local bespoke communication and education strategy with a specific focus on the deprived areas with the longest travel times.

Concerns raised through the public consultation relating to stroke service staffing, particularly a single site at Lincoln County Hospital, and capacity at Lincoln County Hospital are acknowledged.

Consideration by clinical leads confirmed the proposed service change to consolidate hyper-acute and acute stroke services at Lincoln County Hospital is supported by a workforce model that would see an increase in specialist stroke staff at Lincoln County Hospital, and ensure the unit is staffed according to agreed national guidelines for medical, nursing and allied health professional staff.

Alternative suggestions put forward through the public consultation for stroke rehabilitation are also acknowledged. During the clinical discussions it was identified that approximately 49% of stroke patients are discharged from hospital within seven days. It was confirmed there is a very wide spectrum of rehabilitation needs for stroke patients and hospital is not the best place for a majority of these patients. The best place for rehabilitation is in the patient's own home and they can progress with the right level of support, the longer a patient stays in hospital the more deconditioned the patient becomes and is more dependent.

The rehabilitation element was acknowledged as an important part of the whole process and the proposed Centre of Excellence is crucial to the development of community services.

### **Travel and transport**

It is acknowledged that feedback on the consultation on the four service change proposals has identified travel and transport as a significant concern for patients and the public, as well as the Health Scrutiny Committee (HSC) for Lincolnshire. This concern was generally expressed in terms of:

- The effect of the proposed changes on the ability of patients and their family/carers to access services that may be at a more distant site than currently.
- Hospital discharges in the evening or overnight when public transport tends not to operate creating an additional challenge for people without their own transport.

A Travel and Transport Report has been considered which contains an assessment of the current situation together with a set of enablers to help mitigate the impact of the proposed service changes on access. These enablers are:

- Emergency and Urgent Transport
- Non-Emergency Patient Transport
- Other Transport

Comments received from the consultation feedback indicated concerns about the impact on the ambulance service of the additional journey times associated with the proposals in the ASR.

EMAS have been fully engaged in the ASR and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. EMAS have confirmed they are able to accommodate the additional small demand on their services.

As referred to previously the DMBC provides resource to EMAS to support their increase in service provision. If the decision is taken forward, then detailed discussions would need to take place with EMAS.

Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. This means Lincolnshire residents who meet the eligibility criteria receive free transport in certain situations, the details of which were set out in the report.

The Lincolnshire health system is committed to using any revisions arising from the implementation of the national criteria, including any flexibility in those criteria, to the full for the benefit of patients in Lincolnshire.

The patient transport service is also required to signpost patients who do not meet the eligibility for patient transport to alternative transport providers. The 'other transport' category presents the most complex area for consideration as it covers transport and travel services that the CCG does not have a duty to provide.

Through the work completed to consider the travel and transport feedback received during the consultation it was identified a number of solutions already exist and strengthening the current arrangements is seen as central to tackling the challenges.

Opportunities to strengthen current arrangements include:

- Promoting the use of public transport options to try to reduce reliance on car usage
- Promote and use existing infrastructure wherever possible
- Making the best use of existing public transport facilities wherever possible – including engagement with transport operators to discuss how services could accommodate changing travel patterns
- Ensure users have clear and easily accessible information about public transport options to encourage uptake
- Tackling issues relating to expanding existing volunteer driver schemes

The NHS in Lincolnshire is committed to working in partnership with all partners, particularly Lincolnshire County Council, to support and improve travel and transport solutions for health and care services in the widest sense, not just in relation to the four proposed services changes.

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Irrespective of whether the change proposals are agreed the NHS in Lincolnshire will continue to work with Lincolnshire County Council and ensure joint working groups and forums are in place to improve travel and transport solutions for health and care services in the widest sense.

If the change proposals are agreed, this ongoing work between the NHS and Local Authority will be informed further through the monitoring of the transport impact overall.

### **Finance and Resource Implications**

The economic and financial analysis has been developed by the Lincolnshire Integrated Care System (ICS) finance team, working with the relevant service leads and reporting to the ICS Financial Leaders Group (FLG).

This group is chaired by the NHS Lincolnshire CCG Director of Finance.

The four services in the scope of this Decision Making Business Case (DMBC) are forecast to deliver a financial benefit of c.£1.9m in total by the time all the service changes are in place.

Three of the proposed service changes can be achieved without capital requirements, the one area that will require estates reconfiguration and associated capital is the consolidation of stroke services on the Lincoln County Hospital site, through the construction of an extension to the existing unit. Current cost estimates for this estates solution are £7.5m.

The Financial Leaders Group (FLG) has concluded that since preparing the Pre-Consultation Business Case there has been no material change in the proposals or the assumptions underpinning financial sustainability of the proposals. There are risks to the overall deliverability of the DMBC and they are set out in the report together with mitigations.

### **Legal Implications**

These had already been covered earlier in the meeting so would not be touched on again.

### **Risk Implications**

There are key risks associated with the proposed changes, and mitigations to these, are included in the Decision Making Business Case. If the change proposals are agreed these will be reviewed and developed further through implementation.

An implementation risk register would be developed and managed by the relevant implementation group, and it is proposed these would be overseen by an Implementation Oversight Group (IOG). As part of its establishment its relationship with existing Integrated Care System, commissioner and provider governance arrangements would be confirmed.

### **Implications for equalities and health inequalities**

An Equality Impact Assessment (EIA) was included in Appendix H of the Decision Making Business Case and was reviewed by the Quality and Patient Experience Committee (QPEC) as identified earlier in the meeting.

Finally, and in terms of the next steps, a comprehensive engagement process has underpinned the Acute Services Review Programme, engaging clinicians, provider organisations and the local population. If the proposals are agreed then further engagement and scrutiny will continue to be sought, both leading up to, and as part of, the implementation process. This will help to ensure that the service changes and improvements proposed meet the needs of the Lincolnshire population.

The ICB when it comes into being on the 1<sup>st</sup> July 2022 will oversee the strategic commissioning of the new model of care and implementation of the service changes, as the new NHS commissioning authority for the Lincolnshire health system.

It is recommended by the Chief Executive of NHS Lincolnshire CCG, supported by the CCG Executive, that the NHS Lincolnshire CCG Board **approve** the following proposed service changes as discussed around:

- Orthopaedics
- Urgent and Emergency Care
- Acute Medicine
- Stroke Services

Dr McSorley expressed his appreciation to Mr Burnett for his detailed and extremely thorough presentation of the DMBC.

Dr McSorley advised that he had initially had some concerns about transport implications having read the report produced by the ORS, but had been assured by the level of work covered in the DMBC, particularly sections 1.10 through to 1.12, and the workstreams set out to be carried forward.

Mr Gaunt advised that during the course of Mr Burnett's very full expedition of the DMBC, he had been reflected at various stages of the legal duties as referred to by Mr Edwards and his advice and the prospect of balancing of those, such as access, equality, service improvement, choice and integration. Across the range of the different proposals it appeared there was a really good balance in all those areas, particularly around service improvement, access and ways of tackling inequalities. In summary there was clear evidence that fine balancing line had been taken and also, given the considerations given to travel and transport, that provision had been made for expansion of the range of transport. There was also a clear commitment to a number of areas that would be closely monitored going forward.

Mr Fahy referred to the weight of clinical evidence that supports these new models of working and there is a real opportunity here to bring about sustained and continued improvement in patient outcomes, and to bring about that critical mass, particularly the chance to develop centres of excellence. Mr Fahy just wanted to emphasise those points in terms of reducing the waiting lists and overall better outcomes for patients.

Dr Boldy advised that he was completely in support of previous comments from his Board colleagues. For many years patients from Lincolnshire have had to go to Nottingham for neurological services and/or Leicestershire or Nottingham for their thoracic and cardiac surgery based on the fact that outcomes are so much better when you concentrate patients in a specialist facility. The orthopaedic and stroke services affords the opportunity to produce real real excellence for the county as has already been demonstrated with the cardiology service. Dr Boldy advised that he accepts some people will have to travel further, that is trumped by the likely and already demonstrated quality of care that can be offered to patients.

Dr Parkin added that building on the comments by Dr Boldy it is really important to understand the word excellence; by providing this type of service it allows for in a sense a spin off to be developed, for example in relation to radiological services. There is clear evidence that provision of specialist services attracts the right type of workforce which is critical to grow these specialties, which includes rehabilitation services such as Speech and Language Therapy, which is really important if services and outcomes are going to be improved in Lincolnshire for patients.

Dr Baker advised that he wanted to reiterate the points raised by his Board colleagues and added that this whole process was started many years ago primarily due to concerns about the fragility of some services throughout the county. However, as the process has been gone through, the proposals that have been developed will tackle that fragility but also will undoubtedly improve quality and outcomes, which is absolutely key.

Mrs Chambers asked if Mr Burnett could comment on the consideration of the impact of the proposed changes on health inequalities and that none of the proposals are likely to exacerbate any of those. Mr Burnett advised that as described in the report the key for addressing health inequalities is improving health outcomes for patients. As described in the stroke impact better outcomes is achieved by receiving treatment from skilled clinical teams in centres of excellence with the right resource around them, which leads to better outcomes for patients. The same can be said for orthopaedics, again which was set out in the report – it is all about achieving better outcomes for patients which in turn reduces health inequalities.

Dr McSorley at this point referred to the question received by Jody Clark, member of the public, at this point.

If the public consultation is approved today, how long until Grantham Hospital gets the 24hr UTC?

**Response:** If the decision is taken to approve the recommendation it could take up to 12 months before a 24/7 UTC is put in place as we would need to go out for procurement for the service.

Dr McSorley then moved on to the recommendations. It is recommended that the NHS Lincolnshire CCG Board **approve** the proposed service changes:

**Recommendation 1: Orthopaedics - approved**

- Consolidate planned orthopaedic surgery at Grantham and District Hospital, to establish a 'centre of excellence' in Lincolnshire-
- Establish a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery.

**Recommendation 2: Urgent and Emergency Care - approved**

- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC).

**Recommendation 3: Acute Medicine - approved**

- Develop integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.

**Recommendation 4: Stroke Services - approved**

- Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

In summary all four recommendations were approved, with no dissenting views expressed by the Board.

Dr McSorley advised that this now drew that item to a close and expressed his appreciation to everyone involved and the citizens of Lincolnshire for their contributions on the proposals and emphasised that continued engagement and involvement will continue with the public going forward.

**22/401 AREAS OF RISK TO BE INCLUDED ON THE RISK REGISTER**

The Board considered whether there were any new areas of risk to be included on the Corporate Risk Register. There were no new items identified.

The Board agreed to:

- **Note the verbal update.**

**22/402 DATE AND TIME OF THE NEXT MEETING**

The next meeting will be held on Wednesday, 29<sup>th</sup> June 2022 at 9.00 am and held as a Live Event via Microsoft Teams.

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**Chair Signature**

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**Date**

Not Delivered
In Progress
On Track to Deliver
Delivered

## ACTION LOG - PUBLIC

<b>Date of Meeting:</b>	Wednesday, 29 <sup>th</sup> June 2022
<b>Agenda Item:</b>	2
<b>Reporting Officer:</b>	Dr Gerry McSorley, Acting CCG Chair

Date of Meeting	Minute Number	Item	Action	Lead	Due Date	Progress
25/05/22	22/391	COVID-19 update report	To share the letter from NHSE on recovery (EPRR).	Mrs Raybould	May 2022	Delivered.
25/05/22	22/392	Integrated Performance Report	To bring back details on the increase in waiting lists following the outcome of the review.	Mrs Raybould	May 2022	Delivered.
25/05/22	22/394	ICB Constitution	To check the Constitution in respect of equality and diversity being applicable to the whole ICB Board.	Mrs Ellis-Fenwick	May 2022	Delivered.

## BOARD MEETING – PUBLIC

<b>Date of Meeting:</b>	29 <sup>th</sup> June 2022	Agenda item:	4.1
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<b>Title of Report:</b>	Update – NHS Lincolnshire Response to and Management of COVID-19 Pandemic
<b>Report Author and Title:</b>	Clair Raybould – Director of Operations
<b>Appendices:</b>	1. Appendix 1 - Daily Update – COVID-19 in Lincolnshire as of 22 <sup>nd</sup> June 2022

<b>1.</b>	<b>Purpose of the Report (including link to objectives)</b>
<p>The purpose of this paper is to provide assurance to the CCG Board in relation to:</p> <ul style="list-style-type: none"> <li>i. The latest position in terms of the COVID-19 pandemic in Lincolnshire</li> <li>ii. Update on Emergency Preparedness Resilience and Response (EPRR)</li> <li>iii. Covid Recovery headlines</li> <li>iv. Update on Covid Vaccination Programme</li> </ul>	
<b>2.</b>	<b>Recommendations</b>
<p>The Board is asked to note and consider all of the information in this report and the actions being undertaken.</p>	
<b>3.</b>	<b>Executive Summary</b>
<p>Coronavirus infections, as in other parts of the country, are now on an upward trajectory and in Lincolnshire, we have seen a rise in the impact of Covid infections particularly during the last seven days on services, staff, and the population.</p> <p>The links between serious illness and infections remain weakened because of excellent progress in the vaccination programme but it should be noted that hospital admissions are increasing and it remains vitally important that people come forward for vaccination when offered now and in future campaigns.</p> <p>The report details the position for Lincolnshire of Covid 19 Pandemic, current pressures, Vaccination, all of which the Board are aware are managed under a Single EPRR Incident Operating Model nationally, regionally, and locally. The NHS incident level has now dropped to Level 3 Incident from national to regional control.</p>	
<b>4.</b>	<b>Management of Conflicts of Interest</b>
<p>N/A</p>	
<b>5.</b>	<b>Finance, QIPP and Resource Implications</b>
<p>Workforce shortages as a result of Covid have had an impact on the use of bank and agency staff across providers.</p>	
<b>6.</b>	<b>Legal/NHS Constitution Considerations</b>
<p>Any considerations will be identified in the main part of the paper.</p>	

<b>7.</b>	<b>Analysis of Risk including Assessments</b>																
Please state if the risk is on the CCG Risk Register.      Yes   x   No <input type="checkbox"/>																	
<b>8.</b>	<b>Outline engagement – clinical, stakeholder and public/patient</b>																
On-going clinical and stakeholder engagement during the pandemic and public communications are undertaken with a particular focus on health inequalities.																	
<b>9.</b>	<b>Outcome of Impact Assessments</b>																
Not applicable to this paper.																	
<b>10.</b>	<b>Assurance Departments/Organisations who will be affected have been consulted</b>																
Insert details of the departments you have worked with or consulted during the process:																	
<table border="1"> <tr><td>Finance</td><td><input type="checkbox"/></td></tr> <tr><td>Commissioning</td><td><input type="checkbox"/></td></tr> <tr><td>Contracting</td><td><input type="checkbox"/></td></tr> <tr><td>Medicines Optimisation</td><td><input type="checkbox"/></td></tr> <tr><td>Clinical Leads</td><td><input type="checkbox"/></td></tr> <tr><td>Quality</td><td><input type="checkbox"/></td></tr> <tr><td>Safeguarding</td><td><input type="checkbox"/></td></tr> <tr><td>Other</td><td><input type="checkbox"/></td></tr> </table>	Finance	<input type="checkbox"/>	Commissioning	<input type="checkbox"/>	Contracting	<input type="checkbox"/>	Medicines Optimisation	<input type="checkbox"/>	Clinical Leads	<input type="checkbox"/>	Quality	<input type="checkbox"/>	Safeguarding	<input type="checkbox"/>	Other	<input type="checkbox"/>	
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<b>11.</b>	<b>Report previously presented at:</b>																
A previous update was presented to the May Board meeting.																	
<b>12.</b>	<b>For further information or for any enquiries relating to this report, please contact</b>																
<b>Clair Raybould – Director of Operations</b> <a href="mailto:Clair.raybould@nhs.net">Clair.raybould@nhs.net</a>																	

## Appendix 1

### 1. COVID-19 General Update

- i. During the last two weeks reported below, cases of COVID have risen steadily. This is evident both locally and nationally.
- ii. Over the last 7 days reported positive cases across all localities in Lincolnshire has increased.

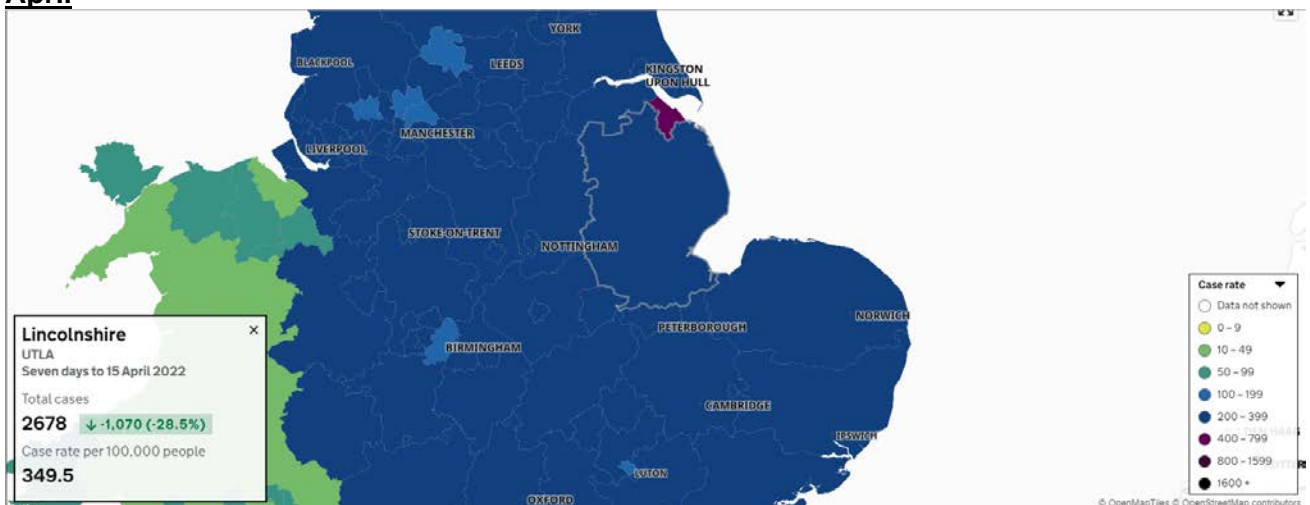
Cases recorded over the past 7 days (per 100,000 rate) up to 22<sup>nd</sup> June 2022 are displayed below.

Location	30/05/2022 (Rates per 100,000)	06/06/2022 (Rates per 100,000)	13/06/2022 (Rates per 100,000)	22/06/2022 (Rates per 100,000)
England	72.6	64.4	74.5	137.1
Lincolnshire	68.6	46.7	58.1	129.3
Boston	57.9	24.0	25.4	103.1
East Lindsey	73.2	48.6	55.6	111.9
Lincoln	77	42.0	55	125.9
North Kesteven	86.3	51.6	73.6	128.7
South Holland	44.9	37.6	52.2	126.2
South Kesteven	59.3	48.9	59.3	148
West Lindsey	76.9	65.5	73.8	153.9

- iii. Nationally there were 77,550 new infections reported on 16<sup>th</sup> June 2022 in contrast to the 22,337 new infections reported on 16<sup>th</sup> May 2022. An increase of 31.9% over the last 7 days.
- iv. The current R rate in England is between 0.7 and 0.9; in the Midlands is it between 0.7 and 0.9.
- v. The number of COVID positive patients in Lincolnshire provider hospital beds is 49, 47 at ULHT, 1 at LCHS and 1 at LPFT, this has increased sharply over the last 7 days.
- vi. We have received further guidance in relation to Infection Prevention and Control (IPC) measures for the NHS which has been reviewed across the system to provide guidance for all providers and staff in the NHS.

Experimental map from gov.uk available here: <https://coronavirus.data.gov.uk/details/interactive-map> (Latest map based on 15<sup>th</sup> April 2022 data latest available on 16<sup>th</sup> June 2022)

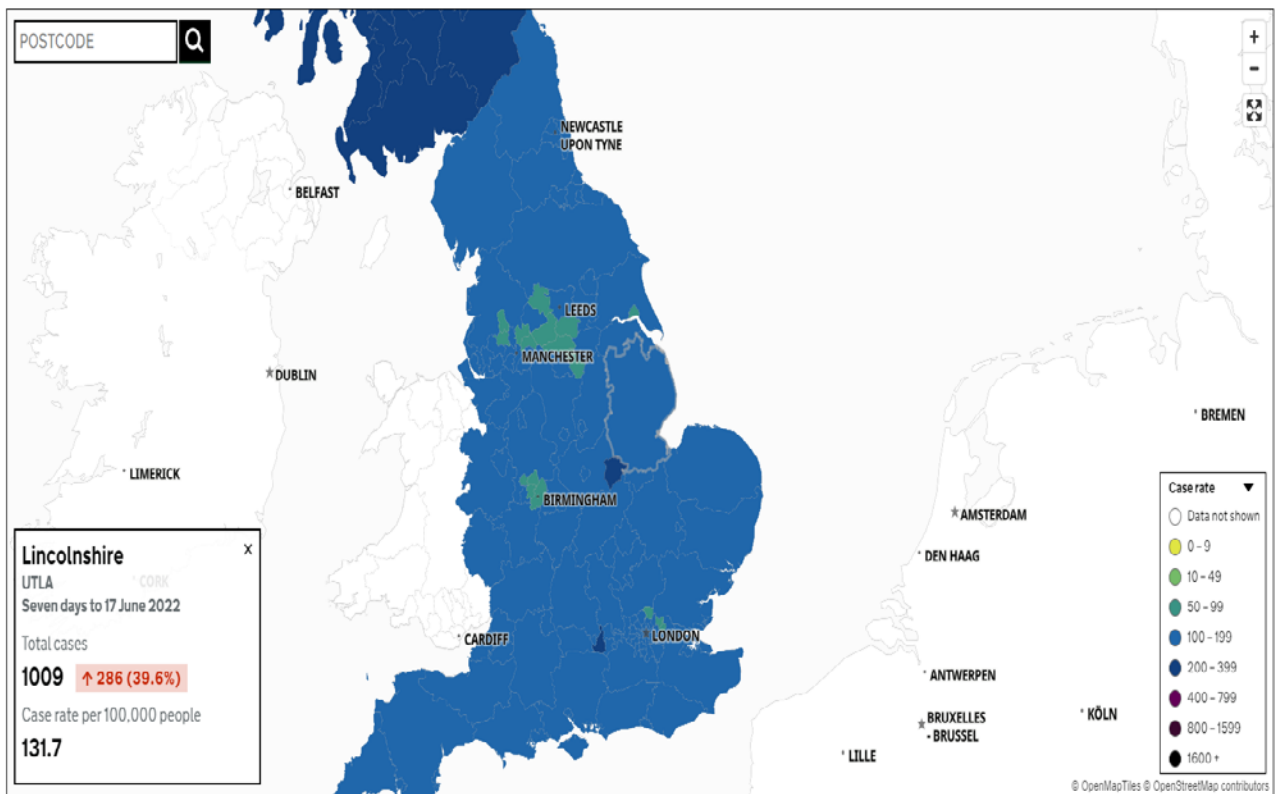
### April



## May



## June



## 2. Emergency Planning, Resilience and Response (EPRR)

- i. The CCG is currently a Category 2 responder for EPRR which means it supports in the event of an emergency from the 1<sup>st</sup> July the Integrated Care Board (ICB) will become a category 1 responder in its own right. The key changes associated with transitioning to ICB, and category 1 responder status are:
  - Category 1 responders are likely to be at the core of any emergency response.
  - The ICB will be required to assess both national, regional, and local risks to prepare appropriately for threats identified.
  - The ICB will be required to develop a generic incident response plan to prepare for the common consequences of emergencies. In some cases, there will be specialist response plans to prepare for threats such as mass casualties, chemical, biological, radiological, or nuclear incidents, and adverse weather.

- Local resilience partnerships will provide the forums for the ICB to lead collaborative system preparation. Special arrangements will be in place to warn, inform and advise the public in the event of an emergency. This will include a dedicated communications strategy and plan for incident response.

ii. **ICB Category 1 assurance**

The ICB Incident Response Plan (IRP) has been developed. This will provide arrangements to manage the common consequences of emergencies. The plan will enable a state of readiness for ICB on-call managers to effectively command a response. An exercise took place on the 21<sup>st</sup> June which tested both the IRP and the communications cascade. This cascade is the mechanism which allows system wide alerting in the case an incident occurring. An overarching EPRR framework and policy has also been developed. This will detail a commitment to fulfill; our category 1 responder duties, local resilience forum engagement, staff training and emergency arrangements. The ICB has been assured that it can meet the duties placed upon it from 1<sup>st</sup> July. Lincolnshire has unfortunately had a large number of incidents over recent years whereby the CCG has been able to demonstrate both formally and informally its ability to command a response.

iii. **Resource**

All current on-call managers will attend *Principles in Health Command* training provided by NHSE (Midlands EPRR team). Further training has been drafted into a training schedule and register. This will cover; strategic command, tactical command, and decision loggists. Those managers who provide an on-call function also have access to drop-in sessions which will provide on-going support. The CCG Executive has agreed to increase the resilience for on call to ensure that it meets the new duties placed upon it.

iv. **Responses**

Since the last board meeting the NHS Covid Incident Level was dropped from Level 4, National control via the national operating centre to Level 3 Regional control, via regional operating centre. Level 3 incident requires the CCG/ICB to have an Incident Command Centre operational 5 days a week as opposed to 7 days previously. The CCG has received communication about the National Operating Standard framework and that is being worked through to ensure a resilient system is in place within the ICB.

On the 15<sup>th</sup> June, ULHT declared a critical incident due to compromised Urgent and Emergency Care pathways. Information and intelligence was shared across the system to gain a joint understanding of risk. This was evaluated and a level 2 EPRR response was agreed. Coordination was provided by the CCG in liaison with NHSE (Midlands). Coordinating groups were stood up with a system wide membership. On the 16<sup>th</sup> June, ULHT stood down their incident status but robust support arrangements remained. An EPRR lessons learned process followed immediately afterwards.

v. **Core Standards**

Draft core standards have been received which will be part of the 22/23 EPRR annual assurance that is undertaken. These core standards will remain in place for the next 5 annual assurance submissions. This year's evidence will be submitted by 31<sup>st</sup> August, this will be followed by the assurance process. Providers will be assessed by NHSE (Midlands) and the ICB. The ICB will be assessed by NHSE (Midlands). It is planned that this assurance of providers will move to ICB responsibility later this year. There will a specific deep dive into arrangements for *mass evacuation and shelter*.

**The Local Resilience Forum (LRF)**

- i. The CCG continues to be represented at all LRF meetings as required, two CCG Executives have attended the Multi Agency Gold Incident Command course (MAGIC) organised by the LRF with the National College of Policing with further places booked. This will ensure that Directors are able to take strategic gold command of a major incident or civil emergency and understand the legal frameworks in that context.

### **3. COVID-19 Recovery**

- i. All Urgent and Emergency care services are continuing to operate under significant pressure and that is particularly noticeable in Emergency Departments and Ambulance Trusts. This is due to a combination of demand, workforce pressures and lack of discharges from hospital where patients no longer need to reside.
- ii. In terms of elective care, we remain on track to ensure there are no patients waiting over 104 weeks by the national target of the end of June for capacity reasons. The system benchmarks very well regionally for elective care and the plan for this year is to use every opportunity to deliver more activity than pre pandemic to reduce waiting times for the population.
- iii. The system Elective Activity Coordination Hub has a robust waiting list management process in place and is tracking all patients over 78 weeks on a daily basis to ensure any further delays are minimal. Additional independent sector capacity is being sought where there are challenges in particular specialties.
- iv. Most diagnostic modalities had restored to greater than pre-COVID capacity. However, the recent fire at Lincoln ED continues to impact whilst the recovery is ongoing across several modalities with CT recovery by end of July but MRI will take several months dependant on being able to retain the mutual aid.
- v. The backlog for cancer patients has shown an improvement for both 62 and 104 days from the peak last month. Levels of urgent referrals and referrals seen are above regional and national average and the proportion of Urgent referrals waiting over 62days is now below regional but higher than national average. As previously outlined work is being undertaken with the cancer alliance to support short- and long-term solutions to colorectal as it is the largest backlog. Patients continue to be monitored via multiple mechanisms and are clinically prioritised as previously reported.

### **4. COVID Vaccination Programme**

- i. The Lincolnshire COVID Vaccination Programme continues to make excellent progress in vaccinating the population across the county and is currently focused on the Spring Booster campaign. The strong Lincolnshire partnership approach within the NHS and with colleagues in Local Government, the Care Sector, and the Voluntary Sector continues to be an impressive hallmark of our programme. The continued dedication and hard work of NHS staff, volunteers, and partners is hugely appreciated.
- ii. The headline position is that we have administered 1,772,190 vaccines in Lincolnshire approximately 617,038 firsts, 587,161 seconds, 490,222 booster doses and 77,769 Spring Boosters.
- iii. Of our most vulnerable population, currently 98% of all those eligible over 80s have been vaccinated with a first, second and booster dose, 68% (of those eligible) have come forward for a Spring Booster. 98% of 75–79-year-old have received a first, second and booster dose and 86% (of those eligible) have come forwards for a spring booster. The overall Lincolnshire position for booster and Spring booster vaccination uptake compares favourably with the national average and regional average.

Data as of 19th June 2022

COHORT	1st Dose (%)	2nd Dose (%)	% of Booster Vaccines administered to those who received 2nd Dose	% of Spring Booster Vaccines administered to those who received Booster dose
1: Care Homes	98.6%	97.7%	96.8%	49%*
2a: 80+	97.7%	97.4%	98.1%	68%
2b: HSCW	98.9%	97.6%	89.3%	-
3: 75-79	97.6%	97.2%	97.9%	86%
4: 70-74 & CEV	96.5%	95.8%	95.2%	-
5: 65-69	95.3%	94.7%	96.7%	-
6: At Risk	88.8%	86.4%	85.5%	-
7: 60-64	92%	91.3%	94.6%	-
8: 55-59	90.1%	89.1%	92.4%	-
9: 50-54	87.8%	86.5%	82.8%	-
10: 40-49	79.5%	77.6%	82.8%	-
11: 30-39	70.7%	67.4%	70.3%	-
12: 18-29	74.1%	69.1%	62.1%	-
13: 12-15 At Risk	70%	50%	-	-
14: 12-17 Household contacts of immunosuppressed	69.1%	49.3%	-	-
15: 16-17	74.3%	57.8%	27.2 %	-
16: 12-15	62.5%	42%	-	-
17: 5-11 At Risk	19.4%	-	-	-
18: 5-11	12%	-	-	-

\* This data is supplied via the care home tracker, which is a self-reported number by care homes, manual data reports by providers indicates 78% of care home residents have been vaccinated with a spring booster to date.

- iv. An initial school based programme was offered to those aged 12-15 with an offer now available through our vaccination centres. 62.5% of 12–15-year-olds have received a first dose and 42% a 2<sup>nd</sup> dose. Lincolnshire is currently the highest-ranking system in England for uptake in this age group (also for uptake in the 16-17 age group), nonetheless a bespoke piece of work is underway to increase uptake of 2<sup>nd</sup> dose.
- v. In addition, the JCVI announced an extension of the 5-11 at risk cohort to include all ‘healthy’ children aged 5-11 from 05/04/21. In line with national targets our ambition is to vaccinate 33% of eligible children. To date we have vaccinated (first dose) 6,734 healthy 5-11s (12%) with 19.4% of ‘at risk’ 5-11s also having received their first dose. Lincolnshire is currently the 5<sup>th</sup> top performing system in England for this cohort.
- vi. On the 3<sup>rd</sup> May 2022 we closed the Lincolnshire Showground Vaccination Centre as the lease agreement expired, we have moved our vaccination offer to walk-in pop-up services advertised through media, social media and the CCGs website to ensure the population of Lincoln and the surrounding area are able to access Spring boosters, 12-15, 5-11 and our evergreen offer. On 17<sup>th</sup> May 2022 we launched a Vaccination Bus to supplement our mobile offer to enhance convenience for our population and plan to launch a Vaccination ‘Van’ in the coming weeks to help with our health inequality work. These developments are a further testament to the joint working across Lincolnshire, in this instance with Lincolnshire County Council, to ensure the success of our vaccination programme and to protect the public health of our people.

- vii. On 22<sup>nd</sup> June 2022 a letter was received by the Lincolnshire System outlining the next steps for Covid Vaccination programme in Lincolnshire (alongside other vaccination programmes). Planning is underway in anticipation of an Autumn Covid Vaccination Programme in line with the JCVI interim guidance alongside the influenza programme. Plans also include the addition of other cohorts beyond those already confirmed by the JCVI (cohorts 1-6) and the development of rapid rollout plan in response to any surge requirements. At this stage we do not anticipate any material differences in the operational delivery models and we currently await further contracting and financial detail and long-term planning assumptions beyond the Autumn programme as part of the national immunisation strategy.

## **Conclusion**

In conclusion the NHS in Lincolnshire whilst now dealing with a lower volume of Covid patients and its associated challenges continues to feel the after math of the pandemic. This manifests in terms of demand, backlog and acuity of patients, fatigue in workforce along with workforce pressures. It will remain operationally challenging as the recovery steps up over the coming weeks and months and remains a significant focus.

## Appendix 2

### DAILY MP COVID-19 SUMMARY 22.06.2022

Date	No. of COVID 19 cases in Lincolnshire	Current No. of COVID 19 cases in hospital (ULHT, LCHS, LPFT)	No. of COVID 19 cases in hospital (ULHT, LCHS, LPFT) in 2021	No. of COVID 19 Deaths in Lincolnshire Hospitals	Cumulative Lincs Hospitals COVID 19 discharges
1 June	231,949	16	2	<b>1149</b>	4,267
2 June	BH	15	2	<b>1149</b>	4,274
3 June	BH	16	2	<b>1150</b>	4,275
4 June	No reporting	17	3	<b>1152</b>	4,278
5 June	No reporting	13	3	<b>1152</b>	4,281
6 June	232,003	16	3	<b>1152</b>	4,282
7 June	232,330	14	4	<b>1152</b>	4,286
8 June	232,427	15	4	<b>1152</b>	4,289
9 June	232,518	16	3	<b>1152</b>	4,290
10 June	232,643	20	3	<b>1152</b>	4,293
11 June	No reporting	20	6	<b>1152</b>	4,298
12 June	No reporting	23	6	<b>1152</b>	4,299
13 June	232,748	26	5	<b>1152</b>	4,302
14 June	233,093	26	5	<b>1152</b>	4,307
15 June	233,246	26	5	<b>1152</b>	4,311
16 June	233,398	18	3	<b>1152</b>	4,317
17 June	233,562	23	4	<b>1152</b>	4,323
18 June	No reporting	31	4	<b>1152</b>	4,328
19 June	No reporting	35	3	<b>1152</b>	4,331
20 June	233,726	47	3	<b>1152</b>	4,332

Please note that as of 21.02.2022, GOV UK data is no longer updated over the weekends

**All Data highlighted in bold – Data as per 22<sup>nd</sup> June 2022 subject to validation**

## BOARD MEETING – PUBLIC

<b>Date of Meeting:</b>	29 <sup>th</sup> June 2022	<b>Agenda item:</b>	5.
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<b>Title of Report:</b>	Integrated Quality & Performance Report – June 2022
<b>Report Author and Title:</b>	Tim Fowler, Associate Director of Contracting and Performance
<b>Appendices:</b>	None

### 1. Purpose of the Report (including link to objectives)

This report provides the Board with information on achievement against the CCG's key performance targets and quality standards. This report includes:

- A performance overview dashboard setting out the position for key performance metrics;
- A more detailed summary of performance achievement and actions in place for a number of the performance metrics;
- A summary of elective activity recovery against the CCG plan.

### 2. Recommendations

The Board is asked to note this report and consider the actions underway.

### 3. Executive Summary

The report is presented for discussion and feedback. The approach has been to incorporate targets presented in the Quality Performance report, into a single Integrated Quality & Performance Report for the CCG.

This report shows information of normal variation, trends and shifts in performance over time for key metrics and measures across a number of areas of CCG delivery. It also highlights those areas where there is an immediate cause for concern. The report is designed to provide assurance to the Board that there full understanding of the drivers for performance and that actions are in place to address off track performance and quality in areas that are likely to have the most significant impact for patients.

#### **Overview**

The June integrated performance report incorporating constitutional standards, quality and safety measures and elective recovery activity, presents CCG and system performance updated to May where available. The focus areas continue to be urgent care pathways, cancer, elective treatment backlog, long waiters and mental health. There was also one never event for a Lincolnshire patient in May.

#### **Urgent & Emergency Care**

The Lincolnshire system continues to experience significant pressures, however the number of people waiting more than 12 hours in A&E did reduce to 680 from 745. Overall urgent treatment centre activity numbers and performance remained stable. Within ambulance performance, response times and 2hr handover delays at both Lincoln and Pilgrim have reduced, though remain high. The system focus remains on Discharge and Flow and attendance and admission avoidance. 111 pathway to Same Day Emergency Care (SDEC) commences this month, it will support de-escalation at the front door, reducing the clinical risk in community.

### **Cancer**

The backlog position peaked in April at 508 and is now reducing again, currently 491 patients are over 62 days, this increase is attributed to the impact of multiple bank holidays and is normal variation. The number of patients waiting 104 days or more also increased in April to 154, from 144 in April. In addition, the number of patients receiving treatment for cancer within 62 days has slightly reduced to 53% with 56.6% being told their cancer diagnosis outcome within 28 days.

Referral rates remain higher than previous years which places additional pressure over and above existing covid backlogs. Lower GI referrals account for around 25% of all two week wait referrals which is adding to the overall workload in Lower GI.

### **Elective backlog**

The total waiting list size for Lincolnshire patients at all hospitals has increased by 914 to 103,467 in May- a much slower growth then has been seen in recent months. The system is committed to eliminating 104 week breaches by the end of June and is on track to achieve that trajectory, performance remains better than the national average.

### **Mental Health**

Performance of early intervention in psychosis (EIP) waiting times continues to be a low of 9% seen within 2 weeks, much lower than the 60% standard. The current wait for the service, although over 2 weeks, is 3 weeks.

The service is re-focusing so all cases are reviewed and to standard. The service is aware of and is proactively managing the drop in performance. Ultimately the issues remain ongoing- the service is running at 25% absence rates (sickness, maternity and vacancies), there has been an increase in accepted referrals levels which has impacted on capacity to respond, and ultimately demand is currently outstripping capacity. The service has adverts are out for all vacancies with one vacant post filled, but two remain vacant. An additional extra fixed term/secondment post has been created and is out for recruitment but also recruited one agency member of staff. Meanwhile, two staff on maternity leave return in September, plus the service is offering incentivised bank hours and is training staff up from other services to complete the initial assessment and is also closely monitoring referrals weekly. These actions will help ensure the target is met in the short/medium term but will place additional pressure on the service in terms of existing caseloads.

### **Never Event**

ULHT have declared a never event in May 2022. This was categorised as a no/low harm incident and investigation is currently taking place. Further information can be found on page 37.

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

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

#### **5. Finance, QIPP and Resource Implications**

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

#### **6. Legal/NHS Constitution Considerations**

Not applicable.

<b>7.</b>	<b>Analysis of Risk including Assessments</b>				
Risks to the achievement of performance standards are outlined in the body of this report.					
Please state if the risk is on the CCG Risk Register.					
	<table border="1"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> <td>No</td> <td><input checked="" type="checkbox"/></td> </tr> </table>	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		

<b>8.</b>	<b>Outline engagement – clinical, stakeholder and public/patient</b>
Not Applicable	

<b>9.</b>	<b>Outcome of Impact Assessments</b>
Not Applicable	

<b>10.</b>	<b>Assurance Departments/Organisations who will be affected have been consulted</b>
Insert details of the departments you have worked with or consulted during the process:	
Finance	<input type="checkbox"/>
Commissioning	<input type="checkbox"/>
Contracting	<input type="checkbox"/>
Medicines Optimisation	<input type="checkbox"/>
Clinical Leads	<input type="checkbox"/>
Quality	<input type="checkbox"/>
Safeguarding	<input type="checkbox"/>
Other	<input type="checkbox"/>

<b>11.</b>	<b>Report previously presented at:</b>
A draft version of the Performance Report was originally shared with the CCG Executive Committee on 13 May 2021. The Report has subsequently been updated and developed to reflect the latest available data.	

<b>12.</b>	<b>For further information or for any enquiries relating to this report, please contact</b>
<p>Tim Fowler Associate Director of Contracting and Performance e-mail: <a href="mailto:t.fowler1@nhs.net">t.fowler1@nhs.net</a> telephone: 07810 770476</p> <p>James Singleton Performance/Assurance Manager e-mail: <a href="mailto:james.singleton1@nhs.net">james.singleton1@nhs.net</a></p>	

# Integrated Quality & Performance Report (GB)

June 2022

# Contents

1. Executive Summary	<a href="#"><u>Page 3</u></a>
2. Key to Run Charts	<a href="#"><u>Page 5</u></a>
3. Performance Overview (Dashboard)	<a href="#"><u>Page 6</u></a>
4. Urgent Care	<a href="#"><u>Page 11</u></a>
5. Cancer	<a href="#"><u>Page 14</u></a>
6. Planned Care/Diagnostics	<a href="#"><u>Page 17</u></a>
7. Mental Health	<a href="#"><u>Page 21</u></a>
8. Quality	<a href="#"><u>Page 23</u></a>
9. Primary Care	<a href="#"><u>Page 31</u></a>

# Executive Summary

## Overview

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## Urgent & Emergency Care

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# Executive Summary

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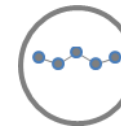
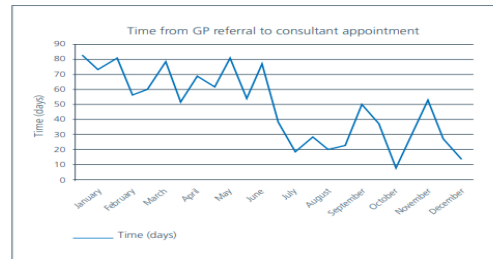
# Run Charts Key

Run charts are displays of time-series data shown in graph form and are very useful tools for improvement work – particularly in terms of how you understand and communicate variation in a process. Being able to analyse and understand current system variation is key to being able to make changes that improve processes and systems.

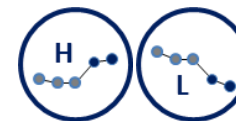
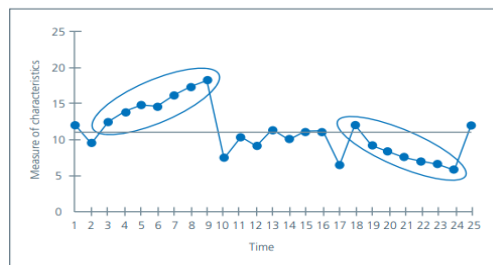
Extreme Values



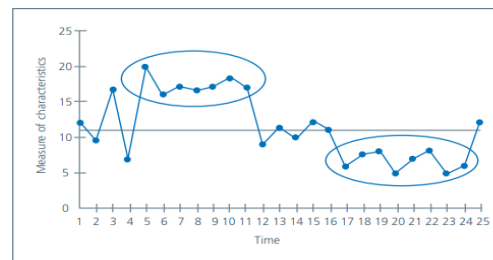
Normal Variation



A Trend  
*(upward or downward trend)*



A Shift  
*(a run above or below the mean)*



# Performance Overview

## Constitutional Standards

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
A&E admission, transfer, discharge within 4 hours	95%	May-22	73.0%	67.0%	73.0%		→		Page 12
% Suspected Cancer Referrals First Seen Within 14 Days (LCCG)	93%	Apr-22	68.2%	73.7%	79.1%		↓		-
Patients receiving treatment for cancer within 62 days of an urgent GP referral (LCCG)	85%	Apr-22	53.0%	54.4%	65.2%		↓		Page 15
RTT: % of incomplete pathways within 18 weeks	92%	Apr-22	54.7%	58.0%	61.7%		↓		-
Percentage waiting six weeks or less for a diagnostic test	99%	Apr-22	59.8%	63.1%	71.6%		↓		-

## Urgent Care

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
A&E attendances- patients waiting over 12 hours (LCCG)	0	May-22	680	N/A	N/A		↓		Page 12
A&E attendances- time to first clinical assessment within 60 minutes (ULHT)	-	May-22	56.8%	38.4%	36.9%		↓		-
Ambulance response times - Mean response time- Category 1 (LCCG patients)	00:07:00	May-22	00:09:17	00:08:37	00:08:36		↓		-
Ambulance response times - Mean response time- Category 2 (LCCG patients)	00:18:00	May-22	00:53:25	00:12:39	00:39:58		↓		-
Ambulance handover times - number of handover delays of > 2 hours (Lincoln)	-	May-22	113	N/A	N/A		↓		Page 13
Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)	-	May-22	221	N/A	N/A		↓		Page 13

# Performance Overview

## Cancer

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
Total 62 Day Backlog	-	May-22	508	N/A	N/A		↑		Page 16
Total 104 Day Backlog	-	May-22	154	N/A	N/A		↑		Page 16
Faster diagnosis standard- % of patients told cancer diagnosis outcome within 28 days	75.0%	Apr-22	56.6%	67.9%	70.8%		↓		Page 15



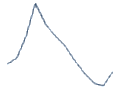







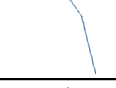

## Planned Care

Indicator	Standard /Plan	Period	Performance	Midlands	England	Trend			Further Detail
Patients waiting over 52 weeks for treatment (% of total waiting list size)	0%	Apr-22	6.1%	7.3%	5.0%		↑		Page 18
Patients waiting over 104 weeks for treatment (% of total waiting list size)	0%	Apr-22	0.10%	0.31%	0.20%		↓		Page 18
Total waiting list size	0	Apr-22	103,467	N/A	N/A		↑		Page 19
Total elective spells	8,978	Apr-22	8,268	N/A	N/A	-	-		Page 19

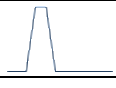

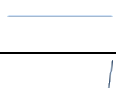



## Mental Health

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
IAPT access - people that enter treatment against the level of need in the general population	2.75%	Mar-22	1.89%	N/A	1.86%		→		Page 22
IAPT recovery rate - people who complete treatment who are moving to recovery	50%	Mar-22	50.6%	N/A	51.0%		↓		-
Inappropriate Out of Area Placements(OAPs) in mental health services for adults in non-specialist acute inpatient care per 100,000	0	Mar-22	38.2	115.5	109.2		↑		-

# Performance Overview

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
People experiencing first episode psychosis or ARMS that wait two weeks or less to start a NICE recommended package of care	60%	Apr-22	9%	59.6%	67.4%		→		Page 22
Estimated diagnosis rate for people with dementia	66.7%	May-22	61.6%	61.0%	61.9%		↑		-
Severe Mental Illness- people with SMI who have received the complete list of physical health checks in the preceding 12 months	60%	21/22 Q4	45.6%	41.5%	42.8%		↑		-
Children & Young People (CYP) with MH disorder receiving treatment (one contact) in the reporting period last 12 months (gap to LTP trajectory)	0	Dec-21	-2166	N/A	N/A		↑		-
The number of CYP with an eating disorder (routine) referred with a suspected ED that start treatment within four weeks of referral in the reporting period (rolling 12 months)	95%	21/22 Q3	43.0%	N/A	N/A		↓		-
The number of CYP with ED (urgent) referred with a suspected ED that start treatment within one week of referral in the reporting period (rolling 12 months).	95%	21/22 Q3	88.9%	N/A	N/A		↑		-

## Quality











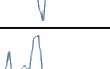

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
Never events (ULHT)	0	May-22	1	N/A	N/A		→		Page 23
Never events (NLAG)	0	May-22	0	N/A	N/A		→		-
Never events (NWAFT)	0	May-22	0	N/A	N/A		↓		-

# Performance Overview

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
Summary Hospital Level Mortality Indicator (SHMI) (ULHT)	1.000	Jan-22	1.0663	1.0408	0.9996		↓		Page 25
Hospital Standardised Mortality Ratio (HSMR) (ULHT)	100.00	Apr-22	94.19	N/A	N/A		↓		-
Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	1.000	Jan-22	1.0401	1.0408	0.9996		↓		-
Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	1.000	Jan-22	1.1113	1.0408	0.9996		↓		Page 25
MRSA Cases- 12 month rate per 100,000 bed days (LCCG)	0	Mar-22	0.79	0.81	1.20		↑		-
C. Difficile Cases- 12 month rate per 100,000 bed days (LCCG)	0	Mar-22	19.71	25.29	25.29		↑		-
E-Coli Cases- 12 month rate per 100,000 bed days (LCCG)	0	Mar-22	71.46	67.42	67.42		↓		-
Cancelled Operations on the day for non clinical reasons (ULHT)	0.8%	Q4 21/22	25.9%	23.0%	32.7%		↑		-
Number of patients of people with a learning disability receiving inpatient care (LCCG)	26	Mar-22	31	-	-		↑		Page 26
Rate per 1000 of people with a learning disability receiving inpatient care (LCCG)	0	May-22	51	46	42		↑		Page 26
Cumulative Learning Disability Healthchecks (LCCG)	0	Mar-22	3513	N/A	N/A		↑		Page 26
Care Home Quality	-	-	-	-	-	-	-	-	Page 28
Safeguarding	-	-	-	-	-	-	-	-	Page 29
Serious Incidents Reported (Lincolnshire patients)	-	May-22	35	N/A	N/A		↓		Page 30

# Performance Overview

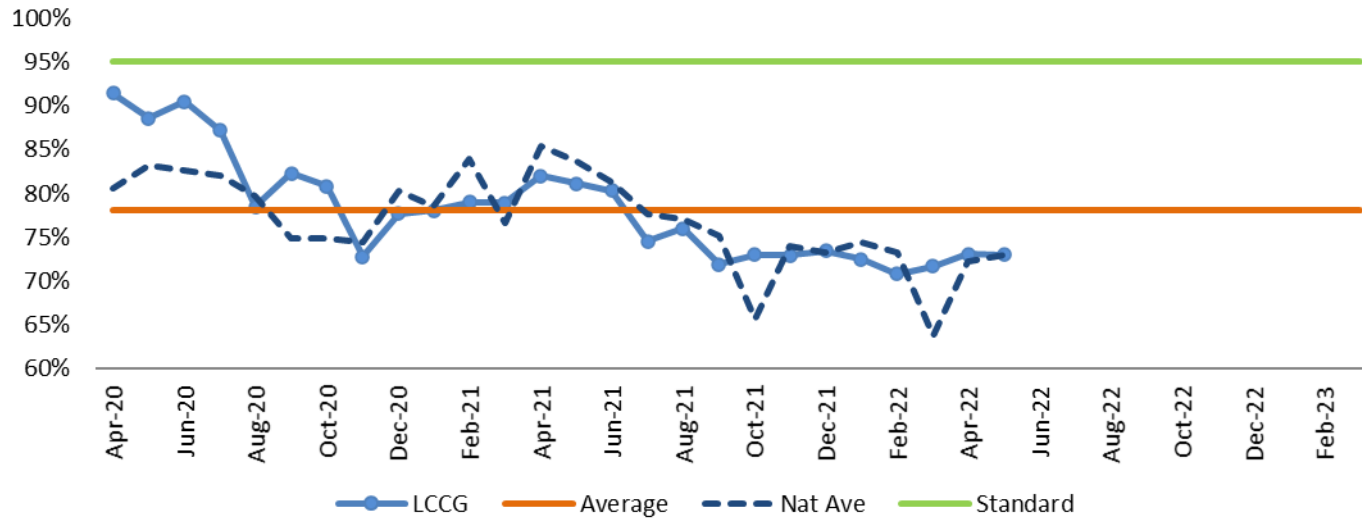
## Primary Care

Indicator	Standard	Period	Performance	Midlands	England	Trend			Further Detail
Primary Care CQC- number of practices rated as 'Inadequate' by CQC	0	May-22	1	N/A	N/A	N/A	N/A	N/A	Page 31
Primary Care CQC- number of practices rated as 'Requires Improvement' by CQC	-	May-22	3	N/A	N/A	N/A	N/A	N/A	Page 31
GP Appointments- percentage seen by a GP	-	Apr-22	35.7%	40.2%	36.9%		↓		Page 32
GP Appointments Mode- percentage seen face to face	-	Apr-22	67.9%	58.9%	62.4%		↑		Page 32
GP Appointments- time from booking to appointment same day	-	Apr-22	48.2%	59.4%	45.6%		↓		Page 33
GP Appointments- time from booking to appointment 1-6 days	-	Apr-22	24.0%	24.5%	28.8%		↑		Page 33
The number of extended access appointments booked excluding did not attends (LCCG)	5588	Apr-22	5439	N/A	N/A		↓		Page 34
The percentage of available GP extended access appointments utilised (LCCG)	80%	Apr-22	71.9%	N/A	N/A		↑		Page 34

# Urgent Care

Cause	Actions To Recover
<p>The Lincolnshire system has continued to experience pressure from an urgent &amp; emergency care perspective throughout May and June to date. The trust has regularly declared site OPEL 4s, and has declared a critical incident in June due to pressures. This was managed as a Level 2 incident and was stood down within 48 hours.</p> <p>The May position was as follows:</p> <ul style="list-style-type: none"><li>• Demand across T1 &amp; T3 activity remained relatively stable throughout May, with only a 5% increase mid month, then returning to April levels.</li><li>• Overall urgent treatment centre activity numbers and performance remained stable.</li><li>• 12 hour decision to admit breaches reduced on both sites, but are still occurring most days.</li><li>• 21+ day Length of stay are higher than at the end of April.</li><li>• Throughout May bed occupancy did not drop below 90%</li><li>• Covid bed occupancy continues to decrease</li><li>• Continue to see the pattern of peak admission Monday – Thursday, dropping Friday and weekends, with peak discharges on Thursdays.</li></ul> <p>The main risk for the system continues to be staffing levels and the level of pressure are also reflected regionally and nationally.</p>	<p>Internal and system wide actions agreed daily on System Resilience Calls. Tactical plan enacted during periods of significant pressure or incident management.</p> <p>The system focus remains on Discharge and Flow and attendance and admission avoidance and 111 to SDEC pathways will come online at the end of June. This will support de-escalation at the front door, reducing the clinical risk in community as a result of ambulance handover delays.</p> <p>Internal acute work on the Pathway 0 processes is ongoing to improve timeliness of these discharges, supported by both IMPOWER and ECIST.</p> <p>Out of hospital flow improvement is ongoing within the flow programme, with the integrated discharge hubs are due to go live at the end of June.</p>

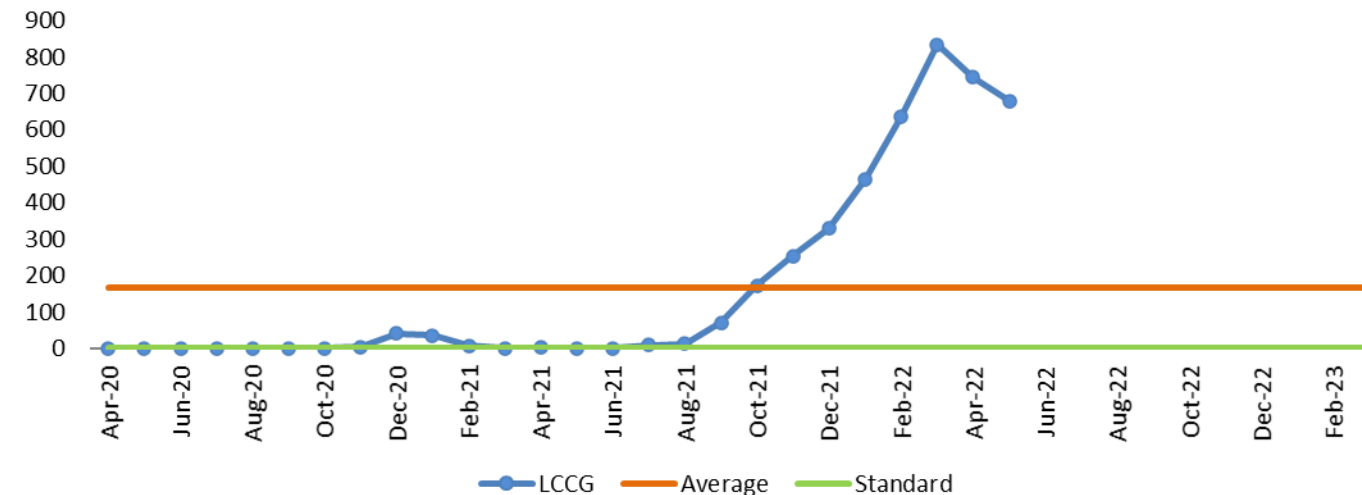
## A&E admission, transfer, discharge within 4 hours (LCCG)



Indicator
A&E admission, transfer, discharge within 4 hours (LCCG)
Standard
95%
Period
May-22
Patients Seen < 4 Hours
18,851
Total A&E Attendances
25,823
LCCG
73.0%
England
73.0%
Trend



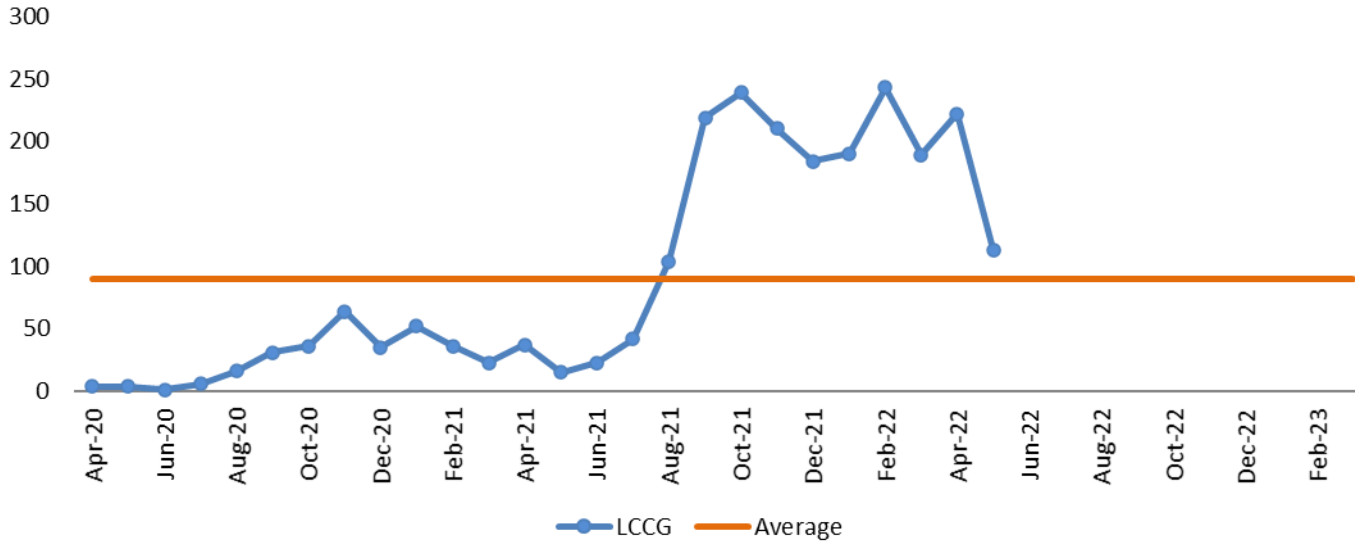
## A&E attendances- patients waiting over 12 hours (ULHT)



Indicator
A&E attendances- patients waiting over 12 hours (ULHT)
Standard
0
Period
May-22
LCCG
680
England
N/A
Trend



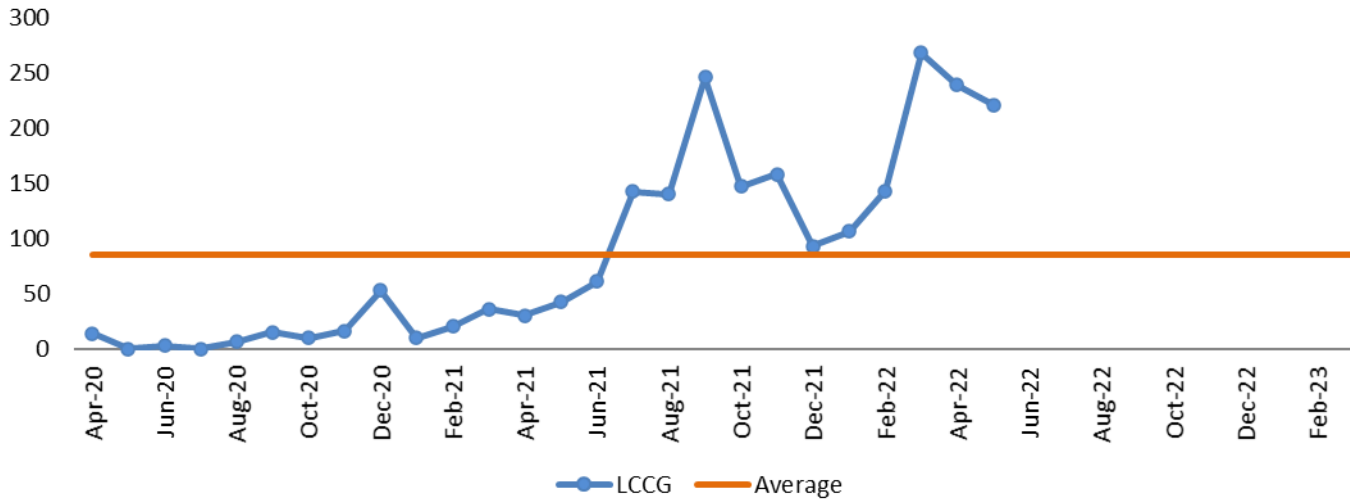
## Ambulance handover times - number of handover delays of > 2 hours (Lincoln)



Indicator
Ambulance handover times - number of handover delays of > 2 hours (Lincoln)
Standard
-
Period
May-22
LCCG
113
England
N/A
Trend



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



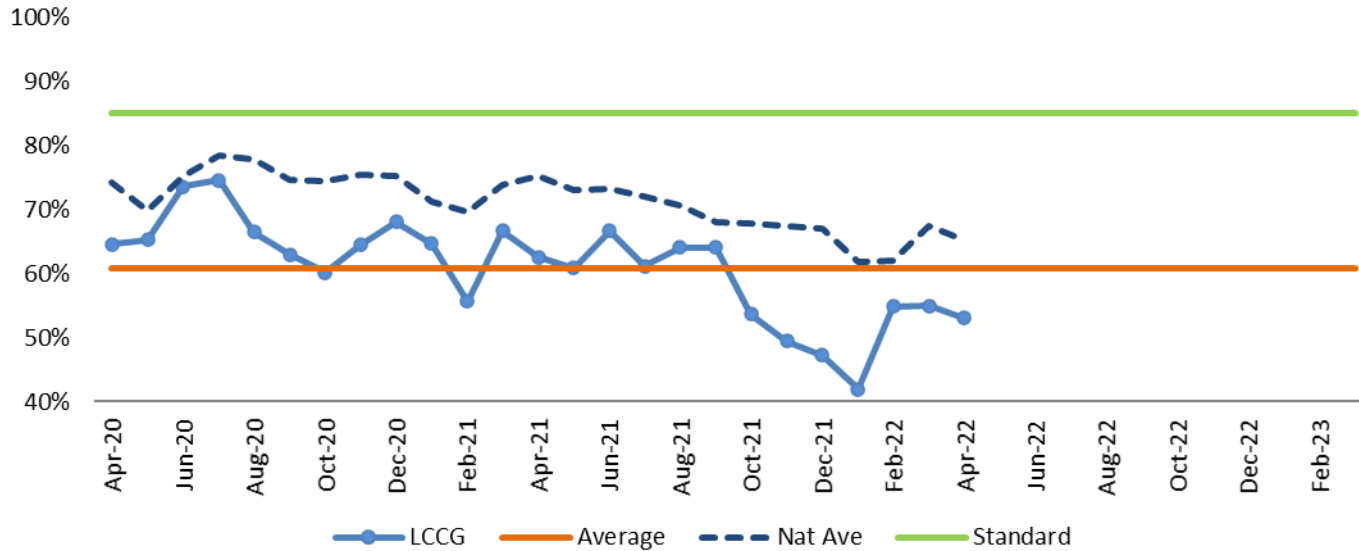
Indicator
Ambulance handover times - number of handover delays of > 2 hours (Pilgrim)
Standard
-
Period
May-22
LCCG
221
England
N/A
Trend



# Cancer

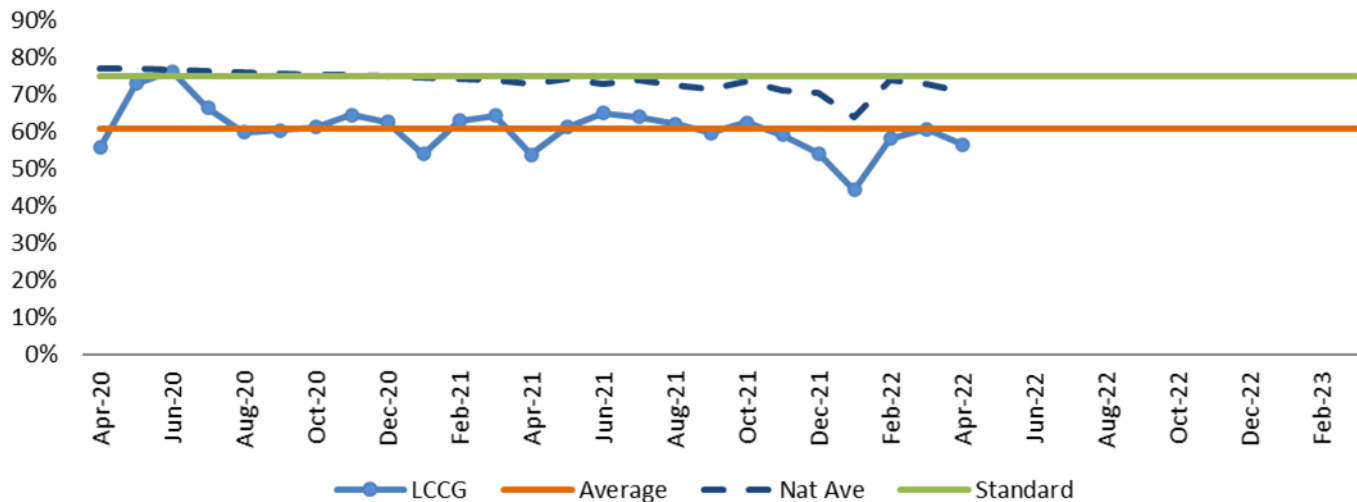
Cause	Actions To Recover
<ul style="list-style-type: none"> <li>• The backlog position peaked in April and is now reducing again currently 491 patients are over 62 days, this increase has been a result of the Easter Bank Holidays. Colorectal continues to account for the largest part of the backlog 57%, the colorectal backlog has grown at the same rate as the overall backlog.</li> <li>• Referral rates remain higher than previous years. Lower GI referrals account for around 25% of all two week wait referrals which is adding to the overall workload in Lower GI.</li> <li>• The volume of the backlog in colorectal is making it difficult to manage and oversee.</li> <li>• The lung team are struggling with capacity and it is likely that this will soon have an impact on their backlog numbers.</li> </ul>	<ul style="list-style-type: none"> <li>• A system wide approach has been taken to undertake a deep dive into the issues around the colorectal pathway. The first phase of the deep dive was presented last week to colleagues across the system, East Midlands Cancer Alliance &amp; NHSI/E. The next phase involves looking at 3 specific areas of the pathway and this work is already underway.</li> <li>• The colorectal team are out to advert for a number of CNS roles which are required to reduce the backlog of outpatient appointments</li> <li>• Infection prevention and control measures have changed meaning that patients undergoing colonoscopy no longer need to swab and isolate prior to their procedures. This will speed up patient pathways.</li> <li>• The first part of the lung pathway is under review in an attempt to free up consultant capacity for the high risk patients</li> </ul>

## Patients receiving treatment for cancer within 62 days of an urgent GP referral (LCCG)



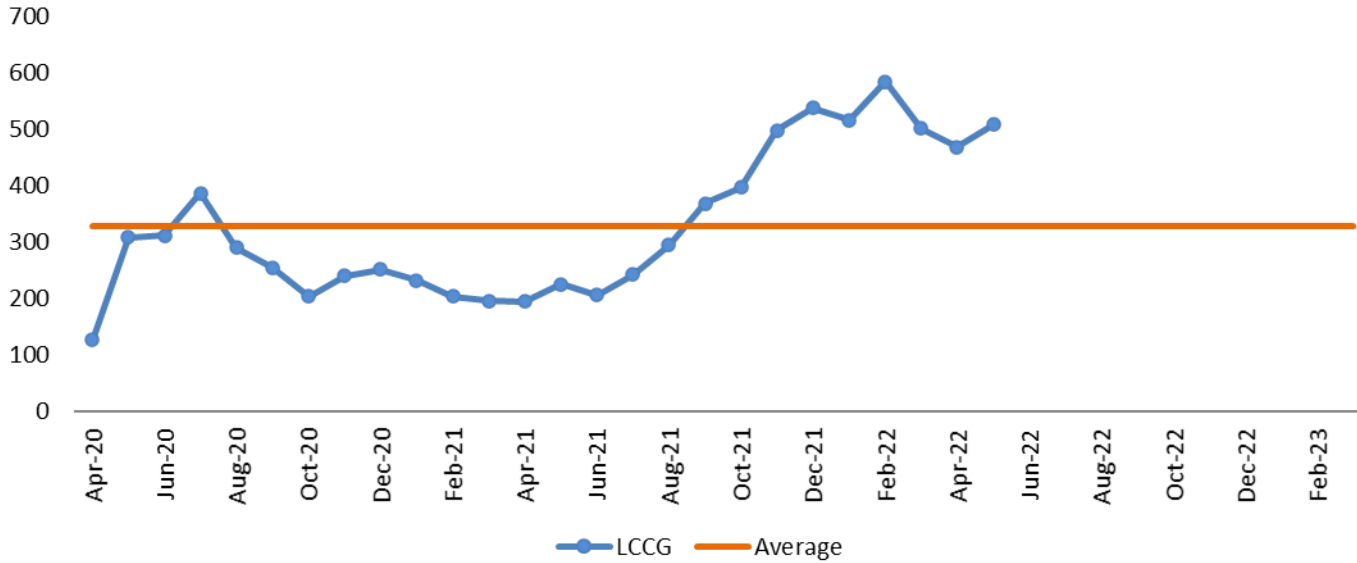
<b>Indicator</b>
Patients receiving treatment for cancer within 62 days of an urgent GP referral (LCCG)
<b>Standard</b>
85%
<b>Period</b>
Apr-22
<b>Patients Seen &lt; 62 Days</b>
122
<b>Total Referrals Seen</b>
230
<b>LCCG</b>
53.0%
<b>England</b>
65.2%
<b>Trend</b>

## Faster diagnosis standard- % of patients told cancer diagnosis outcome within 28 days (LCCG)



<b>Indicator</b>
% of patients told cancer diagnosis outcome within 28 days
<b>Standard</b>
75%
<b>Period</b>
Apr-22
<b>LCCG</b>
56.6%
<b>England</b>
70.8%
<b>Trend</b>

## Total 62 Day Backlog (ULHT)



### Indicator

Total 62 Day Backlog (ULHT)

### Pre-Pandemic Level

81

### Period

May-22

### LCCG

508

### England

N/A

### Trend



### Indicator

Total 104 Day Backlog (ULHT)

### Pre-Pandemic Level

22

### Period

May-22

### LCCG

154

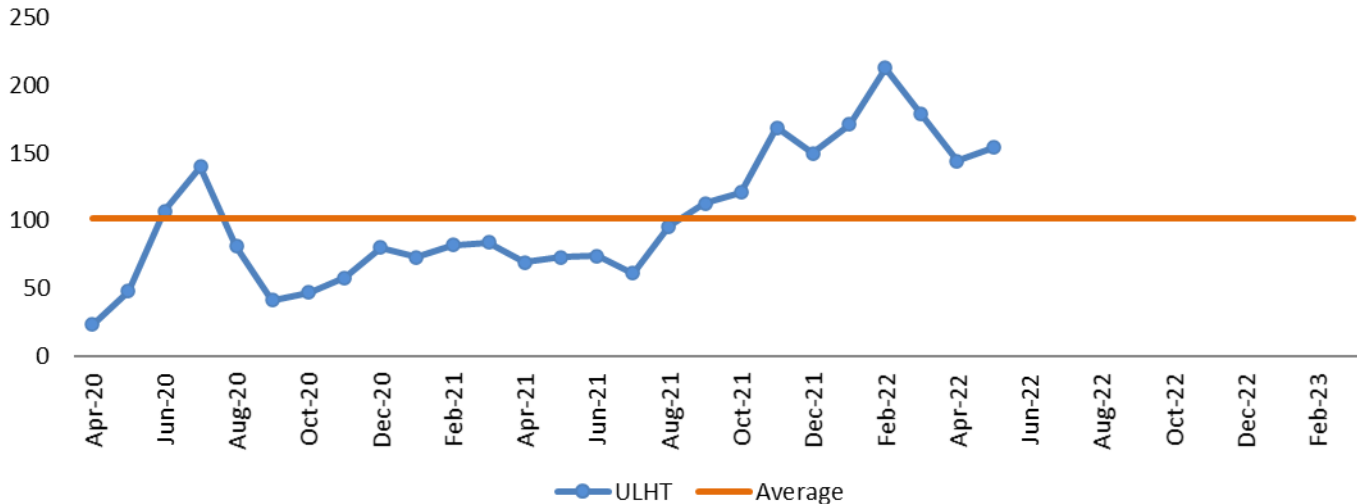
### England

N/A

### Trend



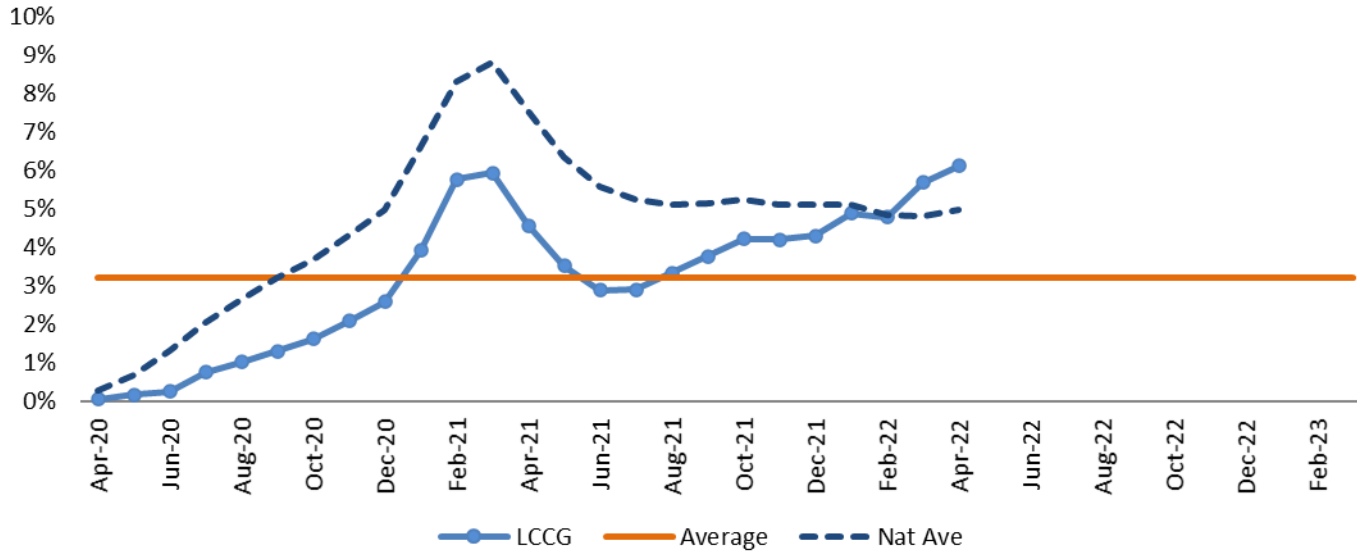
## Total 104 Day Backlog (ULHT)



# Planned Care and Diagnostics

Cause	Actions To Recover
<ul style="list-style-type: none"><li>• It is important to view and read this in the context of the current National Covid Restore Agenda and the move away from a focus on constitutional standards to the expectation of focus upon cancer and clinical urgency.</li><li>• This means there is a clinical risk based patient selection process as opposed to selection based upon the longest waits. Within this context it is unlikely that there will be material improvement to statutory RTT performance for some time.</li><li>• Hospitals continue to experience patients who are reluctant to travel to alternative sites where wait times may be quicker.</li></ul>	<ul style="list-style-type: none"><li>• The system is committed to eliminating 104 week breaches by the end of June and is on track to achieve that trajectory. Mutual aid is being provided by ULHT to support an out of area Provider with their long waiters in 2 specialties</li><li>• Outpatients Recovery &amp; Improvement Group (ORIG) and High Volume Low Complexity (HVLC) are under way with a number of schemes to address productivity and efficiency that will support reduction in waiting list size.</li><li>• Most diagnostic modalities had restored to greater than pre-COVID capacity. However, the fire at LCH at the end of March continues to impact recovery, particularly CT &amp; MRI, although mitigation plans are in place to minimise the disruption as much as possible.</li><li>• A business case to expand the provision of services being delivered at the Grantham CDC will be submitted in July and will increase services to include provision of a full range of diagnostic services including pathology, CT, DEXA, MRI and mammography imaging services as well as a variety of other diagnostic tests over the next 3 years. Plans are also being developed for a new CDC in the county, with the business case due for submission in September 2022.</li></ul>

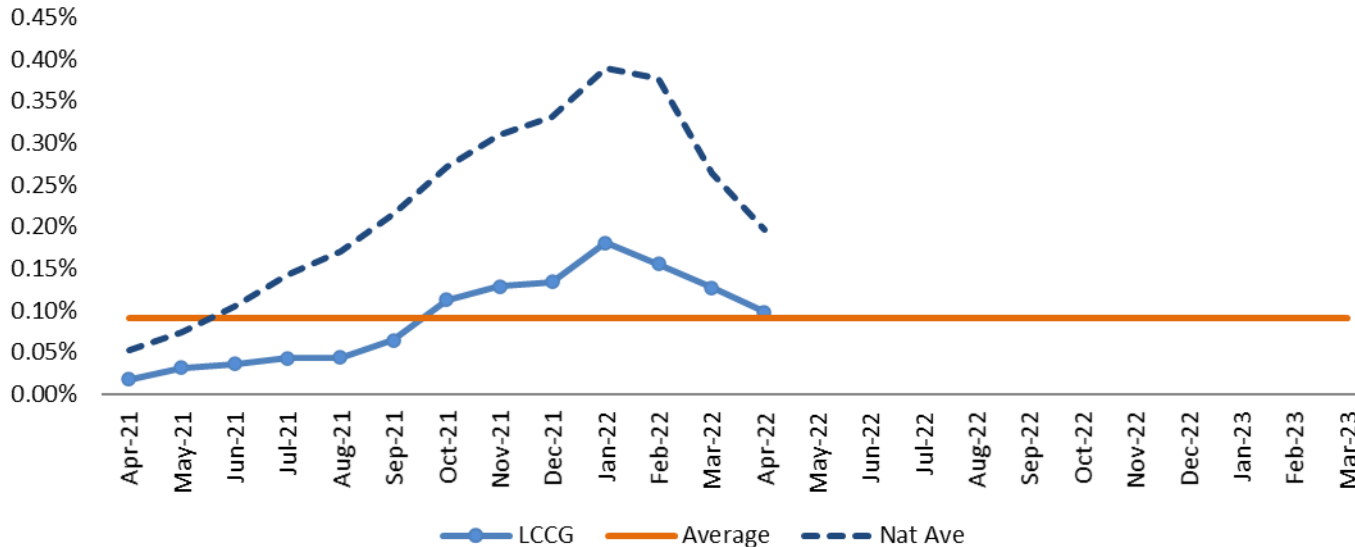
## Patients waiting over 52 weeks for treatment (LCCG)



<b>Indicator</b>
Patients waiting over 52 weeks for treatment (% of total waiting list size)
<b>Period</b>
Apr-22
<b>Total 52 Week Breaches</b>
6331
<b>LCCG</b>
6.1%
<b>England</b>
5.0%
<b>Trend</b>



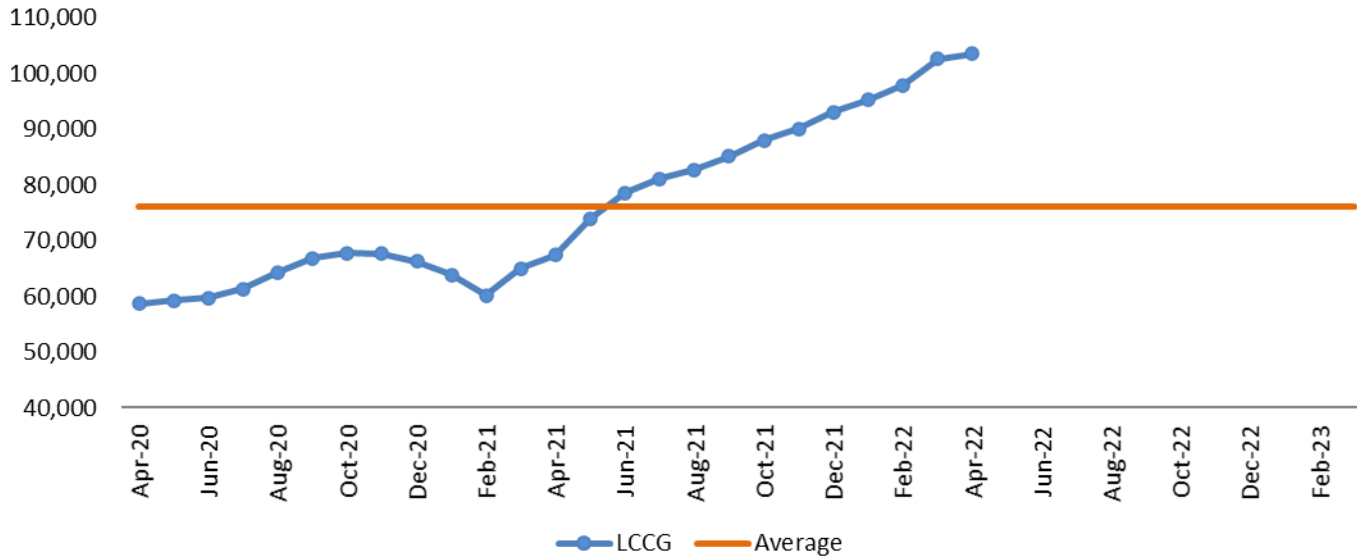
## Patients waiting over 104 weeks for treatment (LCCG)



<b>Indicator</b>
Patients waiting over 104 weeks for treatment (% of total waiting list size)
<b>Period</b>
Apr-22
<b>Total 104+ Breaches</b>
101
<b>LCCG</b>
0.10%
<b>England</b>
0.20%
<b>Trend</b>



## Total Waiting List Size (LCCG)



Indicator

Total Waiting List Size (LCCG)

Plan

0

Period

Apr-22

LCCG

103,467

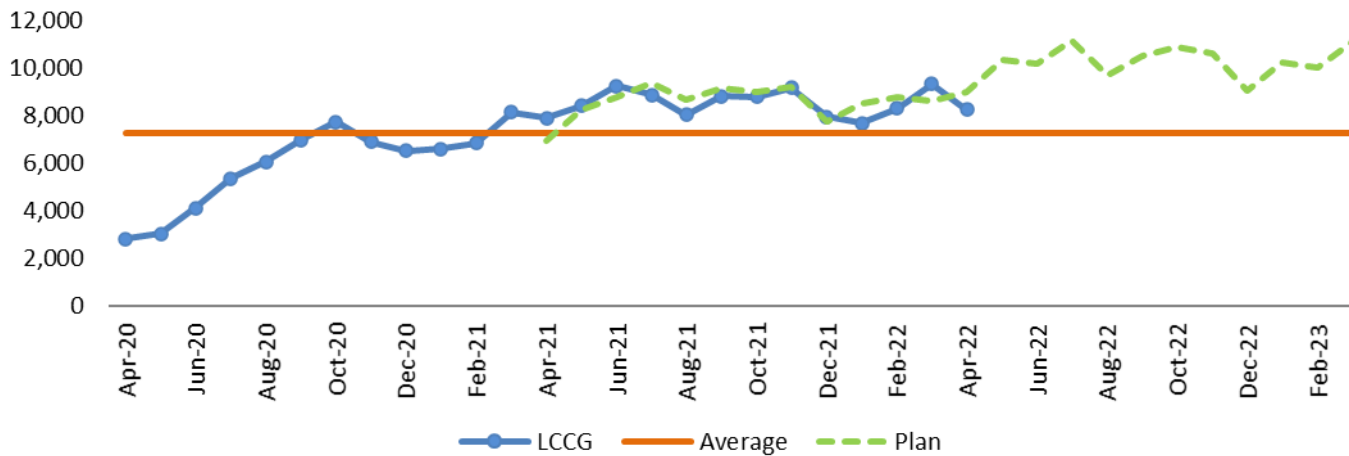
England

N/A

Trend



## Total Elective Spells (LCCG)



Indicator

Total elective spells

Period

Apr-22

Plan

8,978

LCCG

8,268

Trend



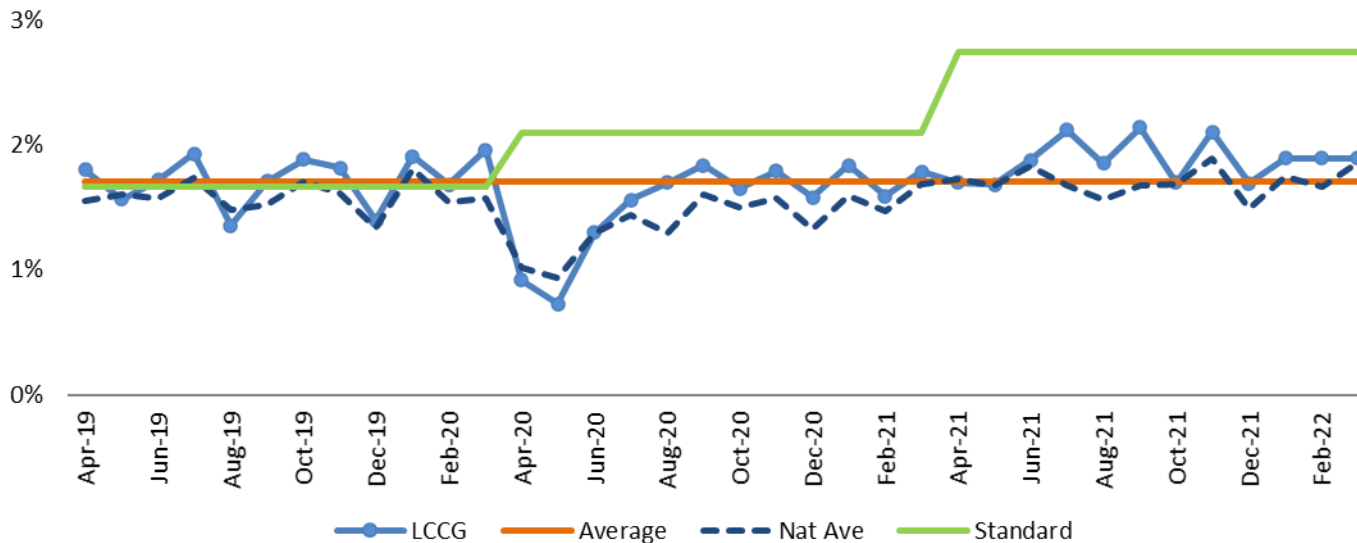
# Elective Recovery

Indicator	Period	Plan	LCCG	Trend	
First Outpatient Attendances	Apr-22	22,723	18,056		
F/up outpatient attendances	Apr-22	34,849	28,993		
Total elective spells	Apr-22	8,978	8,268		
Total referrals	Apr-22	8,978	8,268		
Diagnostics- Magnetic Resonance Imaging	Apr-22	4,536	4,224		
Diagnostics- Computed Tomography	Apr-22	9,350	9,887		
Diagnostics- Non-Obstetric Ultrasound	Apr-22	6,668	8,068		
Diagnostics- Colonoscopy	Apr-22	702	677		
Diagnostics- Flexi Sigmoidoscopy	Apr-22	401	315		
Diagnostics- Gastroscopy	Apr-22	623	717		
Diagnostics- Echocardiography	Apr-22	1,340	1,364		

# Mental Health

Cause	Actions To Recover
<p><b>IAPT Access:</b></p> <ul style="list-style-type: none"><li>The service continues to have a high number of trainees which impacts on capacity, but will improve the overall capacity eventually. A number of trainees have qualified in March 2022 which is helping improve delivery into 2022/23. Trainees currently work to 60% capacity whilst studying but upon qualification this increases to 100%.</li></ul> <p><b>Early Intervention in Psychosis waiting times:</b></p> <ul style="list-style-type: none"><li>The service aware of, and is proactively managing the drop in performance as outlined in May's Integrated Performance Report.</li><li>The current wait for the service, although over 2 weeks, is 3 weeks</li></ul>	<ul style="list-style-type: none"><li>The issues and recovery actions outlined in the May Integrated Performance Report for the failing IAPT and Early Intervention in Psychosis standards still hold for June</li></ul>

## IAPT Access (LCCG)



**Indicator**  
IAPT access - people that enter treatment against the level of need in the general population

**Standard**  
2.75%

**Period**  
Mar-22

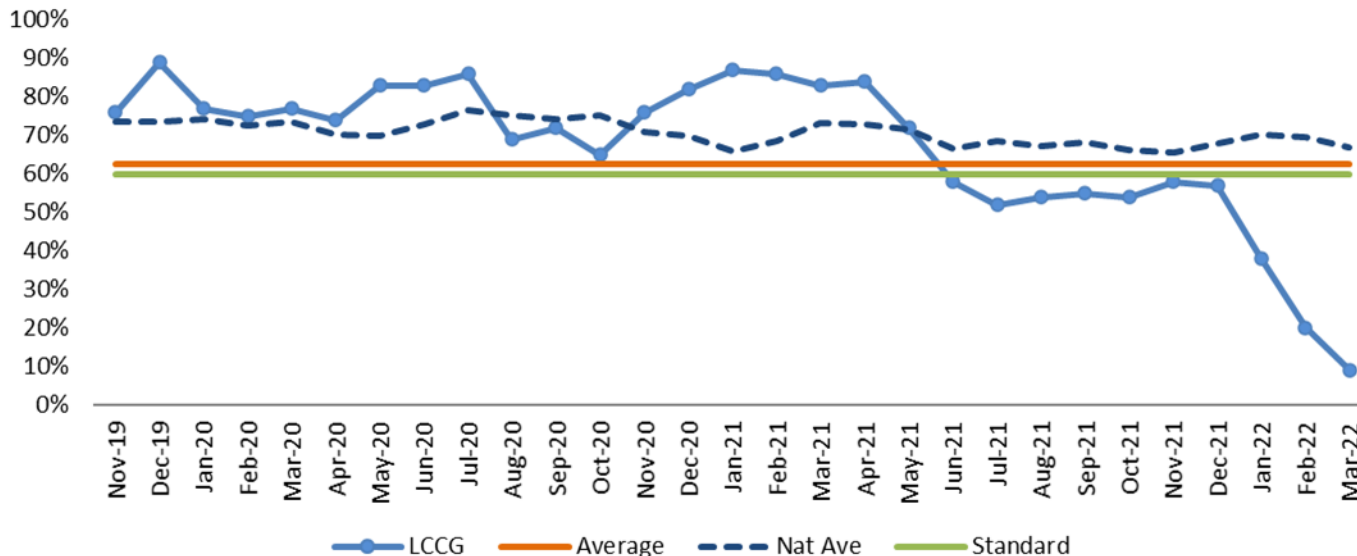
**Patients Entering IAPT**  
1,260

**LCCG**  
1.89%

**England**  
1.86%

**Trend**

## Early Intervention in Psychosis Waiting Times (LCCG)



**Indicator**  
People experiencing first episode psychosis or ARMS that wait two weeks or less to start a NICE recommended package of

**Standard**  
60%

**Period**  
Apr-22

**Seen < 2 Weeks**  
5

**Total Patients**  
80

**LCCG**  
9.0%

**England**  
67.4%

**Trend**

# Never Events

## Cause

### ULHT

ULHT declared one Never Events in May 2022. This was recorded as a no/low harm incident. Investigation is currently taking place. Rapid review report received.

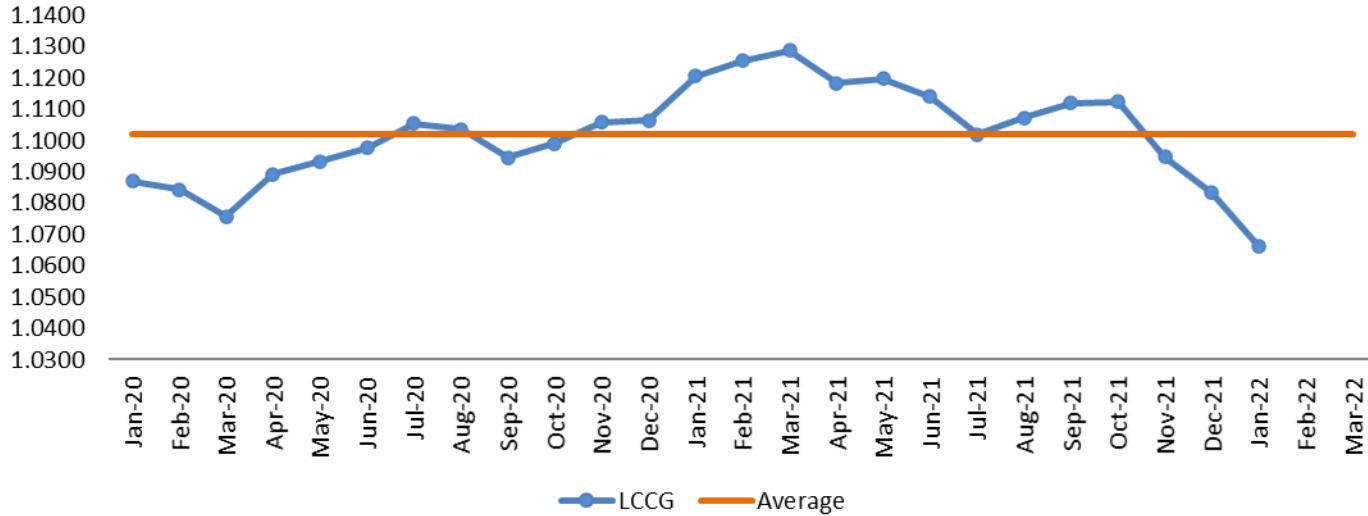
### 5 May 2022: Lincoln County Hospital Theatres

Patient having laparoscopic hysterectomy, bilateral salpingectomy and unilateral oophorectomy. Patient was consented for unilateral oophorectomy however the surgeon proceeded to remove both ovaries. Patient was 2 years post-menopausal so hence being no/low harm but there will be increased follow up for the patient to confirm.

# Mortality (NWAFT)

Cause	Actions To Recover
<p><a href="#">SHMI data</a> (NHS Digital Feb 2021-Jan 2022) Trust wide: 1.1113, as expected range PCH: 1.1860, higher than expected HH: 0.9783 as expected Published 16/06/22</p> <p>Current alerting groups on SHMI: Pneumonia and Acute Bronchitis - review as part of Respiratory Deep Dives.</p> <p>A deep dive analysis of SHMI data to analyse data and identify themes/trends was planned for February 2022 with report shared in May 2022. We are not assured. Unclear whether this is a coding, reporting or a quality of care/ patient safety issue</p>	<ul style="list-style-type: none"> <li>• NWAFT have agreed to procure a 3rd party to undertake scrutiny on their Mortality workstream. Still awaiting update.</li> <li>• Virtual clinical coding session has been introduced as a pilot with Respiratory Consultants at HH which if successful will be rolled out across the Trust.</li> <li>• QI project has been set up to measure knowledge at PCH, and identify 'HSMR Champions' who will share information and knowledge about data quality and coding.</li> <li>• Assurance issue remains outstanding at PCH.</li> </ul>

## Summary Hospital Level Mortality Indicator (SHMI) (ULHT)



### Indicator

Summary Hospital Level Mortality Indicator (SHMI)

### Standard

1.0000

### Period

Jan-22

### Neighbouring Trusts

ULHT:	1.0663
NLAG:	1.0401
NWAFT:	1.1113
NUH:	1.0239
QEH:	1.0317

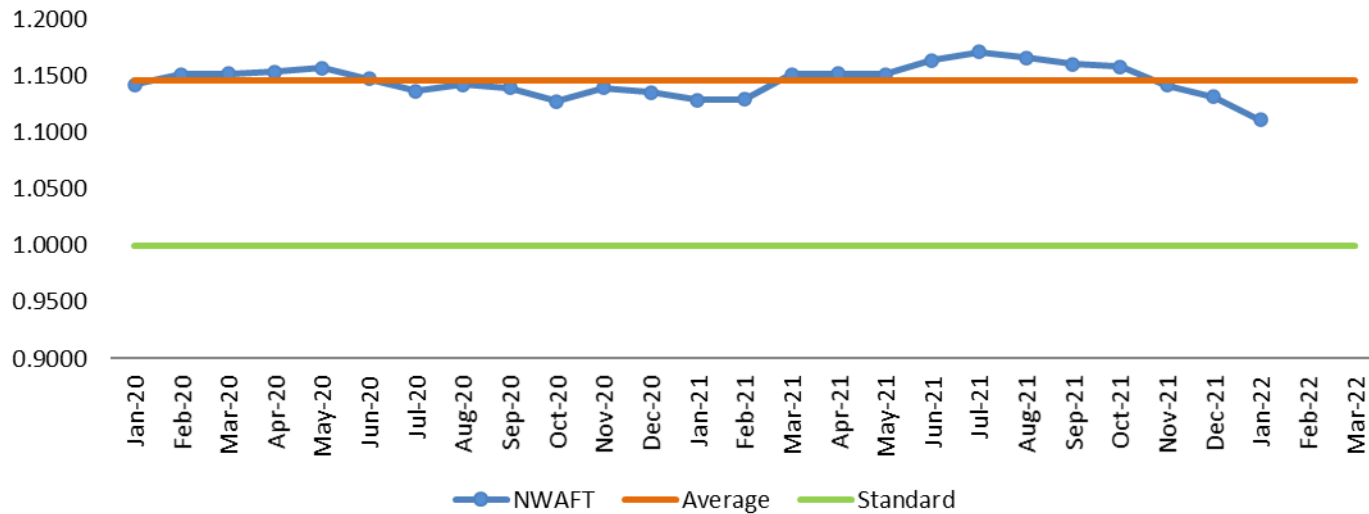
### England

0.9996

### Trend



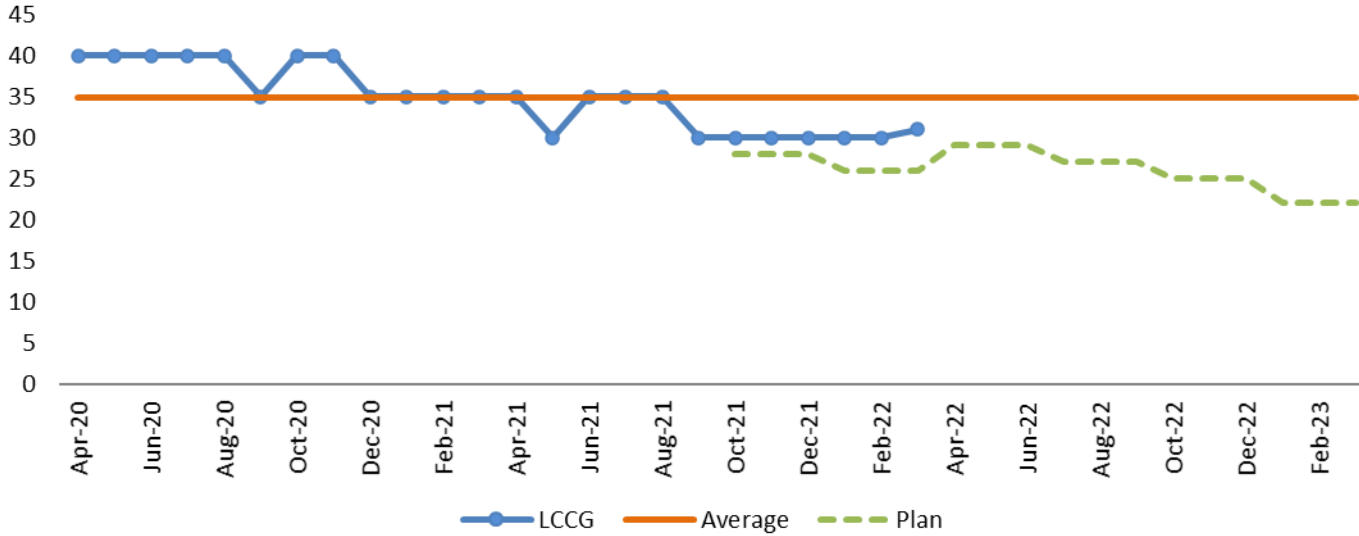
## Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)



# Learning Disability Inpatients & Annual Healthchecks

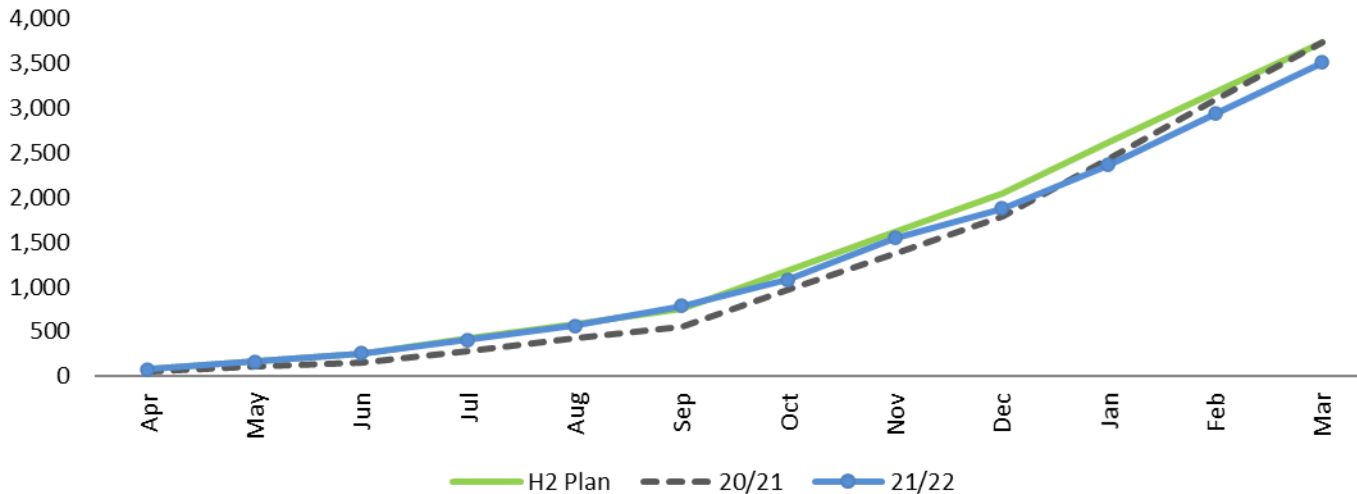
Cause	Actions To Recover
<p><b>LD Inpatients</b></p> <ul style="list-style-type: none"> <li>• Performance shown is rate per 100,000 persons aged 18+. However there are currently has 31 Inpatient (17 CCG, 14 impact beds , 2 children and 1 patient remaining on long term section 17 leave). This current figure is above the end of year 21/22 target of 26.)</li> </ul> <p><b>LD Annual Healthchecks</b></p> <ul style="list-style-type: none"> <li>• Year end delivery is 3,513 delivered, 80% of the total LD register – some practices not able to bring forward when health checks are delivered in year due to competing pressures.</li> </ul>	<p><b>LD Inpatients</b></p> <ul style="list-style-type: none"> <li>• The issues and recovery actions outlined in the May Integrated Performance Report for learning disability inpatients and annual health checks still hold for June</li> </ul> <p><b>LD Annual Healthchecks</b></p> <ul style="list-style-type: none"> <li>• People not receiving a health check on 21/22 (c.227) to be prioritised in April 2022 (and ongoing within Q1 &amp; Q2). A review of practice variation has been undertaken and Locality Managers are engaging with practices to review their plans.</li> <li>• A funding bid has been submitted to NHSE to support.</li> </ul>

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



Indicator	Number of people with a learning disability receiving inpatient care (LCCG)
Plan	26
Period	Mar-22
LCCG	31
Trend	

## Learning Disability Annual Healthchecks (LCCG)



Indicator	Cumulative Learning Disability Healthchecks (LCCG)
Plan	0
Period	Mar-22
LCCG	3513
England	N/A
Trend	

# Care Home Quality

CQC rating	Outstanding	Good	Requires Improvement	Inadequate
<b>May 2022</b>				
No. of Homes: 273				
10 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	193 ( decrease of 1 from last month)	52 (decrease of 1 from last month)	2 (increase on 1 from last month)

CQC rating	Outstanding	Good	Requires Improvement	Inadequate
<b>June 2022</b>				
No. of Homes: 273				
10 Care homes without a rating due to no inspection since registration	16 (remains the same as last month)	193 (remains the same as last month)	52 (remains the same as last month)	2 (remains the same as last month)

## Update

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

Care Homes with high risk issues – under enhanced level of surveillance via CCG/LCC officers: x7 providers

### Suspensions in place by Health and Lincolnshire County Council

**Care Home 1 - (West Locality)** – Nursing and Residential setting. New manager with limited experience, high use of agency staff, lack of governance and support from provider. Default notice by LCC

**Care Home 2 - (West Locality)** – LD placements. Whistleblowing. CQC have proposed notice of closure and de-registration of manager. Default notice in place by LCC

**Care Home 3 - (West Locality)** – Lack of leadership and governance. Lack of engagement with commissioners and regulators. High use of agency staff impacting on the safety of residents due to complex behaviours. Inadequate care plans/risk assessment

**Care Home 4 - (East Locality)** – Residential setting. Lack of management oversight and governance and inadequate staffing levels. Default notice by LCC.

### Default Notices by Lincolnshire County Council

**Care Home 5 - (East Locality)** – default notice for poor record keeping and policies and procedures

**Care Home 6 (South West Locality)** – poor quality care plans, risk assessments and training

**Care Home 7 (South West Locality)** – lack of reporting, safeguarding and whistleblowing

**Care Home 8 (West Locality)** – poor quality policies and procedures, quality issues and inadequate governance

**Care Home 9 (West Locality)** – poor governance

**Care Home 10 (South Locality)** – safeguarding concerns

**Care Home 11 (East Locality)** - Contract standards medication management, IPC, quality assurance & continuous improvement and governance

**Care Home 12 ( East Locality)** – staff training, moving and handling and governance

**Care Home 13 ( South West Locality)** – Inadequate governance

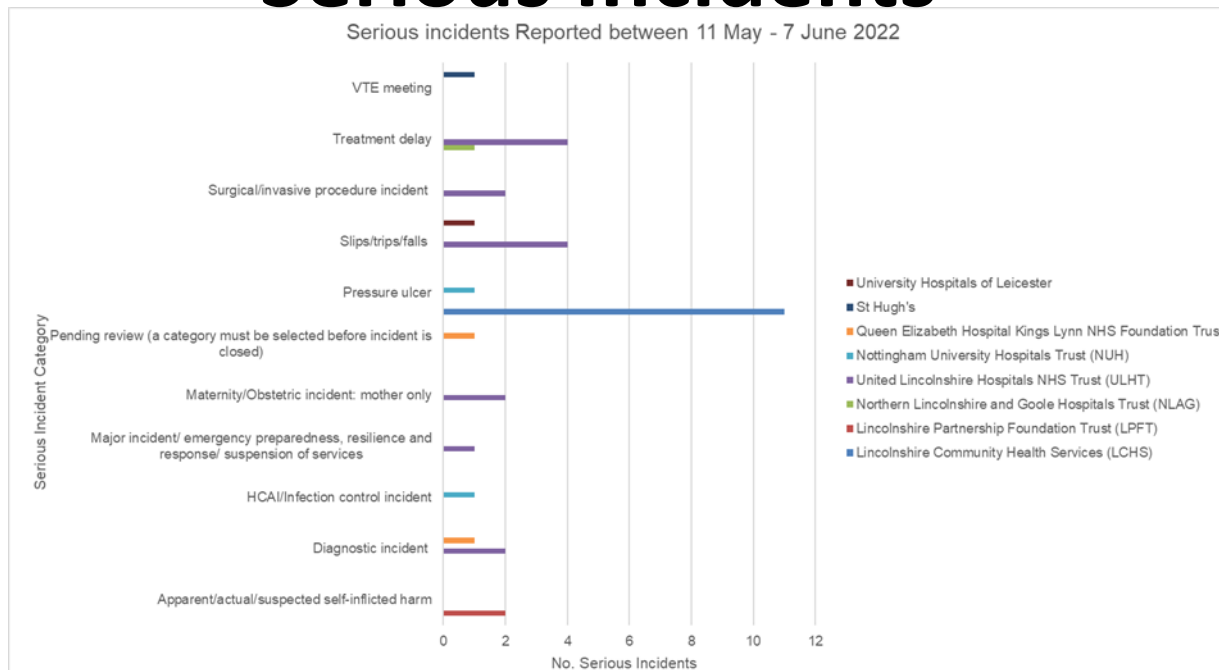
June 2022

# Safeguarding

## **Child Death Overview Panel (CDOP)**

- Statistical analysis carried out by Public Health in 2018 showed that since 2001 there had been no change in suicide rates in Lincolnshire among 10-19 year olds and that since 2007, rates were lower than the national rates. On average, there is one child suicide in Lincolnshire per year.
- Lincolnshire CDOP receives notification of the death of every Lincolnshire child and from January 2021 to February 2022, it has been noted that there have been six deaths that are suspected to be suicides. Due to this apparent increase a themed panel was undertaken in order to recognise any themes to help inform policymakers, commissioners, those providing services to children and young people and those involved in reviewing deaths of children and young people. As a result of this, seven recommendations have been made to the Assurance Executive of the LSCP and sign off is awaited.

# Serious Incidents



## Actions To Recover

- There has been a total of 35 serious incidents reported between 11 May 2022 – 7 June 2022, this represents a slight decrease when compared to last month (n=42). It is noted that there have been fewer serious incidents reported by Lincolnshire Partnership Foundation Trust, which has impacted upon the figures presented.
- There has been a slight increase in the number of serious incidents reported by Lincolnshire Community Health Services this month (n=11), compared to (n=7) last month. As previously referenced, the category of incidents reported remains consistent i.e., category 3 and 4 pressure ulcers.
- nA total of (n=15) serious incidents have been reported by ULHT during the month referenced, this remains relatively consistent when compared to last month (n=17). Slips/trips/falls continue to be a focus of reporting for the Trust (n=4). In addition, treatment delays have featured more in this month's report (n=4). There have been (n=2) incidents reported respectively for each of the following serious incident categories: diagnostic incidents; maternity/obstetric incident: mother only and surgical/invasive procedure incidents. The Trust also reported a single major incident which related to the fire within the Emergency Department at Lincoln County Hospital in March 2022. There had been a single never event reported by ULHT last month relating wrong site surgery (included in the surgical/invasive procedure incident numbers).
- LPFT reported a total of (n=2) serious incidents in the timeframe referenced, this represents a decrease when compared to last month (n=10). However, is consistent with previous serious incident reporting numbers. The focus of the serious incidents reported by LPFT continues to be apparent/actual/suspected self-inflicted harm.

# Primary Care Quality

## Practices Rated Inadequate: 1

Practice	Inspection Date	Locality
Lakeside Medical Centre	08/10/2021	South

## Practices Rated 'Requires Improvement: 3

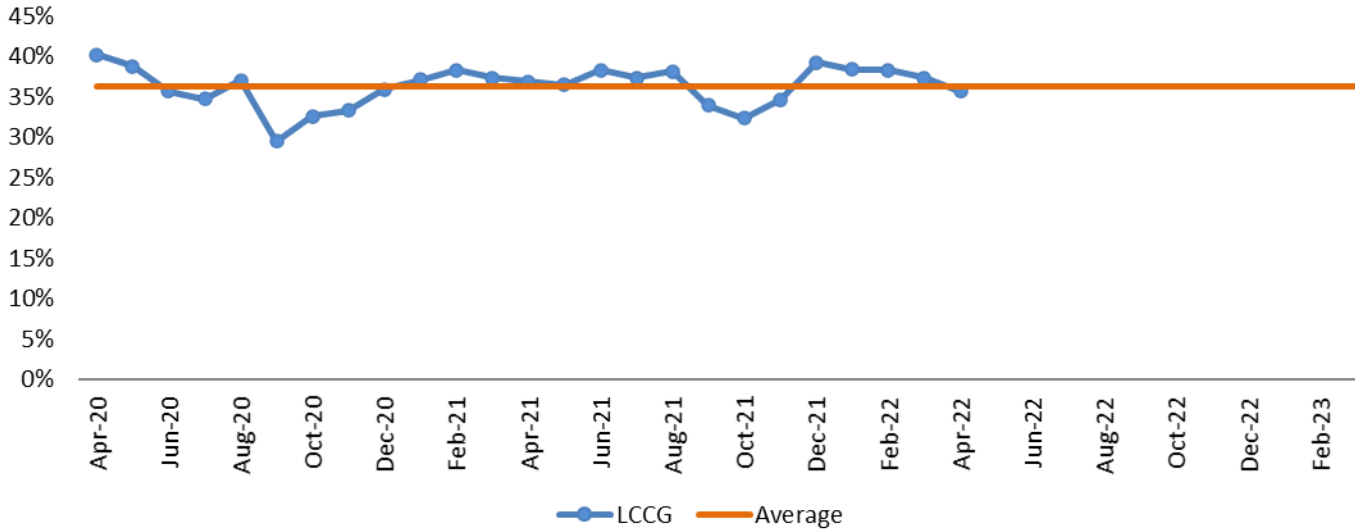
Practice	Publication Date	Locality
Branston Surgery	09/11/2022	West
The Spalding GP Surgery	30/11/2021	South
Marisco Medical Centre	19/01/2022	East

## Actions to recover

### Lakeside

Lakeside received inadequate CQC rating in June 2021. At follow up inspection visit in September 2021 improvements noted, but still areas to address regarding staffing and governance. **Further CQC full inspection in early March 2022 – the CQC report for this inspection was published on the 1<sup>st</sup> June with an overall requires improvement rating. The Practice remains in Special Measures for a further six months to ensure the improvements still required are made.** CCG senior representatives continue to meet regularly with the Practice Team to receive assurance on continued actions to address concerns and to support. LMC also supporting.

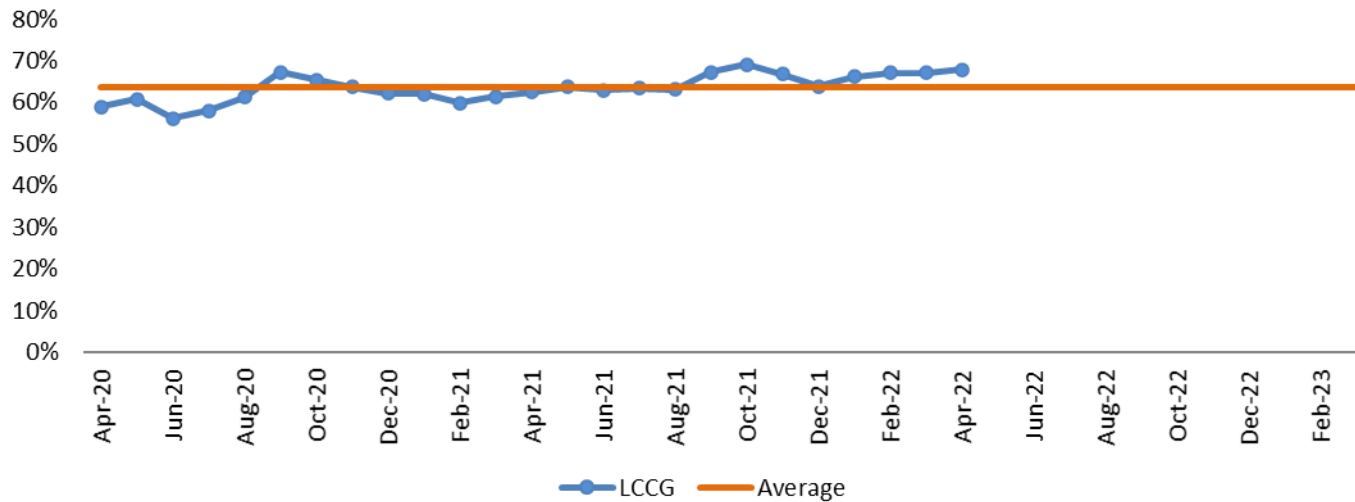
## GP Appointments- percentage seen by a GP



Indicator
GP Appointments- percentage seen by a GP
Period
Apr-22
19/20
40.2%
20/21
36.9%
21/22
35.7%
Trend



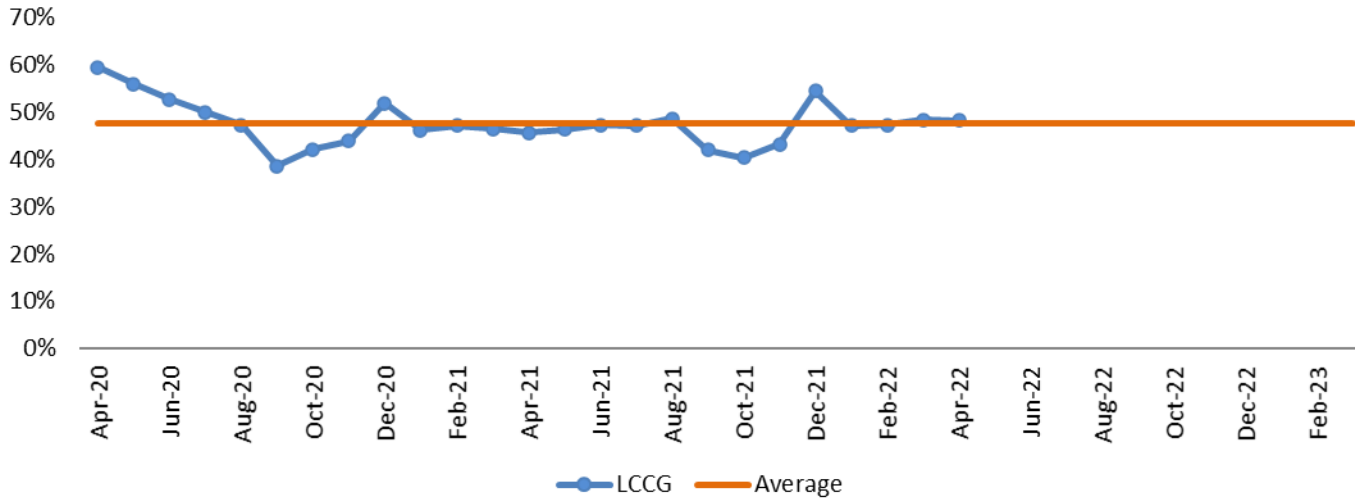
## GP Appointments Mode- percentage seen face to face



Indicator
GP Appointments Mode- percentage seen face to face
Period
Apr-22
19/20
58.9%
20/21
62.4%
21/22
67.9%
Trend



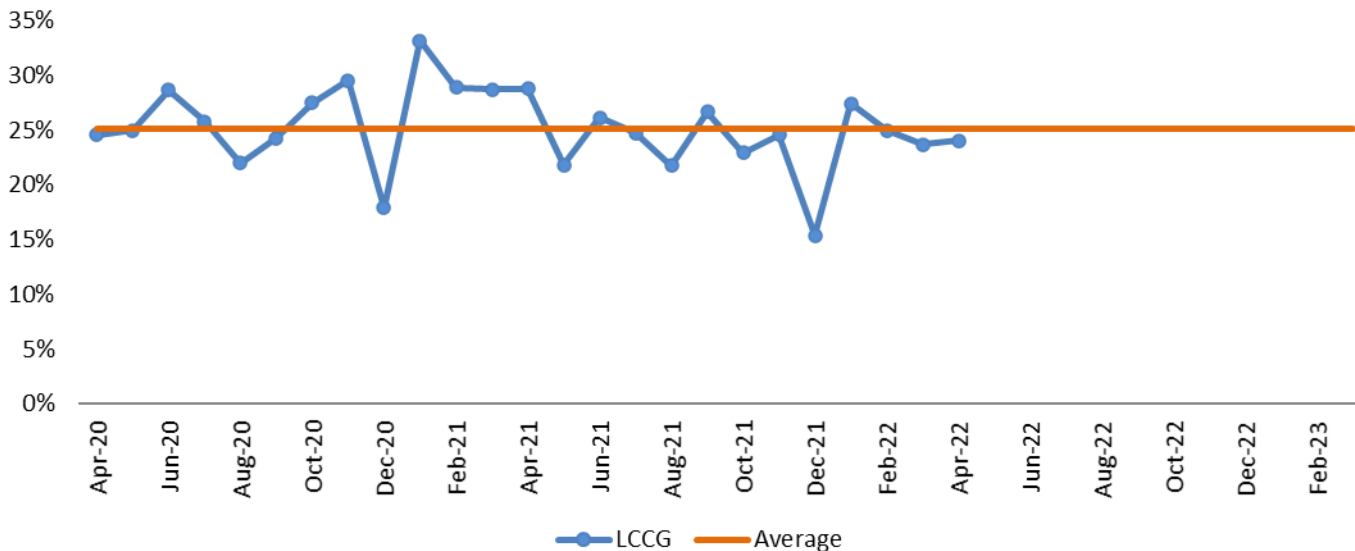
## GP Appointments- time from booking to appointment (Same Day)



Indicator
GP Appointments- time from booking to appointment (Same Day)
Period
Apr-22
19/20
59.4%
20/21
45.6%
21/22
48.2%
Trend



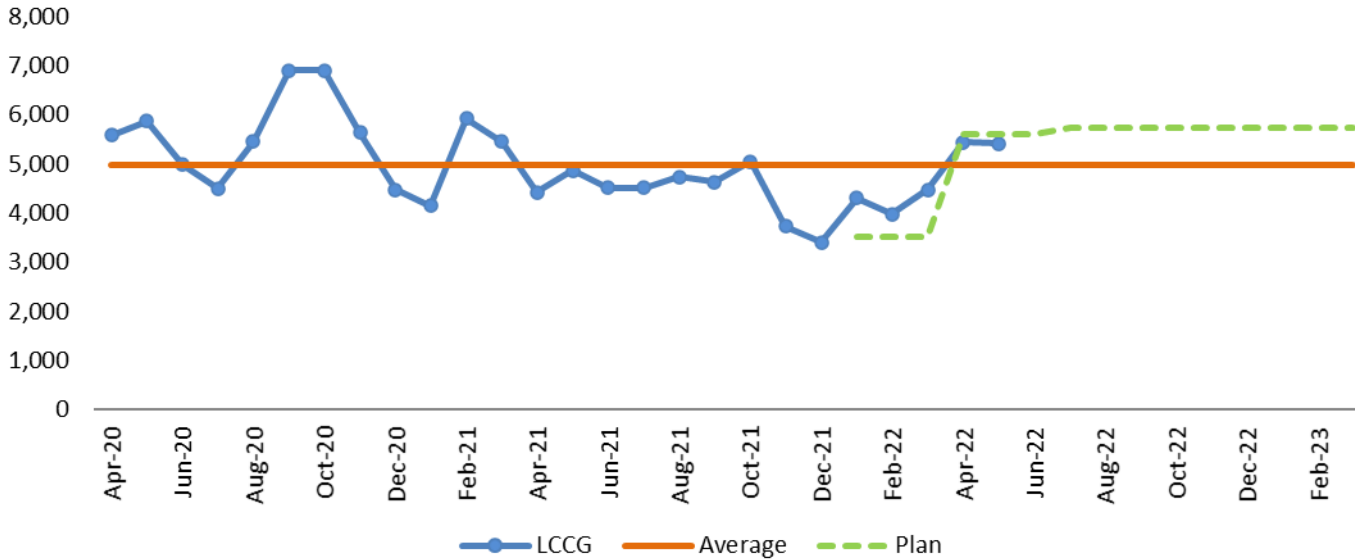
## GP Appointments- time from booking to appointment (1-6 Days)



Indicator
GP Appointments- time from booking to appointment (1-6 Days)
Period
Apr-22
19/20
24.5%
20/21
28.8%
21/22
24.0%
Trend



## GP Appointments-Extended Access Appointments Booked



**Indicator**  
The number of extended access appointments booked excluding did not attends (LCCG)

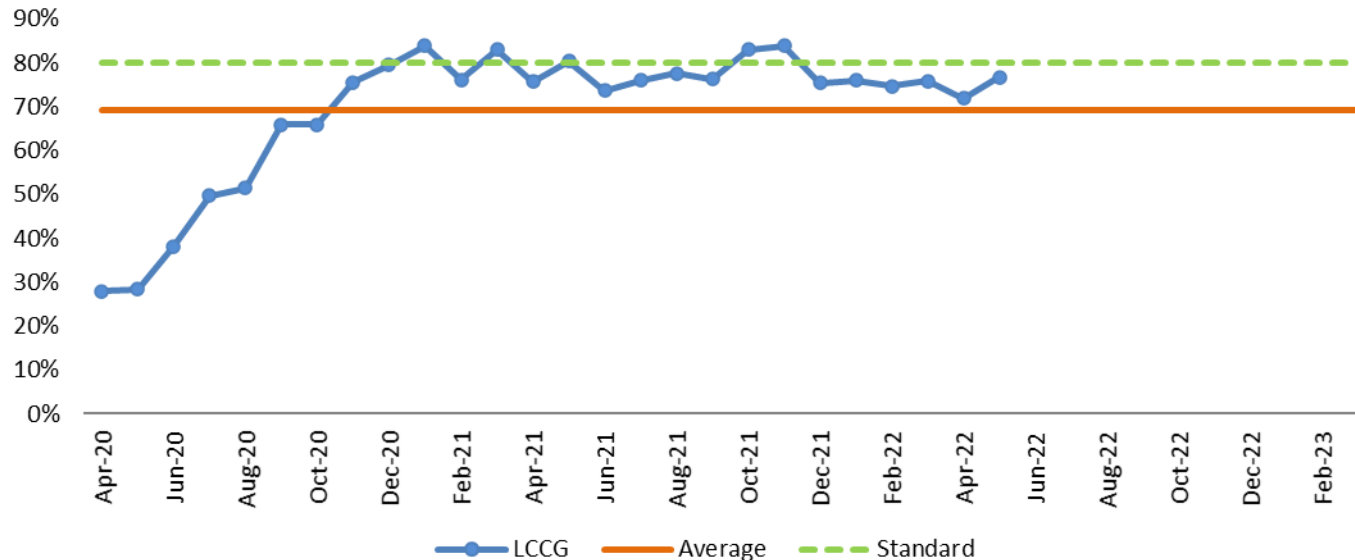
**Period**  
Apr-22

**Standard**  
5588

**22/23**  
5439

**Trend**

## GP Appointments-Extended Access Appointments Utilisation



**Indicator**  
The percentage of available GP extended access appointments utilised (LCCG)

**Period**  
Apr-22

**Standard**  
80.0%

**22/23**  
71.9%

**Trend**

## BOARD MEETING – PUBLIC

<b>Date of Meeting:</b>	29 <sup>th</sup> June 2022	<b>Agenda item:</b>	8.
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<b>Title of Report:</b>	CCG Due Diligence and ICB Readiness to Operate Statement
<b>Report Author:</b>	Pete Burnett, System Strategy and Planning Director
<b>Lead Director:</b>	Pete Burnett, System Strategy and Planning Director
<b>Accountable Officer:</b>	John Turner, NHS Lincolnshire CCG Chief Executive
<b>Attachments:</b>	Appendix 1: Lincolnshire Due Diligence Assurance Letter Appendix 1: Lincolnshire Readiness to Operate Statement Appendix 1: Lincolnshire Readiness to Operate Checklist

<b>1.</b>	<b>Purpose of the Report (including link to objectives)</b>
<p>The purpose of this report is to provide confirmation to the Board that:</p> <ul style="list-style-type: none"> <li>• The due diligence required to close the CCG has been undertaken in line with the NHS England and Improvements requirements</li> <li>• The requirements of the CCG to implement the task required to be mobilised and delivered to prepare for the legal establishment of the NHS Lincolnshire ICB have been carried out in line with the requirements of NHS England and Improvements (NHSEI)</li> </ul>	

<b>2.</b>	<b>Recommendations</b>
<p>The Board is asked to:</p> <ul style="list-style-type: none"> <li>• Note the update and confirmation of the due diligence work to close the CCG in line with national requirements has been delivered</li> <li>• Note the update and confirmation of the work undertaken to establish the NHS Lincolnshire ICB in line with national requirements has been delivered.</li> </ul>	

<b>3.</b>	<b>Executive Summary</b>
<p><b><u>Background and Context</u></b></p> <p>The Health and Care Act 2022 completed the parliamentary process and received Royal Assent on the 28 April. This confirms the establishment of statutory Integrated Care Systems (ICSs) on the 1 July.</p> <p>The Health and Care Bill requires ICS to have two statutory functions:</p> <ul style="list-style-type: none"> <li>• Integrated Care Board (ICB) bringing the NHS together locally to improve population health and care. In addition, the functions currently performed by Clinical Commissioning Groups will be conferred onto ICBs.</li> </ul>	

- Integrated Care Partnership (ICP): a joint committee of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly created by the County Council and Integrated Care Board with specific statutory responsibility for preparing an Integrated Care Strategy for the ICS footprint

In establishing the Integrated Care Boards on the 1<sup>st</sup> July, Clinical commissioning groups will be subsumed into the ICB and will be statutorily dissolved at midnight on 1<sup>st</sup> July.

To ensure the smooth transition to the ICB and effective closure of the CCG, staff within the CCG have been working to deliver the requirements outlined by NHS England and Improvement guidance. The guidance focused on the due diligence requirements to ensure the effective closure of the CCG and the readiness to operate requirements to ensure the legal establishment of the ICB.

### **CCG Due Diligence**

NHSEI published 'ICS implementation guidance: Due diligence, transfer of people and property from CCGs to ICBs and CCG close down' in August 2021.

This document outlines the due diligence process required for the safe transfer of people (staff) and property (in its widest sense) from clinical commissioning groups (CCGs) to integrated care boards (ICBs), and the legal processes used for transfer, establishment and closedown.

#### Key points

- Due diligence is necessary to enable safe and effective transfer from sending organisations to receiving organisations.
- The due diligence process is supported by a bespoke checklist specifically designed for the ICS implementation programme.
- A staff and property transfer scheme is the legal instrument used for the transfer. ICBs will be established by NHS England and CCGs concurrently abolished.
- ICBs will be responsible for any outstanding CCG close down activity.

#### Action required

- CCG Chief Executive should ensure that their teams plan for and undertake robust and proportionate due diligence, and it is recommended that the checklist provided is used for this purpose.
- In June 2022, CCG accountable officers should provide written assurance of due diligence to the chair of the new ICB.

To ensure the due diligence process was delivered effectively a ICB Transition Programme Board was established in December 21 which was chaired by Matt Gaunt, Director of Finance and Contracting, with senior representation for each workstream (Finance, HR, Governance, Quality, IT & IG). The Programme Board has met monthly and regularly reported progress to the Audit and Risk Committee.

The System Strategy and Planning Director (Pete Burnett) and ICS Strategy Director (Tom Diamond) have been members of the Programme Board to ensure alignment with the process for developing the Readiness to Operate.

Each workstream lead developed and has been implementing a transition plan for their areas of responsibility. The Programme Board has monitored overall progress and dealt with risks and issues as they have arisen.

The national Due Diligence checklist has been a key part of the planning and implementation process for the Programme Board. This is a live document and is held in shared document repository currently maintained by the CCG Company Secretary, along with supporting evidence.

Internal Audit have also provided independent assurance on the transition process to the Audit Committee. This has included attendance at all Programme Boards and Finance Workstream project meetings, review of workstream plans, and governance arrangements.

Internal audit performed three specific reviews on the completeness and accuracy of higher risk Due Diligence information – Contract Register, Staff Transfer Information and Quality Governance Metrics. These audits have found the relevant Due Diligence information to reconcile to the source information, but at the same time identified a small number of areas where processes could be improved going forward.

The formal audit report findings will be handed over to the ICB audit committee for any follow up and a handover report has been produced.

To complete the John Turner as Chief Executive of the CCG had to provide in writing assurance that NHS Lincolnshire CCG followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to NHS Lincolnshire Integrated Care Board on 1 July 2022. This letter is included as an appendix to this report.

### **Readiness to Operate Statement**

NHSEI published 'ICS implementation guidance: ICB readiness to operate statement (ROS) and checklist' in August 2021.

The ROS checklist provides a high-level summary of the legal and operationally critical elements that need to be in place for the establishment of ICBs.

The checklist reflects core elements of the ICB functions, governance and leadership arrangements described in the ICS Design Framework. It includes the due diligence activities needed to prepare for the people, property (in its widest sense) and liabilities of CCGs to be transferred to ICBs.

#### Key points

- The ROS is a high-level statement to confirm that all legally required and operationally critical elements are in place ready for the establishment of each ICB as a statutory body on 1 July 2022.
- The statement is underpinned by a ROS checklist.
- The preparations to establish new ICBs will include work described above by CCGs to undertake due diligence in readiness for their closedown and the ROS checklist includes reference to this due diligence work.

#### Action required

- The designate ICB Leadership Team has to use the ROS as the basis for their preparations to establish the new ICB, including working with accountable officers of CCGs to ensure that people and property are safely transferred from CCGs to ICBs. This work was supported by NHS England and NHS Improvement regional teams.
- Reporting on progress against the ROS checklist was required at the end of Q3 2021/22, mid-February, March, May and June 22
- In June 2022, the ICB chief executive (designate) and relevant NHS England and Improvement regional director will jointly sign the ROS.

The ROS Checklist has been submitted in line with NHSEI requirements and supporting evidence was provided at each submission to underpin the assessment. The final submission was made on 10<sup>th</sup> June along with the signed ROS statement.

All but one of the criteria in the checklist was identified as being completed. The exception is the partner member appointment which is still being concluded. NHSEI regional team have supported the assessment and the ROS is now with the national NHSEI Team for final approval.

The ROS Statement and final checklist are included as an appendix to this report.

**4. Management of Conflicts of Interest**

Not applicable in relation to this paper

**5. Finance, QIPP and Resource Implications**

The paper outlines the save transfer of CCG resources to the ICB

**6. Legal/NHS Constitution Considerations**

NHS Clinical Commissioning Groups was required to prepare for the establishment of the ICB in line with national guidance and the Health and Care Act 2022

**7. Analysis of Risk including Assessments**

Yes		No	√
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**8. Outline engagement – clinical, stakeholder and public/patient**

Not applicable in relation to this paper

**9. Outcome of Impact Assessments**

Quality and equality impact assessments (Stage 1 and 2) have been undertaken as part of the process to transfer staff to the ICB

**10. Assurance Departments/Organisations who will be affected have been consulted**

Insert details of the departments you have worked with or consulted during the process:

Finance	√
Commissioning	√
Contracting	√
Medicines Optimisation	√
Clinical Leads	√
Quality	√
Safeguarding	√
Other	√

**11. Report previously presented at:**

Not applicable

**12. For further information or for any enquiries relating to this report, please contact**

Peter Burnett, System Strategy and Planning Director



**Lincolnshire**  
Clinical Commissioning Group

**Lincolnshire CCG**

Bridge House  
The Point  
Lions Way  
Sleaford  
NG34 8GG

**Telephone:** 01522 573939

**Email:** [lccg.office@nhs.net](mailto:lccg.office@nhs.net)

31 May 2022

Sir Andrew Cash  
Designate Interim Chair  
NHS Lincolnshire Integrated Care Board  
Bridge House  
The Point  
Lions Way  
Sleaford  
NG34 8GG

Dear Sir Andrew

**Due Diligence Assurance Letter**

I am writing to provide assurance that NHS Lincolnshire CCG followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to NHS Lincolnshire Integrated Care Board on 1 July 2022.

This assurance is based on review of relevant documentation and assurances that I have received from the Audit and Risk Committee which has assured the CCG ICB Transition Programme Board work which involves colleagues from Internal Audit. I would be happy to share the Audit and Risk Committee minutes and the Due Diligence Checklist if you would like to review these documents.

Our preparations have taken account of the NHSEI ICS implementation guidance: *'Due diligence, transfer of people and property from CCGs to ICBs and CCG close down'* and the accompanying due diligence checklist, covering all aspects of current operations, including people, quality, finance and commissioning.

The CCG has undertaken all the necessary actions prior to close-down. It is not anticipated that there will be any outstanding matters relating to the CCG, which cannot be actioned prior to 1 July. However, in the unlikely circumstance that there are any outstanding actions these will be documented by the Audit and Risk Committee in their close down report which will be provided to the ICB Audit Committee.

The CCG's risk register will be updated prior to 1 July and shared so that the risks to be taken on by the ICB are clear.

A staff list has been prepared in line with tab 2.2 of the NHSEI due diligence checklist and has been shared on a strictly 'need to know'\* basis. It will be kept up to date for 1 July 2022.

Records of CCG property (tangible and intangible assets (including contracts), rights and liabilities) are in good order, to provide the relevant teams in the ICB with a clear baseline position at 1 July 2022.

It is understood that the Staff, Property, Rights and Liabilities Transfer Scheme to be made by the NHS Commissioning Board (NHS England) will give legal effect to the transfer of staff and property from the CCG(s) to the ICB on 1 July 2022.

Should you have any queries regarding the due diligence process or assurance provided, please do not hesitate to contact me.

Yours sincerely

**Matt Gaunt**  
**Director of Finance and Deputy Chief Executive**  
**on behalf of John Turner, Chief Executive**

Copies

Dale Bywater Midlands Regional Director, NHS England and NHS Improvement

\*Person identifiable information will be managed in accordance with the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018 and should be processed and shared in a secure manner i.e. only with people who have a legitimate need to have access to it and to be held no longer than is necessary for the specified purpose. Commercially sensitive data will be handled in the same manner.



**Lincolnshire**  
Clinical Commissioning Group

**Lincolnshire CCG**

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## **NHS LINCOLNSHIRE INTEGRATED CARE BOARD READINESS TO OPERATE STATEMENT**

On the basis of a thorough review of the ICB readiness to operate statement checklist (appended) and the supporting evidence, we are satisfied that adequate preparations have been made for the legal establishment of NHS Lincolnshire Integrated Care Board with effect from 1 July 2022. The NHS Lincolnshire Integrated Care Board will be ready to fulfil its statutory functions from this point. It will develop as a new statutory organisation with ongoing support from NHS England.

The NHS Lincolnshire Integrated Care Board will work with its partners to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

The preparations to establish the NHS Lincolnshire Integrated Care Board and wider integrated care system arrangements, such as provider collaboratives, have been made through engagement with partner organisations.

We note that the NHS Lincolnshire Integrated Care Partnership is also ready to be established between the Integrated Care Board and its partners from 1 July 2022.

**ICB Chief Executive (*designate*) signature:**

**NHS England and NHS Improvement Regional Director signature:**

**Date:**

**SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT**

**Readiness to Operate Statement (ROS) Checklist - to prepare for legal establishment on 1 July 2022**

Please refer to the ROS Guidance before using this checklist

Guidance in relation to the subjects covered in the ROS checklist is / will be available on the dedicated workspace for ICS Guidance on the FuturesNHS Platform:  
<https://future.nhs.uk/ICSGuidance/group/home> on the FutureNHS Collaboration Platform

Name of ICB:	Lincolnshire
Date:	10/06/2021
Completed by:	Pete Burnett
Contact details:	<a href="mailto:peter.burnett4@nhs.uk">peter.burnett4@nhs.uk</a>

**EVIDENCE DOCUMENTS UPLOADED TO NHSEI**

Hierarchy	Ref	Description	Current RAG Rating	Projected RAG Rating at June 2022
High Level Summary	1	<b>Integrated care partnership (ICP): Initial ICP arrangements and principles agreed</b>	Completed	Completed
Supporting elements	1.1	Initial Integrated Care Partnership (ICP) arrangements agreed, including principles for operation from 1 April 2022, in line with relevant guidance	Completed	Completed
High Level Summary	2	<b>Integrated care board (ICB): Designate appointments to the Board of the ICB made and Board quorate in line with relevant guidance</b>	Completed	Completed
Supporting elements	2.1	Designate Chair appointed and ready to take up post on 1 April 2022	Completed	Completed
Supporting elements	2.2	Designate Chief Executive appointed and ready to take up post on 1 April 2022	Completed	Completed
Supporting elements	2.3	Designate Non-Executive Directors (minimum of two) appointed and ready to take up post on 1 April 2022	Completed	Completed
Supporting elements	2.4	Designate Partner members appointed and ready to take up post [timing dependent on the Partner Member Regulations]	On target, no concerns	On target for delivery by June 2022
Supporting elements	2.5	Other designate appointments made and post holders ready to take up post on 1 April 2022 (minimum additional Executive roles: finance; medical; nursing) to ensure quoracy of the ICB Board, according to its Constitution	Completed	Completed
High Level Summary	3	<b>System development plan, ICB constitution and governance arrangements: System Development Plan, ICB constitution and governance arrangements in place</b>	Completed	Completed
Supporting elements	3.1	System development plan (SDP) in place indicating how the ICB will work with its partners in the ICP from April 2022 to meet the needs of the population, with a focus on reducing health inequalities	Completed	Completed
Supporting elements	3.2	ICB Constitution, including the Standing Orders and agreed ICB name, approved by NHS England before 1 July 2022, ready to be adopted on 1 July 2022 - in line with relevant guidance	Completed	Completed

Supporting elements	3.3	ICB Scheme of Reservation and Delegation (SoRD) prepared and ready to be adopted on 1 July 2022	Completed	Completed
Supporting elements	3.4	ICB Standing Financial Instructions (SFIs) prepared and ready to be adopted on 1 July 2022	Completed	Completed
Supporting elements	3.5	ICB Governance Handbook (setting out the governance arrangements) prepared and ready to be adopted on 1 July 2022	Completed	Completed
Supporting elements	3.6	ICB functions and decision map prepared and ready to be adopted on 1 July 2022 - including (where applicable) place boundaries, place-based leadership, and place-based governance arrangements (e.g. with Health and Wellbeing Boards); delegations (where appropriate); and any supra-ICB governance arrangements	Completed	Completed
Supporting elements	3.7	Any joint commissioning arrangements for 2022/23 (including joint committees with local authorities, trusts / foundation trusts, other ICBs and NHS England and NHS Improvement) documented, ready to take effect on 1 July 2022	Completed	Completed
Supporting elements	3.8	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance [For clarification purposes this relates to Pharmacy, Optometry and Dental commissioning function only]	Completed	Completed
Supporting elements	3.9	Standards of business conduct policy prepared and ready to be adopted on 1 July 2022	Completed	Completed
Supporting elements	3.10	Conflicts of interest policy prepared and ready to be adopted on 1 July 2022	Completed	Completed
Supporting elements	3.11	Essential policies identified through risk assessment (eg commissioning [eg IVF commissioning], safeguarding, HR) and prepared	Completed	Completed
High Level Summary	4	<b>Provider partnerships: Provider partnership arrangements agreed</b>	Completed	Completed

Supporting elements	4.1	Provider partnership arrangements which will apply from 1 July 2022 agreed in line with relevant guidance. These include provider collaboratives, primary care networks and other collaborative arrangements	Completed	Completed
High Level Summary	5	<b>People and culture: People function ready for operation</b>	Completed	Completed
Supporting elements	5.1	Governance and delivery arrangements for people function agreed and ready for operation as set out in line with relevant guidance, and workforce and organisational development priorities identified in the system development plan	Completed	Completed
High Level Summary	6	<b>Quality, safety and EPRR: Quality, safety and EPRR systems and functions ready for operation</b>	Completed	Completed
Supporting elements	6.1	Quality and safety systems and function ready to take effect from 1 July 2022, including implementation of System Quality Groups in line with the National Quality Board's guidance	Completed	Completed
Supporting elements	6.2	EPRR responsibilities clear and systems and function ready to operate from 1 July 2022 in line with relevant guidance	Completed	Completed
High Level Summary	7	<b>Clinical and care professional leadership: Model / arrangements prepared</b>	Completed	Completed
Supporting elements	7.1	ICB leadership model / arrangements prepared in line with relevant guidance	Completed	Completed

High Level Summary	8	<b>Working with people and communities: Public involvement and engagement strategy / policy</b>	Completed	Completed
Supporting elements	8.1	ICB public involvement and engagement strategy / policy prepared in line with relevant NHSEI guidance	Completed	Completed
High Level Summary	9	<b>System oversight: System oversight arrangements between NHS England and NHS Improvement regional team and ICB</b>	Completed	Completed
Supporting elements	9.1	Arrangements for NHS oversight and the MOU to describe the agreed ways of working between the NHS England and NHS Improvement regional team and the ICB prepared, ready to take effect from 1 July 2022	Completed	Completed
High Level Summary	10	<b>Finance and planning: Planning for 2022/23 developed in line with national requirements and finance function and systems ready for operation</b>	Completed	Completed
Supporting elements	10.1	Planning for 2022/23 has been carried out in line with relevant guidance	Completed	Completed
Supporting elements	10.2	Activities as outlined in the NHS SBS finance / ledger reconfiguration programme plan as due by 1 July 2022 have been delivered e.g. new bank account in place for the ICB, ICB able to make payments for goods and services, finance function ready to operate, etc.	Completed	Completed
Supporting elements	10.3	Plan for ESR changes in place (if using IBM for a technical merge of ESR systems, technical slot booked)	Completed	Completed
High Level Summary	11	<b>Data, digital and information governance: Systems ready to operate and information governance activities on target</b>	Completed	Completed
Supporting elements	11.1	Activities outlined in the Organisation Data Service (ODS) reconfiguration toolkit as due by 1 July 2022 have been delivered	Completed	Completed
Supporting elements	11.2	Activities outlined in the Information governance / data security and protection toolkit (DPST) (e.g. Caldicott Guardian, Information Asset Owner, Senior Information Risk Owner, records retention, etc.) as due by 1 July 2022 have been delivered	Completed	Completed
Supporting elements	12.1	<b>Equalities duties</b>	Completed	Completed
Supporting elements	12.1.1	Evidence of compliance with the Public Sector Equalities Duty, and wider equalities duties, in the transfer and establishment process	Completed	Completed
Supporting elements	12.2	<b>People transfer</b>	Completed	Completed
Supporting elements	12.2.1	TUPE / COSOP consultation completed and staff list shared by sending CCG(s) to receiving ICB(s) (designate Chief Executive) [Data fields defined on tab 2.2 of the Due Diligence Checklist - link added]; Link added to HR Framework (Technical Guidance)	Completed	Completed
Supporting elements	12.2.2	CCG(s) staff due diligence completed and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD) - in line with relevant guidance (HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])	Completed	Completed
Supporting elements	12.3	<b>Property transfer</b>	Completed	Completed
Supporting elements	12.3.1	CCG(s) due diligence completed on all property (assets and liabilities, including contracts e.g. with CSUs) in line with guidance; and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD). List of property and liabilities from sending CCG(s) to receiving ICB(s) produced - in line with relevant guidance (Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])	Completed	Completed

Supporting elements	12.4	<b>First day arrangements</b>	Completed	Completed
Supporting elements	12.4.1	Appropriate arrangements made in relation to NHS Resolution schemes (Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and the Property Expenses Scheme) to provide indemnity in line with NHS Resolution guidance (when available)	Completed	Completed
Supporting elements	12.4.2	First ICB Board meeting to note / approve (as appropriate): Constitution, governance handbook, appointments, key strategies, policies and delegation arrangements (covering both joint commissioning and formal delegations)	Completed	Completed
Supporting elements	12.4.3	First day communications plan in place	Completed	Completed
Supporting elements	12.4.4	ICB website in place	Completed	Completed

**REGIONAL TEAM NHS FUTURES SITE**

Comments
<p>Lincs HWB agreed as forum for ICP in 21/22                      HWB ToRs updated to reflect ICP role (shared as evidence)                      Recent guidance identified ICP as a statutory committee from 1st April 2022 - given HWB is also a statutory body can't now be one in same                      Work underway to confirm how principle of HWB being forum for ICP can work in practice from 1st April 2022 e.g. same membership, meets on same day, one meeting happens immediately before the other.                      Paper on ICP went to HWB in December (shared as evidence) but meeting stood down due to covid                      Updated paper going to March HWB                      Workshop with HWB on ICP held on 36 April                      Agreement on approach and structure - ToRs in development</p>
<p>Lincolnshire ICS did not appoint a Chair in its first round of recruitment                      Interim chair appointed and signed of by SOS                      System needs to go to advert for permanent appointment by 1 July 2022</p>
<p>Appointed</p>
<p>Consideration given and rationale developed for number of ICB NEDs, based on ICB function map and governance arrangements, and experience drawn from NED arrangements from existing system groups.                      Wider system engagement completed                      NED roles out to advert (material shared as evidence)                      All stakeholder panels have happened                      Interviews completed and 4x appointments made                      Interview completed for remaining post on 18 May - appointed and finalising references</p>
<p>Initial consideration and rationale developed                      Wider system engagement underway                      Process now underway                      LA and Trust partner member appointed                      Completing process on Primary Care</p>
<p>Exec role/structure developed based on function map and governance arrangements                      Wider system engagement on roles undertaken                      All interviewed and appointed                      MD interviewed and selected - going through final due diligence</p>
<p>Ongoing evolution and development of overarching strategy System Development Plan document                      Alignment between SDP and ROS complete                      Reporting mechanism for ROS and SDP progress established and being used</p>
<p>Constitution drafted and submitted to NHSEI regional team early Dec 21 (shared as evidence)                      Feedback from regional team received - minor amends to be made as agreed                      NHSEI further version of the template - now issued                      Now approved by NHSEI</p>

<p>To be included in ICB Governance Handbook  First draft of ICB Governance Handbook Completed (shared as evidence)  Separate SoRD document being developed to be dropped into ICB Governance Handbook when complete - 1st draft completed (shared as evidence)  Now completed and submitted</p>
<p>SFIs completed - still to be put into required template  Now completed and submitted</p>
<p>First draft of ICB Governance Handbook completed (shared as evidence)  First draft includes:  - ICB Board structure/membership (based on ICB TOM - shared as evidence)  - ICP membership (based on ICB TOM - shared as evidence)  - Matters reserves to ICB and its constitution (based on ICB Constitution - shared as evidence)  - ICB function and decision map and committee structure. (based on ICB TOM - shared as evidence)  - Statutory committee ToRs  - Board roles (see draft JDs for Exec responsibilities - shared as evidence)  Second draft of the ICB Governance Handbook completed (shared as evidence).  Now completed</p>
<p>ICB function map and governance structure complete - including joint committees  Has been used to inform thinking on ICB Board structure and governance arrangements  Has undergone wider development  Framework for decision map, aligned to ICB governance structure complete, which includes decision making authority of committees  Function map and governance structure included in ICB Governance Handbook</p>
<p>Joint commissioning contracts are on contract register and will be transferred to ICB under the legislation</p>
<p>Not applicable</p>
<p>To be included in ICB Governance Handbook  Currently CCG has a single policy for business conduct and conflicts of interest - intention is to novate these to ICB  Initial versions produced based on existing CCG policies  Now finalised  <b>SINGLE DOCUMENT FOR BUSINESS CONDUCT AND COI</b></p>
<p>To be included in ICB Governance Handbook  Currently CCG has a single policy for business conduct and conflicts of interest - intention is to novate these to ICB  Initial versions produced based on existing CCG policies  Now finalised  <b>SINGLE DOCUMENT FOR BUSINESS CONDUCT AND COI</b></p>
<p>Essential policies were reviewed and consolidated when the Lincolnshire CCG went '4 into 1'.  This consolidated document is the starting point for the ICBs policies.  Review of current CCG policies commenced  Require finalisation  Master Policy has been reviewed and work is underway to review and establish key policies (list attached as evidence).  Currently going through finalisation process and being transferred onto ICB template</p>

Lincolnshire Health and Care Collaborative - Membership clear and preferred governance model identified. Working draft of full alliance agreement shared across for comment and feedback. Next draft incorporating feedback will be shared with lawyers on March 17th. Proposed final version due to be ready on March 25th.  
 Proposed SDP programme architecture (including programme team structure, SDP programme reporting and programme governance structure) developed by PWC experts. This is ready for the LHCC Managing Director Peter Noble taking up post on 1st April 2022. NB as agreed this is confined to the 3 existing transformation programmes within the SDP at present (Care Closer to Home, MSK, Prescribing)

EM MHLA Alliance - established and in place

PCNs as Building Blocks of Transformation - Outline of ICB role re PCN development scoped, including suggested governance framework and forums. New arrangements on track to be operational from 01.07.22. PCN rep engaged in discussion re development of provider alliance agreement and development. Facilitated development of the governance arrangements and capacity and capability of PCN A / PCN is nearing completion.

Key deliverables:

Tricordant out-put & work plan developed- this will provide new milestones including the arrangements to deliver the links with LHCC- April 2022

Legal workshops completed – June 2022

ICB input – milestones as per ICB governance work

Baseline assessment of current state translated into a work plan – April 2022

SRO agreed/in place

Structure and governance agreed

NHSE attend people board

Terms of reference agreed

People plan

Work has been progressing well

Well developed drafts of function and governance framework complete

ALSO REFLECTED IN ICB TOM REQUIREMENTS

Work has commenced, building on current arrangements

However, capacity to complete is challenged due to pressures in the system

Existing EPRR arrangement in place that has been operational throughout pandemic - this will be reframed in existing working arrangements.

First draft of function delivery and governance framework produced - awaiting national guidance for further development.

Clair Raybould confirmed as AEO

Regional team confirmed requirements in place

Initial meeting with Des Breen, ongoing support yet to be finalised

Project management support identified - expected to be in place January 2022

Engaged in NHS Elect action learning set

Key risk is current pressures on this staff group due to covid/vaccinations

Ongoing development

System Clinical Directorate established

Additional project management capacity in place

Cathy Geddes in to provide additional support

Development plan and strategic board ToRs approved in line with guidance

Clinical and Care Directorate still maturing as expected and will continue to over the coming months

<p>Work on public involvement and engagement strategy being developed through system involvement steering group          Consideration being given by system leaders (including LCC) on how/when to engage the public on the development of the ICB          Document completed in line with guidance</p>
<p>Support for the carry forward for the carry forward of existing MOUs into 22/23, and confirm commitment to the          development of revised MOUs in accordance with national guidance (once published)</p>
<p>Robust planning undertaken by system in line with guidance, and due diligence carried out</p>
<p>Latest SBS Ledger Programme shows green on all areas for the system.          We only have 1 bank account already – therefore no change so no risk of cash flow arrangements/cash transactions.          1 element with issues - FALA - however is a national issue due to delay in NHSEI guidance          Completed</p>
<p>Only a name change is required in ESR as we are already on one VPN. This will be actioned by HR (Steve Wright) and is on          track. The change cannot happen until 1st July as pay will need to go through the CCG in June first. No concerns.</p>
<p>For the ODS code we have one and we have registered oro the Information Governance Toolkit as required (Dec 21)          Completed - confirmed with regional Digital Director</p>
<p>Identified Caldicott Guardian and SIRO          Set up a user (local compliance officer)          The DSPT toolkit for the CCG is due to be submitted by 31.03.22. I have attached a snapshot report to show the work is in          progress.          Completed - confirmed with regional Digital Director</p>
<p>People impact assessments completed</p>
<p>Initial engagement with staff has happened          TUPE/COSOP consultation process is now due to start in April and complete by 30 June 2022. We are awaiting national          guidance on this as we have been told there is to be a nationally agreed consultation template for us to work with.          Now completed</p>
<p>With regards to the Due diligence information and PIA this is being kept up dated on our systems it does however contain a lot          of personally sensitive information so we are very restricted as to what can be shared. Again the people impact assessment is          limited by the lift and shift arrangements that are in place for all CCG employees below board level so the impact on staff is          very minimal. The impact on staff at board level complete          Being finalised</p>
<p>1#property – have a list of the properties which are all leased (The CCG does not have any assets/property. It does however          have leases in place with NHS Property Services.)          2#Other assets and liabilities, will be documented in the final accounts working papers. These have been produced for month          9 and will updated monthly until month 12. Again Emma can provide detail, but I understand these have also been shared          with external audit          3#Contracts – finance are in the process of compiling the contract register. The main focus of this is to identify anything outside          of national contract arrangements as these will not novate automatically under statute.</p>

The CCG pays c£11k to NHS R, and there is a payment in respect of all three schemes including CNST.
Agenda agreed
Comms plan agreed
<a href="http://www.lincolnshire.icb.nhs.uk">www.lincolnshire.icb.nhs.uk</a>

## BOARD MEETING - PUBLIC

<b>Date of Meeting:</b>	29 <sup>th</sup> June 2022	Agenda item:	9.
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<b>Title of Report:</b>	Register of Documents Sealed in 2022/23 (months 1-3)
<b>Report Author and Title:</b>	Mrs Jules Ellis-Fenwick, CCG Corporate Secretary
<b>Appendices:</b>	Not applicable

<b>1.</b>	<b>Purpose of the Report (including link to objectives)</b>
To inform the Board of the details of documents signed and sealed during the period 2022/23 (months 1-3 as in 1 <sup>st</sup> April 2022 to 30 <sup>th</sup> June 2022).	

<b>2.</b>	<b>Recommendations</b>
The Board is asked to note the paper and its contents.	

<b>3.</b>	<b>Executive Summary</b>										
<p>The CCGs Constitution and Delegated Financial Authority Limits set out the arrangements for use of the organisation’s Seal. Documents are usually required to be sealed in the following circumstances:</p> <ul style="list-style-type: none"> <li>• All contracts for the purchase/lease of land and/or building.</li> <li>• All contracts for capital works exceeding specified limits.</li> <li>• All lease agreements where the annual lease exceeds beyond five years.</li> <li>• Any other lease agreement where the total payable under the lease exceeds certain limits.</li> <li>• Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed specified limits.</li> </ul> <p>All documents that include the words ‘executed as a deed’ must be signed and sealed.</p> <p>The following individuals are authorised to authenticate use of the Seal by their signature:</p> <ul style="list-style-type: none"> <li>• The Accountable Officer (Chief Executive)</li> <li>• The Chief Finance Officer (Director of Finance and Contracting)</li> <li>• Any senior Officer authorised by the Accountable Officer.</li> </ul> <p>The Standing Orders identify the requirement of yearly reports to be presented outlining the details of the documents sealed during the preceding period.</p> <p>During 2022/23 (months 1 – 3) there was one document signed and sealed:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr style="background-color: #00a651; color: white;"> <th style="width: 15%;">REFERENCE</th> <th style="width: 15%;">DATE</th> <th style="width: 30%;">DETAILS</th> <th style="width: 20%;">SIGNED BY</th> <th style="width: 20%;">WITNESSED BY</th> </tr> </thead> <tbody> <tr> <td>No reference</td> <td>31.05.2022</td> <td>Community Equipment Service S75 Agreement</td> <td>Matt Gaunt, Director of Finance</td> <td>PA to the Director of Finance</td> </tr> </tbody> </table>		REFERENCE	DATE	DETAILS	SIGNED BY	WITNESSED BY	No reference	31.05.2022	Community Equipment Service S75 Agreement	Matt Gaunt, Director of Finance	PA to the Director of Finance
REFERENCE	DATE	DETAILS	SIGNED BY	WITNESSED BY							
No reference	31.05.2022	Community Equipment Service S75 Agreement	Matt Gaunt, Director of Finance	PA to the Director of Finance							

<b>4.</b>	<b>Management of Conflicts of Interest</b>
Not applicable.	

<b>5. Finance, QIPP and Resource Implications</b>																
Documents are presented for sealing by the Chief Executive when they exceed the limits as identified in the CCG Prime Financial Policies.																
<b>6. Legal/NHS Constitution Considerations</b>																
The document has been produced in line with the guidance detailed in the CCG Constitution and Delegated Financial Authority Limits.																
<b>7. Analysis of Risk including Assessments</b>																
There are no risks identified at this stage.																
Please state if the risk is on the CCG Risk Register.      Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																
<b>8. Outline engagement – clinical, stakeholder and public/patient</b>																
Not applicable.																
<b>9. Outcome of Impact Assessments</b>																
Not applicable.																
<b>10. Assurance Departments/Organisations who will be affected have been consulted</b>																
Insert details of the departments you have worked with or consulted during the process:																
<table border="1"> <tr> <td>Finance</td> <td>x</td> </tr> <tr> <td>Commissioning</td> <td></td> </tr> <tr> <td>Contracting</td> <td></td> </tr> <tr> <td>Medicines Optimisation</td> <td></td> </tr> <tr> <td>Clinical Leads</td> <td></td> </tr> <tr> <td>Quality</td> <td></td> </tr> <tr> <td>Safeguarding</td> <td></td> </tr> <tr> <td>Other</td> <td></td> </tr> </table>	Finance	x	Commissioning		Contracting		Medicines Optimisation		Clinical Leads		Quality		Safeguarding		Other	
Finance	x															
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Contracting																
Medicines Optimisation																
Clinical Leads																
Quality																
Safeguarding																
Other																
<b>11. Report previously presented at:</b>																
Not applicable.																
<b>12. For further information or for any enquiries relating to this report, please contact</b>																
Jules Ellis-Fenwick – <a href="mailto:julieellis1@nhs.net">julieellis1@nhs.net</a>																

## BOARD MEETING - PUBLIC

<b>Date of Meeting:</b>	29th June 2022	<b>Agenda item:</b>	10.
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<b>Title of Report:</b>	Declaration of Interest Registers 2022/23 (months 1-3)
<b>Report Author and Title:</b>	Mrs Jules Ellis-Fenwick, CCG Corporate Board Secretary
<b>Appendices:</b>	Declaration of Interest Registers 2022/23 (months 1-3)

<b>1. Purpose of the Report (including link to objectives)</b>
The purpose of this report is to present the Declaration of Interest Registers 2022/23 (months 1-3 – 1 <sup>st</sup> April 2022 to 30 <sup>th</sup> June 2022)

<b>2. Recommendations</b>
The Board is asked to: <ul style="list-style-type: none"> <li>Note the Declaration of Interests Registers for 2022/23 (months 1-3 – 1<sup>st</sup> April 2022 to 30<sup>th</sup> June 2022)</li> </ul>

<b>3. Executive Summary</b>
<p>The CCG is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure and be able to evidence that these decisions secure the best possible services for the population it serves, the CCG must demonstrate accountability to relevant stakeholders, particularly the public, and probity and transparency in the decision-making process.</p> <p>A key element of this assurance involves management of conflicts of interest with respect to any decisions made. Effective handling of such conflicts is crucial for the maintenance of public trust in the commissioning system. Importantly, it also serves to give confidence to patients, provider organisations, Parliament and tax payers that the CCG's commissioning decisions are robust, fair, transparent and offer value for money.</p> <p>The CCG has established a <u>Standards of Business Conduct and Conflicts of Interest Policy</u>. This policy sets out clear and robust procedures on how the CCG manages conflicts of interest. There have been no breaches of the Conflict of Interest policy in 2022/23.</p> <p>The CCG has also established Declaration of Interest Registers for the Board and its Committees. These registers are regularly presented to the Audit and Risk Committee for consideration. One of the CCG Non-Executive Directors is the Conflicts of Interest Guardian.</p> <p>All of the CCG's Board members, GP members, employees and any other individuals who act on the CCG's behalf regularly update a Declaration of Interest form. Members will also raise any emerging issues or specific interests at the start of meetings, including Board meetings.</p>

The Declaration of Interest Registers for 2022/23 (months 1-3 are presented as part of the close down process of the CCG and transition to the ICB from the 1<sup>st</sup> July 2022.

The CCG Declaration of Interest Registers for 2022/23 (months 1-3) will then be archived for six months in line with NHSE Conflicts of Interest guidance.

**4. Management of Conflicts of Interest**

As identified above.

**5. Finance, QIPP and Resource Implications**

Not applicable in relation to this paper.

**6. Legal/NHS Constitution Considerations**

In accordance with the CCG's Constitution and section 140 of The National Health Service Act 2006, the CCG's Accountable Officer (Chief Executive) must be informed of any interest which may lead to a conflict with the interests of the CCG and the public for whom they commission services in relation to any decision to be made by the CCG.

**7. Analysis of Risk including Assessments**

Please state if the risk is on the CCG Risk Register.

Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
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**8. Outline engagement – clinical, stakeholder and public/patient**

Not applicable.

**9. Outcome of Impact Assessments**

Not applicable.

**10. Assurance Departments/Organisations who will be affected have been consulted**

Insert details of the departments you have worked with or consulted during the process:

Finance	<input type="checkbox"/>
Commissioning	<input type="checkbox"/>
Contracting	<input type="checkbox"/>
Medicines Optimisation	<input type="checkbox"/>
Clinical Leads	<input type="checkbox"/>
Quality	<input type="checkbox"/>
Safeguarding	<input type="checkbox"/>
Other	<input checked="" type="checkbox"/>

**11. Report previously presented at:**

Not applicable.

**12. For further information or for any enquiries relating to this report, please contact**

Jules Ellis-Fenwick, CCG Corporate Board Secretary – [julieellis1@nhs.net](mailto:julieellis1@nhs.net)

**DECLARATION OF INTERESTS REGISTER AS AT MAY 2022**

**REGISTER OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**BOARD**

Name	Current position(s) held in the CCG i.e. Board member, Committee member, Member Practice, CCG employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To		
Akram, Majid	Clinical Lead	Deepings Practice	✓				Partner	Ongoing			Declare as appropriate and exclude from any primary care decision making.
		GP Simulation Training Company	✓				Director	Ongoing			Declare. Exclude from any commissioning discussions/decisions relating to GP Simulation Training Company.
		Deepmedicine IT Company	✓				Director	Ongoing			Declare. Exclude from any commissioning discussions/decisions relating to Deepmedicine IT Company.
Baker, David	Clinical Lead, South West Locality	LMC		✓			Member	Ongoing			Declare and note.
		K2 Federation	✓				Member	Ongoing			Declare. Exclude from any commissioning discussions/decisions relating to K2 Federation.
		Nil	✓				Doctor	Ongoing			Note and declare as appropriate.
		Vine House Practice	✓				GP Partner	Ongoing			Declare and note.
Boldy, David	Secondary Care Doctor	United Lincolnshire Hospitals NHS Trust				Indirect	Wife works for ULHT	Apr-20	Ongoing		Note and declare, exclude where appropriate.
		Lincoln Medical School				Indirect	Wife is Director of Clinical Skills	Apr-20	Ongoing		Note and declare, exclude where appropriate.
		East Lindsey Medical Practice, 153 Newmarket, Louth, LN11				Indirect	Patient	Ongoing			Declare as appropriate
Burnett, Pete	Interim STP Programme Director	Nottinghamshire CCG				Indirect	Wife is Deputy Chief Nurse for Nottinghamshire CCG	Apr-19	Date		Note and declare
		Nottinghamshire CCG				Indirect	Mother in law is a Primary Care Commissioning Manager	Feb-20	Date		Note and declare
Chambers, Fenella	Non-Executive Director	Spouse is Director and Shareholder of Lindum Group				Indirect	Spouse	Ongoing			Note and declare
		Washingborough Family Practice			✓		Registered Patient	Ongoing			Note and declare
		Washingborough Family Practice			✓		Husband and Children and Registered Patients	Ongoing			Note and declare
		Hogan Lovells International LLP	✓				Employee	Ongoing			Note and declare
Fahy, Martin	Director of Nursing & Quality	RCN		✓		Member	Jun-20	Ongoing		Note and declare	
Felston, Graham	Non-Executive Director	Northamptonshire CCG	✓			Lay Member				Declare and note accordingly	
Fletcher, Sarah	HW Lincs CEO	HW Lincs		✓			HWLincs holds the contract for Healthwatch Lincolnshire which is the statutory independent consumer champion for health and care services in Lincolnshire	Aug-13	Date		
Gaunt, Matt	Director of Finance and Contracting	Nil	N/A	N/A	N/A						N/A

Howarth, James	Clinical Leader	Spilsby GP Practice	✓				GP Principal. Holds contract for GMS and Enhanced services	Ongoing			Remove self from any final primary care commissioning decisions at level of setting value or awarding contracts
						Indirect	My Wife is a care coordination, a service directly commissioned by the CCG	Ongoing			I always state the COI where relevant and am only involved in higher level discussions
				✓			I am joint cardiology lead for CCG and ICB. I stand to gain reputationally. But only if I do my job right	Ongoing			Declaration.
Inman, Janet	Non-Executive Director	Activity Alliance					Non-Executive Director and Chair of Finance Sub-Group	2016	2024		Note
		Volleyball England					Non-Executive Director and Company Secretary	2017	2025		Note
		Asian Sport Foundation					Non-Executive Director	2019	2027		Note
		Lincolnshire Sport Forum					Chair	2019	Present		Note
Liburd, Sue	Non-Executive Director	Heath Surgery Bracebridge Heath			✓		Registered Patient	01-Dec-09	Present		Note
		Deputy Lieutenant for Lincolnshire			✓		Deputy Lieutenant for Lincolnshire	01-May-20	Present		Note
		University of Lincoln Student Union		✓			Trustee and Board Director	01-Jan-19	Present		Declare and note.
		University of Lincoln Court		✓			Member	01-Feb-19	Present		Declare and note.
		University of Lincoln Business School	✓				Consulting Partner	01-May-19	Present		To be excluded from negotiations of any commercial transactions with UoL Business School
		Government Events Limited	✓				Advisory Board Member and Conference Chair	01-Jul-18	Present		Note
		Sage Blue Limited	✓				Managing Director	01-Dec-00	Present		Note
		NHS England		✓			Armed Forces Public Patient Voice Advisory Group - BAME Lead	01-Oct-20	Present		Declare and note
		Intern Group	✓				Non-Executive Director	01-Oct-20	Present		Declare and note
		International Welfare Business School					Non trading dormant company				Non trading dormant company
		Abstract UK and International Limited	✓				Non-Executive Director	01-Apr-21	Present		Declare and note.
Lyons, Sean (left as of 31st December 2021 - retain on register for 56 months)	Chair	West Nottinghamshire College	✓			Chair of Corporation Board	Feb-19	Present		Note	
Macdonald, Murray (Left the CCG June 2021 - retain on register for 6 months)	Non-Executive Director	Lincolnshire Housing Partnership	✓				Chief Executive	2018	Present		Exclude from any contractual activity in which Lincolnshire Housing Partnership may be interested.
		Manby Scout Association			✓		Chair	2015	Present		Note
		NELC Health & Wellbeing Board		✓			Member	2020	Present		Note and declare.
McSorley, Gerry	Non-Executive Director	Self Employed Management Consultant	✓				Self-Employed	2013	Present		Note
		CQC		✓			Specialist Advisor	2013	Present		Note. Exclude from any CQC related submission work.
		DeFerrers Academy Trust		✓			Trustee	2013	Present		Note
Mills, Sarah-Jane	Chief Operating Officer – West Locality	Nil	N/A	N/A	N/A					N/A	
Moore, Pete	Non-Executive Director	Nil	N/A	N/A	N/A					N/A	
Parkin, Dr John	Clinical Lead – West Locality	Herbal Medicine and Acupuncture Lincoln College				Indirect	Wife is Clinic Manager	2014	Ongoing		Declare and note.
		BMJ Best Practice				Indirect	Daughter is Marketing Manager	2019	Ongoing		Declare and note.
		University of Lincoln				Indirect	Daughter is Physiotherapy Student (Masters Degree) 2nd Year	2019	Ongoing		Declare and note.
Raybould, Clair	Director of Operations	Nil	Nil	Nil	Nil					Nil	
Rix, Andrew	Chief Operating Officer	Sidings Medical Practice	Nil	Nil	Nil	Indirect	Wife is employed as Lead Advanced Nurse Practitioner	Apr-20	Ongoing		Declare at meetings as required
Turner, John	Chief Executive	Nil	N/A	N/A	N/A	N/A	N/A				N/A

Ward, Professor Derek	Director of Public Health - Lincolnshire County Council	University of Lincoln		✓		Visiting Professor of Public Health	Apr-20	Ongoing			Note and declare
Williamson, Sandra	Chief Operating Officer – East Locality	Sidings Practice			✓	Registered Patient	Ongoing				Note and declare.
		Sidings Practice			✓	Family Registered Patients	Ongoing				Note and declare.
		Boston West Academy School			✓	School Governor	Sep-17	Ongoing			Note
		Meadow Edge Care Home			✓	Grandparents are Residents	Apr-19	Ongoing			Note and declare
Woolley, Sue	Health and Wellbeing Board Representative	Lincolnshire County Council			✓	Executive Member	Ongoing				Note and declare.

**REGISTER OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**QUALITY AND PATIENT EXPERIENCE COMMITTEE**

Name	Current position(s) held in the CCG i.e. Board member, Committee member, Member Practice, CCG employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To		
Akram, Majid	Clinical Lead	Deepings Practice	✓				Partner	Ongoing			Declare as appropriate and exclude from any primary care decision making.
		GP Simulation Training Company	✓				Director	Ongoing			Declare. Exclude from any commissioning discussions/decisions relating to GP Simulation Training Company.
		Deepmedicine IT Company	✓				Director	Ongoing			Declare. Exclude from any commissioning discussions/decisions relating to Deepmedicine IT Company.
Baker, David	Clinical Lead, South West Locality	LMC		✓			Member	Ongoing			Declare and note.
		K2 Federation	✓				Member	Ongoing			Declare. Exclude from any commissioning
		Nil	✓				Doctor	Ongoing			Note and declare as appropriate.
		Vine House Practice	✓				GP Partner	Ongoing			Declare and note.
Bates, Sarah	Deputy Board Secretary	West Lindsey District Council	✓				Election Officer	Present			Note, no mitigation necessary
		The Glebe Practice, Saxilby			✓		Registered Patient	Present			Note and declare.
Boldy, David	Secondary Care Doctor	United Lincolnshire Hospitals NHS Trust				Indirect	Wife works for ULHT	Apr-20	Ongoing		Note and declare, exclude where appropriate.
		Lincoln Medical School				Indirect	Wife is Director of Clinical Skills	Apr-20	Ongoing		Note and declare, exclude where appropriate.
		East Lindsey Medical Practice, 153 Newmarket, Louth, LN11 9EH				Indirect	Patient	Ongoing			Declare as appropriate
Chambers, Fenella	Non-Executive Director	Spouse is Director and Shareholder of Lindum Group				Indirect	Spouse	Ongoing			Note and declare
		Washingborough Family Practice			✓		Registered Patient	Ongoing			Note and declare
		Washingborough Family Practice			✓		Husband and Children and Registered Patients	Ongoing			Note and declare
		Hogan Lovells International LLP	✓				Employee	Ongoing			Note and declare
Clarke, Nicola	HW Lincs Rep	Awaiting detail									
Fahy, Martin	Director of Nursing & Quality	RCN		✓		Member	Jun-20	Ongoing		Note and declare	
Howarth, James	Clinical Leader	Spilsby GP Practice	✓				GP Principal. Holds contract for GMS and Enhanced services	Ongoing			Remove self from any final primary care commissioning decisions at level of setting value or awarding contracts
						Indirect	My Wife is a care coordination, a service directly commissioned by the CCG	Ongoing			I always state the COI where relevant and am only involved in higher level discussions
				✓			I am joint cardiology lead for CCG and ICB. I stand to gain reputationally. But only if I do my job right	Ongoing			Declaration.
Inman, Janet	Non-Executive Director	Activity Alliance					Non-Executive Director and Chair of Finance Sub-Group	2016	2024		Note
		Volleyball England					Non-Executive Director and Company Secretary	2017	2025		Note
		Asian Sport Foundation					Non-Executive Director	2019	2027		Note
		Lincolnshire Sport Forum					Chair	2019	Present		Note

Martin, Wendy	Associate Director of Nursing	Maternal and Childhealth Care Advocacy International	✓				Trustee - international medical charity that works with in-country medical/healthcare teams in poor countries to improve emergency care provision (for women and children particularly).	2010	Ongoing			Conflict unlikely with CCG activity, but if any potential conflict this will be declared to the meeting/forum Chair for advice on management.
McSorley, Gerry	Non-Executive Director	Self Employed Management Consultant	✓				Self-Employed	2013	Present			Note
		CQC		✓			Specialist Advisor	2013	Present			Note. Exclude from any CQC related submission work.
		DeFerrers Academy Trust		✓			Trustee	2013	Present			Note
Mills, Sarah-Jane	Chief Operating Officer – West Locality	Nil	N/A	N/A	N/A						N/A	
Neno, Rebecca	Deputy Chief Nurse	Allied Health South Lincolnshire				Indirect	Husband employed as Practice Care Coordinator currently based at	Sep-19	Date			Declare and note. Not to be involved in commissioning
		Littlebury Medical Centre, Holbeach			✓		Registered Patient	Ongoing				Note
		North West Anglia Foundation Trust		✓			Partner/Governor	Apr-19	Present			Declare and note. Exclude from any contractual relationship with NWaFT.
Palmer, Pam (left in 2021)	Associate Director of Nursing	Nil	N/A	N/A	N/A						N/A	
Parkin, Dr John	Clinical Lead – West Locality	Herbal Medicine and Acupuncture Lincoln College				Indirect	Wife is Clinic Manager	2014	Ongoing			Declare and note.
		BMJ Best Practice				Indirect	Daughter is Marketing Manager	2019	Ongoing			Declare and note.
		University of Lincoln				Indirect	Daughter is Physiotherapy Student (Masters Degree) 2nd Year	2019	Ongoing			Declare and note.
Rix, Andrew	Chief Operating Officer	Sidings Medical Practice	Nil	Nil	Nil	Indirect	Wife is employed as Lead Advanced Nurse Practitioner	Apr-20	Ongoing			Declare at meetings as required
Vine, Terry	Deputy Chief Nurse (West Locality)	Marie Curie					Spouse is employed by Marie Curie Cancer Care Rapid Response Service which is commissioned by Lincolnshire CCG.	Ongoing				Declare and note accordingly. Not to be involved in decisions or procurement processes relating to Marie Curie.
		Mainstream Political Party					Member	Ongoing				Declare and note. Consider resignation if compromises CCG role.
Williamson, Sandra	Chief Operating Officer – East Locality	Sidings Practice			✓		Registered Patient	Ongoing				Note and declare.
		Sidings Practice			✓		Family Registered Patients	Ongoing				Note and declare.
		Boston West Academy School			✓		School Governor	Sep-17	Ongoing			Note
		Meadow Edge Care Home			✓		Grandparents are Residents	Apr-19	Ongoing			Note and declare

**REGISTER OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**AUDIT AND RISK COMMITTEE**

Name	Current position(s) held in the CCG i.e. Board member, Committee member, Member Practice, CCG employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		No Change Reported & Date	Action taken to mitigate risk	
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To			
Breadon, Alison	Head of Internal Audit - PwC	Nil	N/A	N/A	N/A						N/A	
Carbonell, Lenka Marvan	Local Counter Fraud Specialist - PwC	Nil	N/A	N/A	N/A						N/A	
Chambers, Fenella	Non-Executive Director	Spouse is Director and Shareholder of Lindum Group				Indirect	Spouse	Ongoing			Note and declare	
		Nil										
		Nil										
		Washingborough Family Practice			✓		Registered Patient	Ongoing			Note and declare	
		Washingborough Family Practice			✓		Husband and Children and Registered Patients	Ongoing			Note and declare	
		Nil	✓			Employee	Ongoing			Note and declare		
Felston, Graham	Non-Executive Director	Northamptonshire CCG	✓			Lay Member					Declare and note accordingly	
Gaunt, Matt	Director of Finance and Contracting	Nil	N/A	N/A	N/A						N/A	
Hann, Tom	Internal Audit Manager, PwC	Nil	N/A	N/A	N/A						N/A	
Sue Liburd	Non-Executive Director	Heath Surgery Bracebridge Heath			✓		Registered Patient	01-Dec-09	Present			Note
		Deputy Lieutenant for Lincolnshire			✓		Deputy Lieutenant for Lincolnshire	01-May-20	Present			Note
		University of Lincoln Student Union		✓			Trustee and Board Director	01-Jan-19	Present			Declare and note.
		University of Lincoln Court		✓			Member	01-Feb-19	Present			Declare and note.
		University of Lincoln Business School	✓				Consulting Partner	01-May-19	Present			To be excluded from negotiations of any
		Government Events Limited	✓				Advisory Board Member and Conference Chair	01-Jul-18	Present			Note
		Sage Blue Limited	✓				Managing Director	01-Dec-00	Present			Note
		NHS England		✓			Armed Forces Public Patient Voice Advisory Group -	01-Oct-20	Present			Declare and note
		Intern Group	✓				Non-Executive Director	01-Oct-20	Present			Declare and note
		International Welfare Business School					Non trading dormant company					Non trading dormant company
Abstrac UK & International Limited	✓				Non-Executive Director	01-Apr-21	Present			Declare and note		
Moore, Pete	Non-Executive Director	Nil	N/A	N/A	N/A						N/A	

**REGISTER OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**PRIMARY CARE COMMISSIONING COMMITTEE**

Name	Current position(s) held in the CCG i.e. Board member, Committee member, Member Practice, CCG employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To		
Audis, Adrian	Locality Development Manager	NHS Lincolnshire CCG				Indirect	Wife employed by CCG	Present			Declare and note.
Baker, Reid	LMC Representative Observer	Awaiting form to be returned									
Bates, Sarah	Deputy Board Secretary	West Lindsey District Council	✓				Election Officer	Present			Note, no mitigation necessary
		The Glebe Practice, Saxilby			✓		Registered Patient	Present			Note and declare.
Boldy, David	Secondary Care Doctor	United Lincolnshire Hospitals NHS Trust				Indirect	Wife works for ULHT	Apr-20	Ongoing		Note and declare, exclude where appropriate.
		Lincoln Medical School				Indirect	Wife is Director of Clinical Skills	Apr-20	Ongoing		Note and declare, exclude where appropriate.
		East Lindsey Medical Practice, 153 Newmarket.				Indirect	Patient	Ongoing			Declare as appropriate
Fahy, Martin	Director of Nursing & Quality	RCN		✓		Member	Jun-20	Ongoing		Note and declare	
Felston, Graham	Non-Executive Director	Northamptonshire CCG	✓				Lay Member				Declare and note accordingly
Liburd, Sue	Non-Executive Director	Heath Surgery Bracebridge Heath			✓		Registered Patient	01-Dec-09	Present		Note
		Deputy Lieutenant for Lincolnshire			✓		Deputy Lieutenant for Lincolnshire	01-May-20	Present		Note
		University of Lincoln Student Union		✓			Trustee and Board Director	01-Jan-19	Present		Declare and note.
		University of Lincoln Court		✓			Member	01-Feb-19	Present		Declare and note.
		University of Lincoln Business School	✓				Consulting Partner	01-May-19	Present		To be excluded from negotiations of any commercial transactions with UoL Business School
		Government Events Limited	✓				Advisory Board Member and Conference Chair	01-Jul-18	Present		Note
		Sage Blue Limited	✓				Managing Director	01-Dec-00	Present		Note
		NHS England		✓			Armed Forces Public Patient Voice Advisory Group - BAME Lead	01-Oct-20	Present		Declare and note
		Intern Group	✓				Non-Executive Director	01-Oct-20	Present		Declare and note
		International Welfare Business School					Non trading dormant company				Non trading dormant company
Martin, Wendy	Associate Director of Nursing	Maternal and Childhealth Care Advocacy International	✓				Trustee - international medical charity that works with in-country	2010	Ongoing		Conflict unlikely with CCG activity, but if any potential
		Self Employed Management Consultant	✓				Self-Employed	2013	Present		Note
McSorley, Gerry	Non-Executive Director	CQC		✓			Specialist Advisor	2013	Present		Note. Exclude from any CQC related submission work.
		DeFerrers Academy Trust		✓			Trustee	2013	Present		Note
Mills, Sarah-Jane	Chief Operating Officer – West Locality	Nil	N/A	N/A	N/A						N/A
Moore, Pete	Non-Executive Director	Nil	N/A	N/A	N/A						N/A
Parkin, Dr John	Clinical Lead – West Locality	Herbal Medicine and Acupuncture Lincoln College				Indirect	Wife is Clinic Manager	2014	Ongoing		Declare and note.
		BMJ Best Practice				Indirect	Daughter is Marketing Manager	2019	Ongoing		Declare and note.
		University of Lincoln				Indirect	Daughter is Physiotherapy Student (Masters Degree) 2nd Year	2019	Ongoing		Declare and note.
Pilton, Kate	LMC Representative	LMC	✓			Director	2016	Date		Declare and note accordingly	

Sharrok, Dr Kieron (left LMC in April 2022 - remain on Register for a period of 6 months)	LMC Representative/Observer	Spilsby Practice	✓			Employed as GP in Lincolnshire	Jul-20	Ongoing		As observer will not comment if discussions directly affect employment status. Not to be involved in any decision making that may compromise position.
		Lincolnshire Local Medical Committee		✓		Medical Director	Jul-20	Ongoing		Declare and note accordingly
		BMA		✓		BMA Representative	Jul-20	Ongoing		Declare and note accordingly
		Wife works in general practice			Indirect	Wife works in general practice	Ongoing			Declare and note accordingly. Not to be involved in decisions regarding wife's Practice.
Williamson, Sandra	Chief Operating Officer – East Locality	Sidings Practice			✓	Registered Patient	Ongoing			Note and declare.
		Sidings Practice			✓	Family Registered Patients	Ongoing			Note and declare.
		Boston West Academy School			✓	School Governor	Sep-17	Ongoing		Note
		Meadow Edge Care Home			✓	Grandparents are Residents	Apr-19	Ongoing		Note and declare
Woolley, Sue	Health and Wellbeing Board Representative	Lincolnshire County Council			✓	Executive Member	Ongoing			Note and declare.

**REGISTER OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**REMUNERATION COMMITTEE**

Name	Current position(s) held in the CCG i.e. Board member, Committee member, Member Practice, CCG employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		No Change Reported & Date	Action taken to mitigate risk	
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To			
Chambers, Fenella (Chair)	Non-Executive Director	Spouse is Director and Shareholder of Lindum Group				Indirect	Spouse	Ongoing			Note and declare	
		Washingborough Family Practice			✓		Registered Patient	Ongoing			Note and declare	
		Washingborough Family Practice			✓		Husband and Children and Registered Patients	Ongoing			Note and declare	
		Nil										
		Nil										
		Hogan Lovells International LLP	✓					Employee	Ongoing			Note and declare
Felston, Graham	Non-Executive Director	Northamptonshire CCG	✓				Lay Member				Declare and note accordingly	
Inam, Janet	Non-Executive Director	Activity Alliance					Non-Executive Director and Chair of Finance Sub-Group	2016	2024		Note	
		Volleyball England					Non-Executive Director and Company Secretary	2017	2025		Note	
		Asian Sport Foundation					Non-Executive Director	2019	2027		Note	
		Lincolnshire Sport Forum					Chair	2019	Present		Note	
Liburd, Sue	Non-Executive Director	Heath Surgery Bracebridge Heath			✓		Registered Patient	01-Dec-09	Present		Note	
		Deputy Lieutenant for Lincolnshire			✓		Deputy Lieutenant for Lincolnshire	01-May-20	Present		Note	
		University of Lincoln Student Union		✓			Trustee and Board Director	01-Jan-19	Present		Declare and note.	
		University of Lincoln Court		✓			Member	01-Feb-19	Present		Declare and note.	
		University of Lincoln Business School	✓				Consulting Partner	01-May-19	Present		To be excluded from negotiations of any commercial transactions with UoL Business School	
		Government Events Limited	✓				Advisory Board Member and Conference Chair	01-Jul-18	Present		Note	
		Sage Blue Limited	✓				Managing Director	01-Dec-00	Present		Note	
		NHS England		✓			Armed Forces Public Patient Voice Advisory Group - BAME Lead	01-Oct-20	Present		Declare and note	
		Intern Group	✓				Non-Executive Director	01-Oct-20	Present		Declare and note	
		International Welfare Business School					Non trading dormant company				Non trading dormant company	
McSorley, Gerry	Non-Executive Director	Abstract UK Limited	✓				Non-Executive Director	01-Apr-21	Present		Declare and note	
		Self Employed Management Consultant	✓				Self-Employed	2013	Present		Note	
		CQC		✓			Specialist Advisor	2013	Present		Note. Exclude from any CQC related submission work.	
Moore, Pete	Non-Executive Director	DeFerrers Academy Trust		✓			Trustee	2013	Present		Note	
		Nil	N/A	N/A	N/A						N/A	

**REGISTER OF THE NHS LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**FINANCE AND PERFORMANCE COMMITTEE**

Name	Current position(s) held in the CCG i.e. Board member, Committee member, Member Practice, CCG employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To		
Felston, Graham	Non-Executive Director	Northamptonshire CCG	✓				Lay Member				Declare and note accordingly
Gaunt, Matt	Director of Finance and Contracting	Nil	N/A	N/A	N/A						N/A
Inman, Janet	Non-Executive Director	Activity Alliance					Non-Executive Director and Chair of Finance Sub-Group	2016	2024		Note
		Volleyball England					Non-Executive Director and Company Secretary	2017	2025		Note
		Asian Sport Foundation					Non-Executive Director	2019	2027		Note
		Lincolnshire Sport Forum					Chair	2019	Present		Note
Pilkington, Paula	Assistant Director Finance (Business Development)	Nil	N/A	N/A	N/A						N/A



## BOARD MEETING – PUBLIC

<b>Date</b>	29 <sup>th</sup> June 2022	<b>Agenda item:</b>	11.
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<b>Title of Report:</b>	Quality & Patient Experience Committee Update
<b>Report Author and Title:</b>	Mrs F Chambers – Chair - Non-Executive Director Mr M Fahy – Director of Nursing and Quality Ms S Bates – Deputy Board Secretary
<b>Appendices:</b>	QPEC Committee Handover

<b>1.</b>	<b>Purpose of the Report (including link to objectives)</b>
<p>This paper provides an update on the discussions that took place at the QPEC (Quality and Patient Experience Committee) meeting on Tuesday 7<sup>th</sup> June 2022.</p>	

<b>2.</b>	<b>Recommendations</b>
<p>The Board is asked to note the update and recommendations from the meeting.</p>	

<b>3.</b>	<b>Executive Summary</b>
<p>The QPEC meeting on 7<sup>th</sup> June 2022 focused on a number of areas including updates on the following:-</p> <ul style="list-style-type: none"> <li>• <b>HealthWatch Update:</b> no update available.</li> <li>• <b>Integrated Quality Update:</b> an update was provided on the key areas including:- <ul style="list-style-type: none"> <li>➤ <b>Urgent &amp; Emergency Care</b> – it was noted that there continues to be significant pressures however there has been a reduction in the numbers of patients waiting 12 hours in A&amp;E. It was noted that EMAS (East Midlands Ambulance Service NHS Trust) are continuing to experience pressures which impact risk in the community, ambulance handover delays are contributing to this. At the Lincoln site 2-hour handover delays have increased, however they have reduced at Pilgrim site. It was noted that from a system perspective there is a system plan to share the clinical risk across the community, with the intention of &gt;60min handover delays.</li> <li>➤ <b>Cancer</b> – in terms of performance for the 62 and 104-day cancer standards this has improved. It was noted that there is an increase in the number of patients receiving treatment in the 62-day standard however colorectal remains an area of concern and work is ongoing with the East Midlands Cancer Alliance. There is recruitment of a number of Cancer Improvement Managers to each of the divisions to support implementation of the 28 faster diagnosis standard in a number of tumour sites and additional capacity is being put in place.</li> <li>➤ <b>Elective Care</b> – it was noted that there are currently 102,553 patients waiting for treatment which is above plan, however plans are on track to eliminate any 104 week waits by the end of June. In addition, it was noted that further capacity in the independent providers continues to be sourced for some specialties and is being explored for other specialties where there are concerns over recovery timescales and also mutual aid between neighbouring systems is also being explored.</li> </ul> </li> </ul>	

- **Mental Health** – it was noted that performance of early intervention in psychosis (EIP) waiting times fell in April to a low of 9% seen within 2 weeks, much lower than the 60% initial assessment. Work is taking place to proactively manage the drop in performance with recruitment ongoing and work taking place on re-modelling to fully utilize the staff skill mix and address the backlog. It is hoped that by the end of July 2022 performance should be back to 65%.
- **Never Events** – it was noted that there has been two never events at ULHT (United Lincolnshire Hospitals NHS Trust).
- **Ockendon Review** – it was noted that a system action plan to act upon the Ockendon recommendations has been written, with internal Trust assurance through ULHT Maternal & Neonatal Oversight Meeting which reports through ULHT Quality Committee to Board and also through to the LMNS (Lincolnshire Maternity Neonatal Services).
- **Children and Young People** – an update was provided on the context and challenges. It was noted that in terms of the Eating Disorders Service there has been a marked increase in demand which is impacting routine referrals within 4 weeks. It was noted that investment discussions have taken place and support is being made available which will deliver improvements over the coming year, however these will take time to demonstrate impact due to factors such as needing to recruit staff to the service.
- **Harm Reviews** – it was noted that for the period April 2020 – 2022 there had been a total of 24 harms rated as moderate or above of which 20 rated as moderate, two severe and two deaths. The two severe and two deaths related to the urgent care pathway. In addition, those reviews that are identified through the Clinical Harm Review process are triangulated against any incidents that are identified through normal incident reporting mechanisms. It was noted that a further nine severe harm incidents and one death was identified through this process.
- **Mortality and SHMI rates** – for NWaFT (North West Anglia Foundation Trust), in particular the Peterborough site, remains a concern. It was noted that a recent quality assurance meeting took place and that further assurance had been requested.
- **Serious Incidents** – it was noted that there has been a total of 42 serious incidents reported between 6 April 2022 – 10 May 2022, this represents an increase when compared to the previous two months where the level of serious incidents reported was recorded as (n=26) and (n=29) respectively. It is noted that this increase in reporting of serious incidents related particularly to LPFT and ULHT.
- **Lakeside Practice** – it was noted that the CQC published the inspection report on 1st June 2022 with an overall rating of “Requires Improvement” and “Inadequate” for the safety domain. The CCG continues to support the Practice.
- **Combined Quality Risks:** an update was provided in relation to the Corporate Risk Register of which there are 27 risks currently recorded for the CCG of which 11 are assigned to QPEC. It was noted that there are two risks rated as 16 which relate to the non-delivery of cancer performance standards and the delivery of safe and effective services in ED, which has recently been reduced from 20 to 16. As the CCG transitions into the ICB the Risk Register will be archived appropriately, and a system wide Risk Register created.
- **COVID Vaccination Update:** an update was provided on the number of vaccinations undertaken within Lincolnshire and that to date the headline position is that 1,769,538 vaccines have been delivered in Lincolnshire with approximately 624,643 firsts, 593,466 seconds, 489,488 booster doses and 61,941 Spring Boosters.

It was noted that on the 3<sup>rd</sup> May 2022 the Lincolnshire Showground Vaccination Centre closed, and the CCG moved the vaccination offer to walk-in pop-up services advertised through media, social media and the CCGs website to ensure the population of Lincoln and the surrounding area are able to access Spring boosters. In addition, on 17<sup>th</sup> May 2022 the CCG launched a Vaccination Bus to supplement the mobile offer to enhance convenience for the local population. Discussions took place regarding the current performance and the anticipated performance at the end of June 2022 and that there had been some issues with the availability of the vaccine. A lengthy debate took place regarding the offer and uptake to Care Homes and the systems in place to monitor and support Care Homes with a centralised coordinated approach supported by a local delivery model. An update was provided on the future model arrangements for the Autumn campaign and the work taking place with PCN's and Community Pharmacies.

- **ICS Quality Committee Update:** it was noted that the next meeting is due to take place on 14<sup>th</sup> June 2022. The Committee will be discussing and reviewing the revised Terms of Reference for the Committee.
- **Safeguarding by Exception Update:** an update was provided on the Birmingham/Solihull Joint Targeted Area Inspection and that a benchmarking exercise was undertaken in Lincolnshire. It was noted that areas for improvement had been highlighted particularly in relation to information sharing and ensuring that arrangements are in place for the strategic meetings in out of hours. A lengthy discussion took place regarding the challenges with information sharing across organisations and that IT systems are not compatible.

An update was also provided in relation to the recent Independent Review of Children's Social Care which highlighted a number of recommendations. Discussions took place regarding the recommendation "schools should be made a statutory safeguarding partner and contribute to the strategic and operational delivery of multi-agency working" and that this is a positive step. Lastly, an excellent example was shared of a GP Practice and a patient who was subject to coercion and control and that through the safeguarding training an appropriate referral was made, which is one example of demonstrating the processes are embedded within primary care.

- **Liberty Protection Safeguards:** it was noted that the Liberty Protection Safeguards will replace the current DoLS (Deprivation of Liberty Safeguards) and Court of Protection (CoP) processes. For the CCG/ICB this will expand current responsibilities to include all patients that are fully funded through CHC in the community and going forward in care homes, for authorisation.
- **Policies:** the following Policies were ratified by the Committee: Safeguarding Adults Policy, Quality Impact Assessment Policy, Complaints Policy and Non-Medical Prescribing Policy. The Safeguarding Supervision Policy was discussed, and it was noted that this requires some further amendments. It was agreed that this would be circulated to members for ratification.
- **Board Committee Handover Template:** it was noted that this will be populated and shared with members for comment prior to presentation at the June 2022 Board meeting (attached at Appendix One).

The Committee agreed to escalate the following risks/concerns to the Board:

- SHMI and HSMR rates at NWaFT.
- Never Events.

Areas of recognition that the Committee wished to share with the Board include:

- Covid-19 programme and the transition to the ICB recognising the complexity of the programme and the work that has taken place to achieve the current performance.
- Infection, Prevention and Control measures and the reduction in the number of cases now reported for MRSA and C-Difficile, recognising the significant amount of work that has been undertaken to support this area.

Mrs Chambers wished to thank the Committee for their support and contribution. Dr McSorley also thanked Mrs Chambers for assuming the role of Chair of the Committee.

**4. Management of Conflicts of Interest**

N/A

**5. Finance, QIPP and Resource Implications**

N/A

**6. Legal/NHS Constitution Considerations**

Nil specific to note. Through the Covid 19 response the aim has been to maintain constitutional standards where appropriate to do so, however in several areas e.g., referral to treatment times these were relaxed to ensure organisations could create the additional bed and critical care capacity to cope with the expected surge in patient numbers due to the adverse health effects of the virus.

**7. Analysis of Risk including Assessments**

Please state if the risk is on the CCG Risk Register.

Yes	<input type="checkbox"/>	No	X
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**8. Outline engagement – clinical, stakeholder and public/patient**

As detailed in the Executive Summary.

**9. Outcome of Impact Assessments**

Not applicable to this paper.

**10. Assurance Departments/Organisations who will be affected have been consulted**

Insert details of the departments you have worked with or consulted during the process:

Finance	
Commissioning	✓
Contracting	✓
Medicines Optimisation	✓
Clinical Leads	✓
Quality	✓
Safeguarding	✓
Other	

**11. Report previously presented at:**

N/A

**12. For further information or for any enquiries relating to this report, please contact**

Martin Fahy – Director of Nursing and Quality – [m.fahy@nhs.net](mailto:m.fahy@nhs.net) ☎ 07880157221

## **BOARD COMMITTEE HANDOVER TEMPLATE**

**Committee: QPEC**

**Name of the Committee Chair: Fenella Chambers**

**Date: 7<sup>th</sup> June 2022**

**Author: Martin Fahy, Director of Nursing & Quality**

### **Summary of Key issues/areas of focus in 2021/22:**

- **Urgent & Emergency Care**
- **Cancer**
- **Elective Care**
- **Maternity - Ockendon Review; Nottingham University Hospitals Maternity Services**
- **Never Events and Serious Incidents**
- **Mortality**
- **Infection, Prevention and Control**
- **Primary Care**
- **Covid Vaccination**
- **Safeguarding**
- **Patient Feedback – Healthwatch; Complaints**
- **HealthLinc House**
- **CHC – Personal Health Budgets;**

## Position of these key issues/areas of focus as of 30<sup>th</sup> June 2022:

- **Urgent & Emergency Care** - continues to be significant pressures; EMAS continue to experience pressures which impact risk in the community and ambulance handover delays are continuing to contribute to this. 'Failure to deliver safe and effective services in the Emergency departments' (previously referenced Acute 4) is on the Corporate Risk Register (LCCG1.04) and current risk rating is 16.
- **Cancer** - 62 and 104-day cancer standards have improved and there is an increase in the number of patients receiving treatment in the 62-day standard, however colorectal remains an area of concern. 'Non-delivery of performance and quality standards for Cancer' (previously referenced Acute 2) is on the Corporate Risk Register (LCCG1.02) and current risk rating is 16.
- **Elective Care** - 102,553 patients waiting for treatment which is above plan, however plans are on track to eliminate any 104 week waits by the end of June 2022.
- **Maternity - Ockenden Review; Nottingham University Hospitals Maternity Services** - a system action plan to act upon the Ockenden recommendations has been written, with internal Trust assurance through ULHT Maternal & Neonatal Oversight Meeting which reports through ULHT Quality Committee to Board and also through to the LMNS (Lincolnshire Maternity Neonatal Services). An NHSEI led site visit taking place 22/23 June 2022 to visit to test compliance with the immediate and essential improvement actions (IEA) which the LMNS will participate in. There are approximately 780 Lincolnshire women who are cared for in the Nottingham maternity system every year, it has now been confirmed Donna Ockenden has been appointed as Chair of the new independent review into maternity services at Nottingham University Hospitals NHS Trust and the CCG Nursing & Quality team are continuing to liaise to ensure the CCG is sighted on any Lincolnshire women or babies impacted by the issues highlighted through this review process.
- **Never Events and Serious Incidents** – there have been 2 Never Events reported since April 2022, both from ULHT (United Lincolnshire Hospitals NHS Trust), one in April and one in May, both were no/low harm incidents and investigation is currently taking place. There was a total of 42 serious incidents reported between 6 April 2022 – 10 May 2022, this represents an increase when compared to the previous two months where the level of serious incidents reported was recorded as (n=26) and (n=29) respectively and the increase in reporting of serious incidents related particularly to LPFT (Lincolnshire Partnership NHS Foundation Trust) and ULHT.
- **Mortality** - NWaFT (North West Anglia Foundation Trust), in particular the Peterborough site, remains a concern. A quality assurance meeting took place end of May 2022, further assurance had been requested and concern escalated to Cambridge and Peterborough CCG as lead commissioners. Work continues to establish a Medical Examiner office for Primary Care in Lincolnshire to review all non-coronial deaths at pace, however, there was some slippage in timeframe for the pilot. The LeDeR (Learning Disability Mortality Reviews) Annual Report was presented to the July 2021 QPEC which highlighted that key themes relate to the Mental Capacity Act and the application of it and when people lack capacity.

- **Infection, Prevention and Control** – have achieved reduction in the number of cases now reported for MRSA and C-Difficile and recognition of the significant amount of work that has been undertaken to support this area.
- **Primary Care** – Lakeside; Marisco; Spalding and Branston Practices have all been rated as “Requires Improvement” by the CQC and the CCG is continuing to support these Practices
- **Covid Vaccination** – 7<sup>th</sup> June 2022 QPEC meeting update identified 1,769,538 vaccines have been delivered in Lincolnshire with approximately 624,643 firsts, 593,466 seconds, 489,488 booster doses and 61,941 Spring Boosters.
- **Safeguarding** – Lincolnshire has undertaken a benchmarking exercise in relation to the Birmingham/Solihull Joint Targeted Area Inspection which has highlighted areas for improvement, particularly in relation to sharing of health information and securing appropriate health representation at strategic meetings. Actions are being taken forward to address this and the LSCP (Lincolnshire Safeguarding Childrens Partnership) has agreed to include in the LSCP risk register.
- **Patient Feedback – Healthwatch; Complaints** – last update to QPEC from Healthwatch was March 2022 where it was noted that HealthWatch Lincolnshire are undertaking a patient experience survey commencing from April 2022 on clear, understandable information that is important to help make the right health and care decisions; and a report was in the process of being compiled that details hospital discharges including the trolley waits, delayed transfers of care, capacity constraints and the demand for domiciliary services. The last update from Complaints was presented at the March 2022 meeting, for the six-month period (Quarter 1 and Quarter 2) from 1 April 2021 to 30 September 2021; the Annual Complaints Report for 2020/21 was submitted to QPEC in August 2021
- **HealthLinc House** – had received an inadequate CQC inspection rating in April 2021 but is now closed, work is taking place to consider the learning.
- **CHC – Personal Health Budgets(PHBs); Liberty Protection Safeguards (LPS)** - for 2021/22 the CCG achieved the 2021/2022 year end NHSE target for the number of PHBs in place and it is anticipated the further 500 target set for 2022/2023 to be achievable. LPS when implemented will replace the current DoLS (Deprivation of Liberty Safeguards) and Court of Protection (CoP) processes, for the CCG/ICB this will expand current responsibilities to include all patients that are fully funded through CHC in the community and going forward in care homes, for authorisation.

**Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of:**

- **Risk Register** – the discussion at June 2022 Lincolnshire Quality Committee highlighted the need for system risk register to be developed but the Board sub-committee decision making needs to be within the context of agreed ICB risk appetite and related risk management processes
- **Policies** – were ratified by QPEC following recommendation from Clinical Policy Sub-Group or CHC Programme Board. Discussion at the June 2022 Lincolnshire Quality Committee

highlighted there is further work that needs to take place before the Quality Committee membership would feel comfortable in ratifying ICB specific policies.

## BOARD MEETING – PUBLIC

<b>Date of Meeting:</b>	29 June 2022	Agenda item:	12.
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<b>Title of Report:</b>	Audit & Risk Committee Update
<b>Report Author and Title:</b>	Mr G Felston – Interim Chair of the Audit and Risk Committee (Non-Executive Director) Mr M Gaunt – Director of Finance & Contracting
<b>Appendices:</b>	Committee Handover, including supporting appendices

### 1. Purpose of the Report (including link to objectives)

This paper provides an update on the discussions that took place at the Extra-Ordinary Audit & Risk Committee held on Wednesday, 15 June 2022.

### 2. Recommendations

The Board is asked to note the update and progress.

There are no issues from the meeting that the Committee need to escalate to the Board.

### 3. Executive Summary

The Extra-Ordinary Audit & Risk Committee meeting held on 15 June 2022 focused on the following:

- Annual Report and Annual Accounts for 2021/22.
- Audit and Risk Committee Annual Report 2021/22
- Committee Handover to the ICB.

#### ***Annual Report and Annual Accounts for 2021/22***

The External Auditors provided the Committee with an update on the drafts with the submission date for the Statement of Audit being 20.06.22. The Auditors highlighted the following:

1. Following consideration of reporting requirements relating to the regularity of CCG expenditure, we expect our audit report will include a qualified regularity opinion due to the issuance of a Section 30 referral. More detail is included in Section 6.
2. Emphasis of Matter – Transition to an Integrated Care Board.
3. Following changes to the nature of approvals for severance and exit payments, consider clarifying measures around formal notice of redundancy and the role of Remuneration Committee.
4. The Annual Report is concluded subject to final proof reading and minor amendments.

The Committee was in agreement with the approach to be taken in terms of any additional amendments being agreed via email and all necessary authorities in place for sign off by the Board and Chair and Chief Executive.

***Audit and Risk Committee Annual Report 2021/22***

The Committee approved the draft Report for submission to the Board subject to some minor amendments.

***Committee Handover to the ICB***

The Committee received a comprehensive report at the meeting which took place on 18.05.22. The main areas to hand over to the new ICB Audit Committee are:

- Closing position from External Audit
- Transition to ICB
- Reflecting on Annual Report of the Committee
- Outstanding Internal Audit Actions

The Committee Handover template is attached along with supporting enclosures:

- Audit and Risk Committee Annual Report 2021/22 (including Self-Assessment).
- CCG Risk Register as at 30<sup>th</sup> June to handover to the ICB.

**4. Management of Conflicts of Interest**

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

**5. Finance, QIPP and Resource Implications**

Detailed in individual reports, if applicable.

**6. Legal/NHS Constitution Considerations**

Nil specific to note.

**7. Analysis of Risk including Assessments**

This section should identify known or potential risks and how these are being mitigated, including conflicts of interest.

Please state if the risk is on the CCG Risk Register.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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**8. Outline engagement – clinical, stakeholder and public/patient**

Not Applicable.

**9. Outcome of Impact Assessments**

Not Applicable.

**10. Assurance Departments/Organisations who will be affected have been consulted**

Insert details of the departments you have worked with or consulted during the process:

Finance	✓
Commissioning	✓
Contracting	✓
Medicines Optimisation	
Clinical Leads	
Quality	✓
Safeguarding	
Other	

**11. Report previously presented at:**

Regular updates provided to the Board.

**12. For further information or for any enquiries relating to this report, please contact**

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

## BOARD COMMITTEE

### HANDOVER TEMPLATE

<b>Committee:</b> <b>Audit and Risk Committee</b>	<b>Name of the Committee Chair:</b> <b>Peter Moore/Graham Felston</b>
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<b>Date:</b> <b>20 June 2022</b>	<b>Author:</b> <b>Matt Gaunt/Bill Gregory</b>
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#### Summary of Key issues/areas of focus in 2021/22:

- Internal Audit 21/22 Progress Report and audit findings and improvement recommendations (at each meeting apart from the extraordinary one in June 2021)
  - Internal Audit Reports – ‘Deep Dive’ on Mental Health, Learning Disability & ASD Team, Health Protection Report, Data Security & Protection Toolkit (DSPT) Report, Audit Follow Up Review 2020/21, STP/ICS Review 2020/21, Primary Care Commissioning – Part 2 2020/21, Conflicts of Interest Review, Urgent & Emergency Care, Safeguarding, Finance, Primary Care and Complaints
- Counter Fraud Progress Report (at each meeting apart from the extraordinary one in June 2021)
- Preparation and oversight of statutory reporting and legal compliance: Annual Governance Statement 2021/22, ISA 260 Final Report 2021/22 and Draft ISA 260 2021/22 Letter of Representation 2021/22, Information Governance Toolkit 2021/22.
- Governance Report (presented on a monthly basis and provides an update on the Hospitality and Sponsorship Registers, Losses and Compensations, Single Price Quotations (Waivers) and the Declaration of Interest Registers.
- CCG Transition Plan & Due Diligence Checklist and ICB Readiness to Operate Statement and the Lincolnshire ICB – Transition Programme Reporting, Assurance and Oversight.
- Update on the Board Assurance Framework and CCG Risk Management Arrangements
- Mental Health Investment Standard Compliance Statements
- Information Governance Updates and action plans
- Approval of policies:
  - Counter Fraud & Corruption Policy
- The Transition Programme Board was formalised in December 2021, Chaired by SRO for transition (Matt Gaunt) with senior representation for each workstream (Finance, HR, Governance, Quality, IT & IG). The Programme Board has met monthly and regularly reported progress to the Audit and Risk Committee.

- The System Strategy and Planning Director (Pete Burnett) and ICS Strategy Director (Tom Diamond) have been members of the Programme Board to ensure alignment with the process for developing the Readiness to Operate.
- Each workstream lead developed and has been implementing a transition plan for their areas of responsibility. The Programme Board has monitored overall progress and dealt with risks and issues as they have arisen.
- The national Due Diligence checklist has been a key part of the planning and implementation process for the Programme Board. This is a live document and is held in shared document repository currently maintained by the CCG Company Secretary, along with supporting evidence.
- Internal Audit have also provided independent assurance on the transition process to the Audit Committee. This has included attendance at all Programme Boards and Finance Workstream project meetings, review of workstream plans, and governance arrangements.
- Internal audit performed three specific reviews on the completeness and accuracy of higher risk Due Diligence information – Contract Register, Staff Transfer Information and Quality Governance Metrics. These audits have found the relevant Due Diligence information to reconcile to the source information, but at the same time identified a small number of areas where processes could be improved going forward. The formal audit report findings will be handed over to the ICB audit committee for any follow up.
- The preparation and audit of the 2021/22 accounts and annual report is now substantially complete

#### **Position of these key issues/areas of focus as of 30<sup>th</sup> June 2022:**

There are a number of transition tasks that will necessarily take place in the final run up to 30 June (to ensure the latest position is taken into scope).

- Final circulation of all suppliers and contracts with new organisation details
- Final sign off of Staff Transfer details
- Transfer of all email accounts that will remain live post transition
- The Annual Report and Accounts were finalised and submitted on the 23<sup>rd</sup> June including any associated documentation (such as Letter of Representation and Statement of Accountable Officer Responsibilities) was signed and submitted by the 23<sup>rd</sup> June 2022.
- The Audit and Risk Committee Annual Report, including Self-Assessment was presented to and approved by the Committee for submission to the CCG Board at its meeting held on the 15<sup>th</sup> June 2022 (as attached).
- All external audit work was complete at that stage.

- As at the 30<sup>th</sup> June 2022 the only item outstanding is any actions from the Internal Audit reports, which will be picked up through the Trac system and regular updates provided to the ICB Audit and Risk Committee going forward.

There are also a small number of issues that are reliant on national processes or guidance, again it would be appropriate for the ICB Audit Committee to follow these issues up:

- Arrangements for participation in the National Fraud Initiative for ICBs has not been confirmed. There is low risk for the CCG/ICB in this, but it is good practice to participate
- Completion of the Information Governance Toolkit for the ICB.

**Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of:**

- The Scheme of Delegation/SFI sign off limits for the ICB have been reviewed and signed off by the CCG Audit Committee. Once the ICB management structure and functions have settled, it is likely these will need to be refreshed during 2022/23 to ensure they remain fit for purpose.
- The Transition date of 1 July 2022 means that the final accounting period for the CCG will be 1 April 2022 to 30 June 2022. A national timetable for closing down and auditing this accounting period has been published, and the ICB will need to make arrangements to implement this.
  - CCG (Annual Accounts for months 1-3) – submission on the 22<sup>nd</sup> July 2022.
  - CCG Draft Annual Report (months 1-3) – submission on the 5th October 2022.
- The ICB will inherit the Subject Access Requests (SAR) and Freedom of Information Requests (FOI). These are overseen by Arden GEM CSU who will continue to maintain the registers.
- The development of the system Quality Strategy has been highlighted through the Due Diligence process as work in progress.
- It is recommended that CCG Risk Register at 30 June (as attached) is handed over and reviewed in the context of the ICB as soon as possible.
- The transition programme has necessarily focussed on its core activities; however its work has highlighted a number of opportunities to improve efficiency and effectiveness for the ICB. These do not present a material risk to transition, but provide an opportunity for further improvement, and include:
  - Stocktake of software, laptops and mobile devices actually in use
  - Documentation of contractual arrangements for individual care placements
  - Specification and contracting for clinical advisors to the ICB
  - Reviewing accommodation requirements alongside the exit of the Cross O'Cliff lease.
- The Internal Audit Plan for 2022/23 needs to be agreed.

- Internal Audit need to be commissioned to produce a report for the ICB Audit and Risk Committee covering the most recent HFMA publication - Improving NHS financial sustainability: are you getting the basics right? <https://www.hfma.org.uk/online-learning/bitesize-courses/detail/improving-nhs-financial-sustainability-are-you-getting-the-basics-right>

# ANNUAL REPORT OF THE AUDIT AND RISK COMMITTEE 2021/22

## 1. PURPOSE

The purpose of this report is to brief the Board on the work of the Audit and Risk Committee during the last financial year. This report covers the period 1 April 2021 to 31 March 2022.

This report therefore outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

The Audit and Risk Committee is requested to **consider** and **approve** the report for submission to the CCG Board.

## 2. BACKGROUND

The Audit and Risk Committee is established with approved Terms of Reference that are aligned with the NHS Audit Committee Handbook published by the HFMA and the Department of Health.

## 3. OPERATION OF THE COMMITTEE

The Committee met six times in the year and discharged its responsibilities for scrutinising the management of risk and controls, which affect all aspects of the CCG's business.

The membership of the Audit and Risk Committee during 2021/22 comprised:

Name	Role	Period
Mr Pete Moore	Non-Executive Director - Governance and Chair of the Audit and Risk Committee	Full year
Ms Sue Liburd	Non-Executive Director	Full year
Mrs Fenella Chambers	Non-Executive Director	Full year

The following chart details attendance by the Non-Executive Directors during the year:

	13/04/2021	18/05/2021	09/06/2021	21/09/2021	14/12/2021	09/03/2022
Fenella Chambers	A	A	A	A	A	A
Sue Liburd	A	A	A	X	A	A
Pete Moore	A	A	A	A	A	A

The following people are also in attendance:

Mr Matt Gaunt, Director of Finance and Contracting  
 Mrs Julie Ellis-Fenwick, CCG Board Secretary  
 Internal Audit representatives, PwC  
 External Audit representatives, Ernst and Young  
 Local Counter Fraud Specialist, PwC

The Committee reviewed its Terms of Reference in April 2021 and identified some amendments in relation to virtual working arrangements, which were approved.

The Chair of the Committee has reported to the Board following each meeting and presented an Escalation Report.

#### **4. PRINCIPAL REVIEW AREAS**

##### **4.1 Governance, Risk Management and Internal Control**

The aim of the Audit and Risk Committee is to provide one of the key means by which the CCG ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the Officers of the CCG and members of the Board.

In discharging these duties the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (Annual Governance Statement) which are supported by the Head of Audit opinion and other opinions provided.
- The comprehensiveness of assurances in meeting the Governing Body and the Accountable Officer's assurance needs and reviewing the reliability and integrity of these assurances.
- The adequacy of relevant policies, legality issues and the Codes of Conduct.
- The policies and procedures related to fraud and corruption.

The CCG identifies, evaluates and controls its risks through the Committee structure it has in place. The CCG embeds risk management through:

- The CCG committees (including the Audit and Risk Committee)
- Board Assurance Framework (BAF)
- Risk Register
- Policies and Procedures
- Standing Financial Instructions (referred to as Delegated Financial Authority Limits) and Standing Orders

All staff are responsible for the identification and management of risk appropriate to their own role in the organisation. The use of Quality Impact Assessments, Privacy Impact Assessments, Data Protection Impact Assessments and Equality Impact Assessments as part of our project management framework also helps to identify risks.

The Board Assurance Framework is directly related to an organisation's agreed strategic objectives and sets out the key strategic risks that may prevent the objectives from being met. The BAF provides assurance that the CCG's strategic objectives are being effectively delivered and identified risks are being managed in line with agreed risk appetite.

In February 2021 the CCG agreed six 'themed' objectives through to March 2022. These objectives are mapped to four principal risk themes as illustrated below:

Category	Objective	Executive Lead	Mapping to risk theme
Quality	Commission high-quality, safe and effective services to drive continuous improvement in patient outcomes.	M Fahy	2, 3, 4
People Centred	Promote service improvement by working with the population to design services which help people to achieve their goals and lead healthy, independent lives.	C Raybould	1, 4
Health Inequalities	Tackle health inequalities and wider causes of ill health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire.	S Williamson	1, 2, 3, 4
Communities	Proactively commission a model of high-quality, integrated care at a local level that delivers improvement in health outcomes.	SJ Mills	1, 2, 3, 4
Collaboration	Foster establish and enhance collaborative ways of working throughout a partnership network that delivers measurable improvement in health outcomes.	A Rix	1, 2, 3
Insight led	Develop a systemwide understanding of need to drive good decisions based on evidence and learning from previous or existing work.	M Gaunt	1, 4

The CCG identified four strategic risk themes which have the potential to prevent the CCG from achieving its stated objectives. Each strategic risk has an identified Executive Risk Owner, who is responsible to overseeing the implementation of identified mitigating actions and for ensuring that their respective BAF template is regularly reviewed and updated. These are as follows:

Strategic Risk Themes	Owner
Systems Leadership/ Reputation	Accountable Officer
Quality, safe and effective services	Director of Quality and Nursing
Financial sustainability	Director of Finance and Contracting
Service transformation	Director of Operations

The six themes have been unpinned by four operational objectives in 2021/22.

#### 4.2 Risk Management Group and Risk Management Strategy and Framework

At the request of the CCG Executives, Mr Martin Fahy, Director of Nursing set up a working group to reinstate the previous CCG's Risk Management Group. The first meeting took place on 29 April 2021 and the first objective of the Group was to revise the Terms of Reference and the Risk Strategy and Management Framework to align to the single CCG. During the review it was agreed that there would be an extra step in the governance process, which means that the oversight Committee for the group is now the Senior Managers Operational Delivery Group (SMODG) with an overarching oversight by Audit & Risk Committee.

### 4.3 CCG Risk Register

It had been agreed at a Joint CCG Risk Management Group, prior to COVID-19, to use the format of the Risk Register which had previously been used by South and South West Lincolnshire CCG's. There were 71 legacy risks, dating from 2015, from Lincs East and West CCG's which were still held on Datix. Following review in 2021 it was agreed to archive 62 of these risks as it was felt that they had now been superseded or were no longer relevant and to receive further review of the nine risks which were not archived.

A considerable amount of work has been taking place in 2021/22 to have a baseline Risk Register in place prior to moving into the ICB on the 1<sup>st</sup> July 2022.

The CCG risk scoring matrix is detailed below:

01-03	Very low risk
04-06	Low risk
08-12	Medium risk
15-25	High risk

### 5. INTERNAL AUDIT

During 2020/21, the Internal Audit Service was provided by PricewaterhouseCoopers (PwC) PwC.

Throughout the year the Committee has worked effectively with Internal Audit to strengthen the CCG's internal control processes through discussion and debate over recommendations and deadlines.

The Committee has placed great emphasis on the findings of each internal audit review and the timely implementation by management of action to address these findings.

### 6. EXTERNAL AUDIT

The External Audit Service was delivered by Ernst and Young.

The External Audit work can be divided into two broad headings:

- a) To audit the financial statements and provide an opinion thereon;
- b) To form an assessment of the CCG's arrangements for its use of resources.

The Committee considered the external audit plan including the risks identified by the external auditors and their planned response to them, together with progress reports throughout the year. The Committee also met separately with the auditors to ensure there were no issues the auditors wished to raise privately.

The external auditors also provided regular technical updates throughout the year.

### 7. COUNTER FRAUD

The Committee has reviewed and agreed the Counter Fraud Plan and has discussed and noted regular updates during 2021/22. Recommendations have been logged on a tracker document and reviewed by the Committee at each meeting.

## **8. REVIEW FOR 2021/22**

The work programme of the Committee in 2021/22 was aligned to the Annual Plans agreed with External Audit, Internal Audit and Counter Fraud at the beginning of the financial year. The Committee has completed a Self-Assessment of its work, which is attached to this report for consideration by the CCG Board.

## **9. CHAIR'S OVERVIEW AND CONCLUSION**

In conclusion, the Committee has met its duties delegated by the Board and would like to thank all members and attendees for their contribution in 2021/22.

**Graham Felston**  
**Non-Executive Director and Acting**  
**Chair of the Audit and Risk Committee**  
**June 2022**

## LINCOLNSHIRE CCG AUDIT AND RISK COMMITTEE

### SELF-ASSESSMENT CHECKLIST – 2021/22

Area/Question	Yes	No	Comments/Action
<b>Composition, establishment and duties</b>			
Does the Audit and Risk Committee have written Terms of Reference that adequately define the Committee's role in accordance with relevant guidance?	Y		The TOR were reviewed in April 2021 and approved.
Have the Terms of Reference been adopted by the Board?	Y		
Are the Terms of Reference reviewed annually to take into account governance developments and the remit of other Committees within the organisation?	Y		As identified above.
Are Committee members independent of the management team?	Y		
Are the outcomes of each meeting; the actions taken and the Committee's view on the organisation's systems of internal control reported to the next Board meeting?	Y		
Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board?	Y		Prepared and considered by the Committee at its June 2022 meeting.
Does the Committee assess its own effectiveness periodically?	Y		
Has the Committee established an annual work plan of matters to be dealt with across the year?	Y		Forward plan in place for 2021/22.
Are the Committee papers distributed in sufficient time for members to give them due consideration?	Y		Agenda and papers are usually issued one week in advance of the meeting.
Does the Committee review its risks regularly?	Y		
Has the Committee been quorate for each meeting this year?	Y		
<b>Compliance with the law and regulations governing the NHS</b>			
Does the Committee review assurance and regulatory compliance reporting processes?	Y		Internal and external auditors provide updates of current issues.
Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Y		DOF&C presents items to the Committee. Each report from IA, EA, and CF includes references/links to topical papers.

<b>Internal Control and risk management</b>			
Has the Committee formally considered how it integrates with other committees that are reviewing risk – for example, risk management, quality and clinical governance committees?	Y		
Has the Committee reviewed the robustness and effectiveness of the content of the organisation's assurance framework?	Y		
Has the Committee reviewed the robustness and content of the draft Annual Governance Statement before it is presented to the Board?	Y		The Chair of the Committee has reviewed the AGS along with the DOF&C. The Board has received the draft Annual Report for consideration which includes the AGS.
Is the Committee's role in reviewing and recommending to the Board the Annual Report and Accounts clearly defined?	Y		Yes – as set out in the Scheme of Reservation and Delegation.
Does the Committee consider the external auditor's report to those charged with governance including proposed adjustments to the accounts?	Y		
<b>*Internal Audit</b>			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives, responsibilities and reporting lines?	Y		
Does the Committee review and approve the internal audit plan at the beginning of the financial year?	Y		
Does the Committee approve any material changes to the plan?	Y		
Is the Committee confident that the audit plan is derived from a clear risk assessment process that links closely to the assurance framework?	Y		Planning process is closely aligned to risks.
Does the Committee receive periodic progress reports from the Head of internal Audit?	Y		Update at each meeting.
Does the Committee effectively monitor the implementation of management actions arising from internal audit reports?	Y		Audit recommendation tracker presented at each meeting.
Does the Head of Internal Audit have a right of access to the Committee and its Chair at any time?	Y		
Is the Committee confident that internal audit is free of any scope restrictions and, if not, has it considered the impact of these on the annual Head of Internal Audit opinion?	Y		
Is the Committee confident that that internal audit is free from any operational responsibilities or conflicts of interest that could impair its objectivity?	Y		
Does the Committee hold periodic private discussions with the Head of internal Audit?	Y		At least annually or on request.
Has the Committee evaluated whether internal audit complies with the Public Sector Internal Audit Standards?	Y		
Has the Committee agreed a range of internal audit performance measures to be reported on a routine basis?	Y		
Does the Committee receive and review the Head of Internal Audit's annual opinion?	Y		

<b>*External Audit</b>			
Do the external auditors present their audit plans and strategy to the Committee for agreement and approval?	Y		
Does the Committee receive and monitor actions taken relating to prior years' reviews?	Y		
Does the Committee review the external auditor's ISA 260 report (the report to those charged with governance)?	Y		As part of Accounts approval process
Does the Committee review the external auditor's value for money conclusion?	Y		
Does the Committee hold periodic private discussions with the external auditors?	Y		At least annually or on request.
Does the Committee assess the performance of external audit?	Y		Carried out externally.
Does the Committee require assurance from external audit about its policies for ensuring independence?	Y		
Has the Committee approved policy to govern the nature and value of non-audit work carried out by external auditors?	Y		
Does the Committee receive information on all non-audit work undertaken by external audit?			N/A
Does the Committee review the proportion of audit and non-audit work every time the external auditors change?			N/A
<b>Counter Fraud and Security</b>			
Is the Committee aware of NHS Protect requirements in relation to counter fraud and security activity?	Y		
Does the Committee review the planned counter fraud and security work at the beginning of the financial year and in particular its scope and coverage?	Y		
Does the Committee satisfy itself that the work plan is derived from clear processes based on risk assessments and that coverage is adequate?	Y		
Does the Committee receive notification of any material changes to the plan?	Y		
Does the Committee receive periodic reports about counter fraud and security activity?	Y		At each meeting
Does the Committee effectively monitor the implementation of management actions arising from counter fraud and security reports?	Y		As part of audit recommendations tracker.
Do those working on counter fraud and security activity have the necessary technical knowledge and experience to ensure that work is carried out as it should be?	Y		
Does the Committee receive and review an annual report on counter fraud and security activity?	Y		
Does the Committee receive and discuss reports arising from inspections by NHS protect in relation to the quality of the counter fraud provision?			N/A
<b>Annual report and accounts and disclosure statements</b>			
Is the Committee's role in the approval of the annual report and accounts clearly defined?	Y		
Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?	Y		

Does the committee specifically review: <ul style="list-style-type: none"> <li>• Changes in accounting policies?</li> <li>• Changes in accounting practice due to changes in accounting standards?</li> </ul>	Y Y		None so far
<ul style="list-style-type: none"> <li>• Changes in estimation techniques?</li> <li>• Significant judgements made in preparing the accounts?</li> <li>• Significant adjustments resulting from the audit?</li> <li>• Explanations for any significant variances?</li> </ul>	Y Y Y Y		
Does the Committee ensure it receives explanations for any unadjusted errors in the accounts found by external auditors?	Y		
Does the Committee receive and review a draft of the organisations' Annual Governance Statement?	Y		
Does the Committee receive and review a draft of the organisation's Annual Report and Accounts?	Y		
Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements (for example, as set by the Care Quality Commission)	Y		As necessary
<b>Other Issues</b>			
Does the Committee report regularly to the Board through verbal and written reports and make clear recommendations where necessary, including escalating items for consideration?	Y		Escalation Reports are presented to the Board.
Does the Committee meet the appropriate number of times to deal with planned matters, development and liaison?	Y		
Are arrangements in place to call ad hoc meetings when necessary?	Y		
Has the Committee reviewed its performance in the year for consistency with its: <ul style="list-style-type: none"> <li>• Terms of reference?</li> <li>• Programme for the year?</li> </ul>	Y Y		As part of Audit and Risk Committee Annual Report.

LINCOLNSHIRE CCG CORPORATE RISK REGISTER

LAST UPDATED - 21 June 22

		LIKELIHOOD					
		Risk (L x H) = Score					
		Rare	Unlikely	Possible	Likely	Almost Certain	
		1	2	3	4	5	
Consequence	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Minor	3	6	9	12	15
	2	None	2	4	6	8	10

RESPONSIBLE LOCALITY/SRO	Date added to risk register	Reference	CCG OBJECTIVE	RESPONSIBLE COMMITTEE	PRINCIPAL RISK	KEY CONTROLS & ASSURANCES (Controls should prevent a risk materialising. Assurance gives confidence controls will be effective)	GAPS IN CONTROLS & ASSURANCES	MITIGATIONS (Mitigations are measures to limit harm if, despite controls, a risk materialises)	ACTION PLAN	TIMELINE	SCORE Mar 2022	UPDATE	LIKELIHOOD May 2022	IMPACT May 2022	CURRENT SCORE May 22	RISK OWNER	LAST UPDATED	RISK STATUS	RISK APPETITE
M Fahy		LCOG 1.02	Constitutional Standards & Quality Assurance	OPFC	Non-delivery of performance and quality standards for cancer leading to actual or potential patient harm.	1. The CCG oversees the improvement programme for 5 key specialities, urology, lung, upper GI, colorectal and gynae. The trust continue to oversee the operational and performance & these 2 programmes need to work together to enact change. 2. Monthly cancer board to oversee the performance and improvement programme 3. Quality input into cancer board to oversee cancer quality aspects and programme manager feed in to quality meetings. 4. Weekly oversight with performance and improvement programme 5. NHSE/ support to oversee programme and performance 6. EMCA funding to support both revenue and workforce priorities to support performance and improvement programme 7. System data oversight for Lines 8. Weekly Planned Care, Cancer and Diagnostic recovery cell to oversee programme, improvements and allow deep dives into relevant areas	1. The capacity available through cancer programme manager and team fails to adequately deliver review and improvements across the wider provider networks and therefore doesn't meet the wider needs of the CCG. 2. Understanding of level of harm caused by treatment delays: actual and potential 3. Assurance of provider staffing plans to increase capacity to respond to increasing demand	1. Monitor capacity and highlight early any concerns through SRO/CCG Exec. Lead commissioner to go to neighbouring/border providers 2. Harm Reviews undertaken on long waits 2. Further action plans agreed with NHSE and NHSI in place, some progress made, however, still fragile in areas such as Zww due to staffing shortages 3. Continued scrutiny and monitoring of actions to determine impact and alternative actions to be developed where appropriate 4. Individual patient tracking mechanisms for those patients failing to achieve against mandated timeframes 5. Options continue to be developed to move Prostate Cancer Follow Up's out of secondary care (decision due at future Lincolnshire Joint Commissioning Board).	1. Ongoing 2. Ongoing 3. Ongoing 4. Ongoing 5. Ongoing		16	22/10/21 Backlogs remain high Colorectal and Urology the most challenged areas, engagement with the division continues, monitoring of the large number of clinical reviews outstanding for colorectal. CCG cancer team has offered support to Colorectal to understand the administrative flows to minimise long waits. 31.12.21 The Trust are reviewing their prioritisation of P2s and clinical harm processes and aim to present at planned care cancer recovery cell in January 2022. 21.02.2022 The colorectal backlog remains the greatest concern, CCG Cancer Team members are working within the division to reduce the backlog and make improvements. Concern remains around sustainability of this improvement.	4	4	16	Clair Raybould	21/02/2022		6
M Fahy		LCOG 1.04	Constitutional Standards & Quality Assurance	OPFC	Failure to deliver safe and effective services in the Emergency departments that Lincolnshire residents would attend resulting in non delivery of constitutional A&E targets, timely ambulance handovers and long trolley waits and these may result in patient harm	1 Recruitment of staff 2 STP Urgent Care transformation for longer term sustainability 3 System-wide collaborative approach and monitoring - escalation where required 4 Urgent care funding (not recurrent in contracts) to support additional initiatives 5 Quality team visits 6 Daily real time monitoring and close system collaboration	1. There is a lack of assurance that improvements are being made to patient experience and safety in the Emergency Departments 2. Current improvement plans have sustained the improvements required 3. ULHT continue to struggle with demand, high bed occupancy levels and staffing issues especially at the Pilgrim site. 4. Performance improved with reduced ED attendances as a direct result of Covid 19 effect. Now activity levels returned to normal - now frequently poor A&E standard performance for level 1 activity. Latter compounded by Covid 19 Wave 2 effects on staffing & requirement for bed closures to maintain safe IPC.	Previous escalation to NHSE and intensified monitoring and recovery planning. During pandemic daily operational system calls. Monthly UEC Delivery Board to ensure relevant actions for all partners progressed.	1. CQC unannounced visit - previously completed 2. Risk Summit - NHSE/ - previously completed	ongoing and continuous	16	22.10.21 Urgent and Emergency Services continue to be significantly challenged, with operational pressures escalation levels (OPEL) 3 or 4 for sustained periods throughout September and October 2021 (unprecedented across the county). System wide response to support patient flow. Daily system calls, escalation and assurance plans in place. Targeted comms to promote 111 first and alternative pathways. 24.12.21 Service continues to be significantly challenged with pandemic and winter pressures. Risk emerging of staffing impact from Omicron. OpeL levels 3 & 4 for sustained periods continue. System wide response, escalation and assurance plans remain in place. Targeted comms to promote 111 first and alternative pathways. 01.03.22 - Poor position in Jan & Feb 22 for ambulance handover delays, 12 hr ED waits & MSA breaches for ULHT. Increased SIs for EMAS associated with community response delays. Situation is contributed to by several factors including staffing capacity within acute, IPC restrictions and discharge challenges particularly for domiciliary care. Frequently ULHT at OPEL 4. Initiatives to reduce attendance & admission and improve discharge capacity continue eg. MADE. 21.04.22 - Situation remains as described previously, compounded by further covid 19 surge in March causing significant staff absence/constraints across most services. Fire at Lincoln ED also caused closure of the department in early April for a few days with consequent sequelae to other ULHT services & neighbouring Trusts that provided aid.	5	4	20	Wendy Martin	21/04/2021		4
M Fahy		LCOG 1.05	Constitutional Standards & Quality Assurance	Exec	Failure of provider to deliver NEPTS contracted service resulting in non-collection/late collection of patients and impact on stretched hospital system and possible adverse patient impact	Contract Meetings, Contract/Performance Notices, Additional discharge vehicles in place (1x LCH and 1x PHB)	Provider financial stability is susceptible to notice being given by other CCG that hold contracts with them	Continual Review KPIs, Work with Provider to develop action plan and hold to account on progress, Work with Provider on any system wide issues which require CCG support. Work with AGEM contracting team to issue relevant notices Exchange intelligence with other commissioners of this provider. Secure additional capacity and keep need under review. Additional discharge vehicles commissioned 12 hours per day, 7 days a week (1x LCH, 1x PHB)	Hold provider to account for delivery of a quality service in accordance with contract terms and KPIs. Contingency plan is in place in case of immediate withdrawal of service by provider/withdrawal without full notice period.		6	Plan B development underway 06.07.21 - Additional funding has been provided to main provider in 2020 and 2021 and additional CCG commissioned capacity remains in place. Contract controls with regular meetings with the provider are also in place. Risk likelihood has therefore reduced to 2, for this update.	2	3	6	Tim Fowler	06/07/2021		4
All		LCOG 1.08	Constitutional Standards & Quality Assurance	Exec	There is a risk that Brexit may have adverse impact upon medical consumables and staff recruitment and retention across a number of services commissioned by CCGs.	1 Localities have been advised to manage their stockpiles. 2 Understanding of national mitigations 3. Lead for business continuity planning for a potential No Deal EU Exit are in place. 4 Assurance continues to be managed across the Lincolnshire System. Providers are developing plans as more information is available based on national and local risk assessments. 5 Regional EU Exit webinars and teleconference are supporting the planning process by linking the national risks with regional and local planners.	1. Ongoing risk to population coverage due to providers being served notice. Notices are being served for a variety of reasons including staffing and also financial viability of services. 2. CCG service review in progress. A number of practices served notice on enhanced services including INR gaps in provision still exist due to voluntary nature of provision of services. 3. Impact on NHS and social care staffing from EU workers leaving needs to be clarified.	1. CCG working with practices and PALS to support patients who may be affected by changes to service provision e.g. location. 2. Review of all enhanced services ongoing. 3. LWAB workforce projections being done as part of operational planning.	1. Continue to monitor by CCG lead linking in with regional calls. 2. Potential impact of EU workers leaving to be built into LWAB workforce projections.	1. Ongoing 2. Ongoing	9	A risk assessment process is being undertaken in line with guidance from NHS England/Department of Health and Social Care and the Ministry of Housing, Communities Local Government (MHCLG) as part of a wider health and social care system process. All Governing Body/Boards across the health and care sector are being regularly briefed and consulted on as part of this process.	3	3	9	Sandra Williamson	28/02/2020	Horizon	6
M Fahy	Dec-21	LCOG 1.09	Constitutional Standards & Quality Assurance	OPFC	Failure to sustain contracted specialist community services provided by LCHS due to significant staffing constraints within community teams. Specifically impacting patient access to services in the community such as, but not limited to, community nursing, podiatry and tissue viability. Additional risk that delayed care will then subsequently impact on secondary care with patients requiring acute services due to deterioration / increased complexity of clinical conditions.	1. LCHS actively managing the situation via Director of Nursing. Short term - re-evaluating current service model to explore alternative ways of working. Long term ongoing recruitment and training of staff. 2. System wide collaborative approach for monitoring and escalation. 3. Managed and oversight at contract monitoring performance board (CMPB).	Time it takes to recruit, train and deploy staffing to meet service requirements.	Exploring how the system can support operational pressures.	Continue to work with LCHS on system wide news ways of working.	Monthly	8	22.10.21 Risk added to register. This will be managed as a system wide concern as is not limited to any single locality. Update will be provided following the CMPB meeting on 12 November 2021. 29.12.21 Community Nursing Working Group now established, next meeting 6 January 22. LCHS actively recruiting to build resilience, long term project, and alternative working models being considered that will fit demographic and PCN requirements. 25.02.22 CMPB meeting held and there has been good progress with First Coastal PCN, CCG and LCHS regarding the transitional work plan. The proposal is focussed around a blended model where there are no strict boundaries for any provider but a more focussed effort to provide good quality care. It was also highlighted that LCHS would have identified Clinical Leads as links directly in to PCN's.	4	2	8	Kevin Shaw	25/02/2022		6
M Fahy		LCOG 1.10	Constitutional Standards & Quality Assurance	OPFC	Vulnerability of care home market resulting in increased risk of closures, reduced capacity, increased fragmentation of services; deregistration from nursing to residential and increased costs to CCG for placements. Risk higher during Covid 19 response due to potential workforce and capacity constraints due to infection or adherence to IPC strengthened requirements. Also patients preferring not to reside in care homes risks increased empty beds, affecting care home financial sustainability.	1. Service quality review process in place in partnership with LCC to monitor quality in relation to the market - meeting weekly during Covid 19 2. AQP rate agreed for placement & new AQP contract mobilised 3. Procurement of Transitional Care Beds 4. Enhanced health in Care Home Group (STP) established 5. During Covid 19 daily Care Home & Home Care Cell in place to ensure any care home issues addressed and support provided ( system response, chaired by LCC). - now meets twice weekly during Covid 19 wave 2.	1. Ability to influence private providers providing placements non AQP rate increases agreed 2. Ability for Care Homes to attract registered nurses when shortage of nurses across all specialities - pilot of new workforce models, plus staff redeployment from other areas during Covid 19 if required.	1. Escalate and apply contingency plans to manage and control improvements or closure 2. Ensure individual patients are safeguarded.	1. Continued engagement with LCC and the Service Quality Review process - CHC & CCG Safeguarding Leads 2. Continued engagement and involvement with the Enhanced Health in Care Home (STP) group - CCG Associate DON SRO - EHCH currently through Covid Cell meeting (twice weekly) & newly instigated PCN Directors EHCH meeting. 3. Continued negotiation with all providers in relation to costs 4. Continued engagement with Care Home Cell & all actions required to support Care Homes during Covid 19, including work with PCN Directors to instigate improved locality network response.	1. Ongoing 2. Ongoing 3. Ongoing 4. Ongoing	9	1. The CCGs continue to support care homes through both quality teams and safeguarding professionals- good engagement in work alongside LINCA to review CQC ratings and develop programmes of education and support for care home establishments. 2. New AQP Procurement now completed. 2nd wave completed to attract homes unsuccessful in first round. 3. Regular EHCH steering group to drive improved support to Care Homes and drive quality improvements re: technology; workforce skills; care planning; local MDT support etc. 4. During Covid 19 Pandemic - dedicated Care Home & Home Care Cell to ensure enhanced support network for Care Homes, guide re: Covid guidance, testing, IPC etc. Stood up again in Dec 21 during Omicron surge. There have been more care homes unable to secure registered nurses and homes have deregistered for nursing on a temporary or permanent basis. Currently no shortage of care home beds so residents needing nursing care in these situations have been relocated where necessary. Mar 22 Situation currently stable for Care Homes - weekly Care Home Covid Cell stood down. Challenge is domiciliary care package availability in some areas. Block contract trial by CCG to address in some of the more challenged areas. 21.04.22 - April 22 - significant workforce challenges for care homes and home care at the end of March/early April due to Covid 19 surge. Position as since improved, main area of challenge continues to be domiciliary care packages. Support provided to LCC from CCG with additional funding for Social Care Domiciliary care.	3	3	9	Wendy Martin	21/04/2021		8
M Fahy		LCOG 1.11	Constitutional Standards & Quality Assurance	OPFC	Patients in receipt of fully funded Continuing Health Care, Funded Nursing Care, fast tracks and Joint Packages of Care, do not receive timely reassessments resulting in lack of assurance in relation to quality and appropriateness of placements. Higher risk as a result of suspended CHC processes during surge months of Covid 19 response. This has created a backlog of CHC reviews from March to 31st August. From 1st September rapid 6 week process for required assessments. This process & clearing of backlog promptly will demand additional workforce capacity.	1. Monthly updates provided to CHC Prog Board in relation to the number of assessments/reassessments overdue 2. Successful In-housing of service to the CCG. 3. QIPP Project undertaken in 19/20 to clear backlog and maintain regular assessments. Healthy position as went into Covid 19 response. 4. Quality of placements monitored at a care home level through the service quality review processes in conjunction with LCC. 5. All CHC staff redeployed to other areas during Covid 19 response now returned to CHC. 6. Ask out to system (CNOs) for additional workforce to assist 7. Overtime to be made available for existing CHC staff, plus any CCG nursing staff able to support. 8. additional capacity secured from agency.	1. Risk of further staff leaving CHC team for other opportunities ( lost 3 staff to NHTs as enjoyed redeployment there during Covid response) 2. Successful In-housing of service to the CCG.	1. Maintain agreed funding; SRO Associate Dir Nursing - monthly Prog Board & Operational Mx Group. Regular 1 to 1 meetings with Clinical Team Lead; Business Lead & Finance & Contracting Lead so early awareness of any problem areas. 2. Manage workload/scheduling to ensure timely assessments 3. Successful recruitment campaign to fill vacancies 4. process agreed with LCC for 1st Sept 6 week process 5. additional capacity secured	1. Continued oversight by Ass Dir of Nursing & Dir of Nursing 2. Ensure robust involvement in current stakeholder groups for oversight and early recognition and escalation of concerns - Nursing & Safeguarding Team 3. - assurance through CHC Prog Board & CCG Board/QPEC	1. Ongoing 2. Ongoing 3. Ongoing	12	27.08.2020 Action plan in place to address Covid backlog (360 cases) & 6 week September process. oct 2020 - good progress on covid backlog ; Dec 2020 continued good progress on backlog. March 21 - Covid suspension backlog cleared. Oct 21 - Further backlog in three month and annual reviews has accrued due to staffing vacancies & sickness in the summer - agency support secured to address. DST performance (initial assessments) is very good. Review backlog clearance to be monitored via established governance processes. Mar 22 - additional support secured to further address accrued backlog reviews; staff recruitment good & now in fully recruited position for assessors.	4	3	12	Wendy Martin	01/03/2022		6
All		LCOG 1.12	Constitutional Standards & Quality Assurance	Exec	Failure of the ICC (Integrated Community Care) including PCNs to develop at sufficient pace to deliver the objectives of the long term plan.	1 Close collaboration with the Networks, and their Clinical Leads with the aim of identifying and mitigating any risks at an early stage 2 Practices aligned to each Primary Care Network and are starting to work more closely together 3 ICC Programme Board established - membership from key stakeholder organisations. 4 Target Operating Model developed in conjunction with key stakeholders.	Any gaps will be identified as the programme is developed				6			6	Sarah-Jane Mills	22/01/2020		4	

All		LCOG 1.16	Constitutional Standards & Quality Assurance	Audit & Risk Committee	Successful cyber attack resulting in the loss of data or system outage (including local CCG IT systems) resulting in significant service disruption, harm to patients, financial loss and damage to reputation of CCGs	1. IT service provided by AGEM CSU reports to CFO/ Director on call with regard to operational ICT 2. Draft Cyber Security Plan in place which applies to management of all CCG computer infrastructure, hardware and software and is applicable to all staff 3. In the event of an ICT failure, AGEM CSU IT service is responsible for prompt action to restore service 4. IT policies in place 5. Key messages regarding Cyber Security are regularly issued to all staff members 6. Firewalls and software updates are regularly rolled out across the network	1. Cyber security plan is still in draft 2. Cyber security is constantly evolving and it is difficult to stay ahead of the game 3. Non NHS devices accessing the CCG network, not subject to the same security	1. Use of business continuity plan to ensure the CCGs do not stop due to loss of IT 2. Use of CCG Policies 3. CCG received regular cyber reports highlighting emerging risks and any areas for immediate action	1. Cyber Security Gap Analysis to be carried out to assess the CCGs cyber security preparedness 2. Action Plan covering next steps to achieve fit for purpose cyber security 3. Draft Cyber Security Plan to be finalised and signed off 4. IT policies updated to reflect cyber security threats	1. July 2020 2. July 2020 3. July 2020 4. April 2020	9	31.01.20 - Score to remain at 9. Report with key risks now presented to Boards for East and West, and also shared with South / South West. Main risks identified as email exchange, Windows 10 and staff training. Email exchange transition nearly complete, W10 escalated as a separate risk, training to be completed as part of toolkit. Other risks recognised include Firewall refresh, Application white listing, Disaster recovery, PC refresh, data classification and 5 year strategy. 28.02.20 - Score to remain at 9. Assurance has been given that Win7 software will continue to receive patching and virus updates until Jan21. Expect review of cyber plans and risk appetite when new Board is in place. 21.04.22 - Need to assign a new owner, previously Jo Wright	3	3	9		21/04/2022	Existing	4		
All		LCOG 1.17	Constitutional Standards & Quality Assurance	Audit & Risk Committee	There is a risk that the CCG fails to consolidate the embedding of the requirements of the General Data Protection Regulation due to staff vacancies and the transition to the new CCG.	1. Implementation of the GDPR action plans is a standing agenda item on the Lincolnshire IG Working Group. 2. Progress on GDPR implementation is reported to the SIRO on a regular basis. 3. Completion of data flow mapping exercise as part of the Data & Security Protection toolkit work. 4. There has been an audit of the toolkit submission,	1. Maintenance of strong IG procedure during a period of changing organisational structures 2. Keeping data flow mapping up to date so that key data flows are visible and are controlled 3. Maintaining accountability for information assets in a changing structure. 4. Future of the IG working group and other IG responsibilities to be confirmed	1. Escalation to senior managers and directors if there are gaps in the management structure. 2. New structure will recognise key IG responsibilities for 2020/21.	1. Mandatory cyber training and other toolkit requirements are being rolled out across the organisation 2. Data flow mapping will highlight any changes to the way sensitive data is processed 3. Review of data storage and records management as part of the creation of the new organisation 4. Refresh of Information Asset Owners in the new structure	1. March 2020 2. March 2020 3. June 2020 4. June 2020	12	31.01.20 - data security and protection toolkit being managed by IG working group and delivered by Optum / Arden & GEM CSUs. CCGs supporting by closely monitoring training compliance. IT and IG requirements have been noted in the design of the new CCG structures. Score to remain at 12. 28.02.20 - Score to remain at 12. IG working group meeting in March will summarise current good practice and risks for consideration by responsible officers in the new CCG.	3	4	12		28/02/2020	Existing	8		
All		LCOG 2.01	Joint Working & Organisational Development	Exec	There is a risk that the CCG will fail to keep up with new technologies with impact upon services commissioned and the effective functioning of the CCG	1. Use of a system wide IT strategy group. 2. Progress being made with NHS mail, Windows 10, Office 365, Care Portal developments. 3. Quarterly meetings have been set up for the Local Digital Roadmap. IMTEG remains the central point for driving IT development across Lincolnshire.	1. Challenge for the Lincolnshire NHS is to introduce new systems at scale and turn off the old working practices. 2. Many of the developments are still in their early stages and need more work to establish them as 'business as usual' 3. Potential difficulty in creating clear synergy and direction from the many new emerging technologies 4. Developing consistency of suppliers and of strategy is difficult from a historical pattern where organisations in the STP have contracts with different suppliers and services.	1. Technical Innovations Group are producing a standard catalogue of products to avoid duplication across the system 2. Local Digital Roadmap is focussed on objectives of the SYFV and Long Term Plan 3. Evaluation of all pilot projects before roll out is recognised as essential by DPG members 4. A stock take of systems and contracts is being undertaken to inform the roadmap to new, unified services across the STP.	1. Development of new services through ETTF and GP IT continue 2. Pilot projects in ETTF to be evaluated 3. IT support for system development to be considered as part of system planning 4. Summary report from DPG will show all systems and contract end dates, to inform digital roadmap work.	1. March 2020 2. September 2020 3. March 2020 4. June 2020	12	31.01.20 - ETTF programme for 2019/20 agreed at January DPG meeting. Links between developments and system working reviewed and updated at January Local Digital Roadmap meeting. Processes for evaluating benefits and strategic fit of all new projects strengthened at DPG. Score to remain at 12. 28.02.20 - Score to remain at 12. Work still being done on development of strategy, current position and roadmap. Clinical engagement will be an important factor in effectively embedding new technologies, hence events and workshops being planned. 21.04.22 - Pete Burnett to provide an update (SQ)	3	4	12		21/04/2022	Existing	6		
West		LCOG 1.19	Constitutional Standards & Quality Assurance	OPFC	There is a risk that LCHS do not complete initial health assessment of looked after children within the 28 day standard. This risk is caused by delay in consent processes between LCC and LCHS also availability of GPs to undertake these assessment across the Lincolnshire community. The consequence is a delay in health care planning for vulnerable children in care.	Steering group and task and finish group to address the delays in the stages of the pathway with monthly performance reporting. Steering Group to identify pathway issues and take action to address	14.04.2021 - Gaps in availability of suitably experienced medical staff to fulfill local requirements	Steering Group	Consideration of mixed delivery model between ULHT and LCHS LCHS recruitment of appropriately experienced medical staff Regular report and monitoring of impact via LCC Corporate parenting panel.		9	30.06.2021 - Ongoing discussion between ULHT and LCHS re Paediatrician support to medical model facilitated by Designated Doctor for SG/ CIC - ULHT reviewing Paediatricians workplans to identify capacity. Regular reporting directly to both LCHS Board and LSCP as well as the Local Authority Corporate parenting panel ensure robust oversight of developments. Risk rating remains unchanged. 27.10.21 - LCHS have successfully recruited to substantive medical practitioner posts & secured paediatric support from ULHT, this plus existing GP sessional support should now resolve the delays due to medical staff availability by end 2021. To continue to monitor currently to ensure improvement secured. 21.04.22 - Close monitoring continues, performance has improved with increased medical capacity, but not yet to a level where would reduce oversight further.	3	3	9	Kevin Shaw	01/09/2022	Existing	4		
M Fahy		LCOG 1.22	Constitutional Standards & Quality Assurance	OPFC	The CCG's fail to achieve the mandated reduction of specialist inpatient bed usage for those patients with learning disabilities and/or Autistic Spectrum Disorder, in line with the national Transforming Care programme; Building the right support.	TCP team in place with additional capacity recruited to support admission avoidance, market management and facilitation of discharges, Monthly review of cases monitoring discharge planning and identifying DTOC and key actions. Recovery plan in place and trajectories set. Provider engagement and escalation as part of DTOC process agreed. Lincolnshire Transforming Care Partnership implemented a triage form to ascertain the 'appropriate' transforming care cases. This form had not been utilised initially - This form is now within our local policy to ensure only appropriate cases are under the cohort. Action Completed	Lack of assurance in existing at risk of admission register (AhoAR) process for CYP and adults. Gaps in provision for adults with ASD identified despite ASD liaison service contracted. Community forensic service for adults with LD and or ASD inadequate business case developed funding required.	1. Implemented new systems/processes 2. Escalate to region to seek extra support 3. Intensely Monitoring	1. Continued financial monitoring through the existing S75; and TCP board - DFCO 2. SRO oversight to continue for required data sets - CO M/L/D/ASD 3. Dynamic Risk Register issue raised with LPFT formally at FIGP TCP team have been working with LPFT in the review of existing process and pathway which are inadequate, urgent action plan requested with the aim to have a single process for all agencies and ages in Lincolnshire. - Completion date 28/02/19 4. CP to request LPFT and case managers undertake deep dive of ASD admissions to PCDU Acute and PICU to inform community service review - Completion date 5/03/19 5. F200K allocated to managed care network to stimulate ASD.	1. Quarterly 2. Weekly	6	22/10/21 Recruitment to TCP team on track. Update currently +4 on planned trajectory work ongoing to minimise admissions and CCG team working with LPFT to review all inpatient packages. Recruitment to services planned within the 3 year road has been difficult, revised plan from LPFT to utilise SDF and SR spend in place. Currently working with NHSEI to revise 21/22 trajectories further work planned with regard MM and MOI cases planned for Q3 29/12/21 Recruitment process complete, 50% of safe and well checks completed and host commissioner role in place to coordinate feedback from placing CCG's. Whilst there is significant demand for inpatient provision CTR and LEAP processes are continuing to avoid admission in the majority of cases. Focus in Q4 will be on DTOC to achieve trajectories. 01.03.22 Expected position by 31st March 28 Adult inpatients, (including 1 extended section 17 leave) 2 CYPs against an agreed trajectory target of 26. (slightly below target by 2) however on trajectory for CYP. Therefore not into threshold for escalation.	2	3	6	Richard Eccles	01/09/2022	Existing	6		
All		LCOG 1.23	Constitutional Standards & Quality Assurance	Exec	There is a risk that GP practices become unstable or unviable. This is caused by the recruitment challenges affecting the NHS nationally, workforce supply delays arising from insufficient training, and increasing demands on GP practices which make it increasingly difficult for them to cope as small, independent units. The effect may be the closure of practices and a consequential loss of service provision to some of the CCG population.	1. Quality risk assessment per practice using information gathered by locality managers and the quality team 2. Working with the Primary Care Networks to introduce online consultation systems to support managing demand 3. Quality risk assessment per practice using information gathered by locality managers and the quality team 4. Guidance around Primary Care Networks should hopefully help to manage Primary Care workload by funding more different staff types within practices to support GPs 5. Keeping close links with practices to ensure the CCG has soft intelligence from each practice 6. Robust metrics developed such as waiting times, referral levels, staff turnover, etc	Evaluation of impact of GPV - PDCA cycle to ensure the CCG and GP Practices are getting the benefits of this work. PCN specifications drafted however, concern has been raised nationally regarding PCN capacity to deliver these within the timescales and resource identified. Awaiting information from NHSE regarding final specifications	1. Regular risk assessment of each practice 2. New staff types in General Practice 3. Development and implementation of additional roles 4. New staff types in General Practice		0	0			12	3	4	12	Sarah Jane Mills	22/01/2020	Existing	4
All		LCOG 1.24	Constitutional Standards & Quality Assurance	Exec	The CCG is at significant risk of not being able to fulfil its statutory and legal duty to provide section 12 doctors due to the current arrangements in place and doctors obligations and availability to respond to these requests. Section 12 doctors are approved under the Mental Health Act to carry out assessments and provide medical recommendations which can result in people being forcibly detained under the Mental Health Act 1983	1. Remuneration has been increased for Section 12 Doctor assessments 2. Regular communication with LCC and CCG with regards the continued Risks and issues 3. Issues have been identified on LCC and LPFT risk registers 4. The CCGs are exploring a sustainable solution and plan to implement a new way of working. 5. Advice has been sought from the Procurement Panel who have advised 6. CCG Exec have agreed to fund the cost of a new service	1. In Lincolnshire there are currently a small number of doctors (self employed) undertaking 80% of the activity. Since 2009 the doctors have been remunerated £173.17 per MH assessment regardless of time of day or duration of assessment 4. Due to doctors not being available to do community assessments until after clinics more and more assessments are being passed over to the out of hours (OOH) service EDT. EDT then struggle getting doctors due to them not wanting to go out in the evening after a full days shift 3. This issue sometimes results in the AMHP having to make up to 15 calls to try to get a doctor 4. The EDT is for out of hours emergencies and not only deal with MH act assessments but also social care emergencies, appropriate adult work and safeguarding. Due to the increased pressure on this service for MH act assessments the AMHPS service have put additional staff on duty adding further pressure to the social care. 5. The most significant gap is the absence of a fully commissioned 24/7 service that is both robust and resilient	1. Remuneration has been increased for S12 doctor assessments. This is in the hope that more Doctors will agree to undertake more assessments - LL 2. The CCGs have agreement to undertake a full procurement for a fully funded service. Quotes and specifications from potential providers external to Lincolnshire have been received. 3. Discussions are ongoing with LPFT, to determine if they are in a position to provide the service	1. Complete 2. 31 March 2019 3. 14 March 2019 4. 16 August 2019	6	12.04.21 We will go live with the base platform of the new system on 12th April, which is today. The CCG finance team training is now complete and the remaining AMHPs and doctor user training took place over the last two weeks. The base platform will include the main functionality:  • AMHPs' search and access to S12 approved doctors to organise and complete assessments • Doctors' expenses claims submissions, processing and approval.  Following 12th April we will continue planning for phase 2 of the implementation. 12.04.21The functionality in phase 2 will be:  • Video conferencing between AMHPs and doctors • Electronic section papers.	2	3	6	Andy Risk	20/11/2019	Existing	2			
M Fahy		LCOG 1.25	Constitutional Standards & Quality Assurance	OPFC	There is currently a risk associated with the processes in place to manage NICE compliance. There is a lack of assurance with regards to monitoring compliance against best practice. The effect and consequence the population of Lincolnshire may not receive best practice.	NICE TAs are monitored through PACEF All practices are monitored against QOF and this is based on NICE Guidance. Providers monitored through Patient Safety and Quality Meeting and Quality Review Meetings. Poor compliance has been escalated to Contract Operational Group and Contract Assurance Board.	ULHT's compliance remains poor and on-going monitoring through Quality Assurance meetings.		1. Development of effective efficiency savings 2. Maintain staff resilience using workforce strategy 3. Establishment of robust governance framework for Lincolnshire as part of the new ICB	1. Ongoing 2. Ongoing 3. July 2022	9	05.06.2020 GP Clinical Forums provide opportunity to discuss new Primary Care relevant NICE guidance. System Clinical Forum & Learning Network will provide additional fora to discuss associated pathway changes. PC assurance via CQC & CCG Quality Reviews/visits. 27.10.2021 - ULHT compliance improving & continues to be monitored for improvement via CCG attendance to ULHT Quality Governance Committee. Further work underway to establish ICS clinical learning forum/academy by end 21 which will further support consideration and adoption of relevant NICE guidance and other evidence based practice. 21.04.22 - April 22 - Clinical Academy & Network - inaugural meetings held, development ongoing.	3	3	9	Wendy Martin	21/04/2022	Existing	6		
M Gaunt	14/06/2022	LCOG 3.01	Financial Sustainability	Finance	There is a risk that financial deterioration within the Integrated Care System becomes so severe that they require reductions in the scope and quality of services rather than investment and development in the healthcare of the Lincolnshire population	* Financial plan reviewed by NHSEI and approved by the Board. This is developed in line with the national long-term plan for the NHS. * Monthly monitoring of the financial position by NHSEI and the Board. * More scrutiny and questions at Finance and Performance Committee * Governance management structure across Lincolnshire to control investments, target priorities and address cost pressures * PMO teams in providers and the CCG to help identify savings opportunities	* It is possible that the impact of the pandemic on staff resilience and waiting times will make it harder to implement service transformation and new investments at pace * Resources and processes for delivering savings plans are still work in progress * External pressures may create a shortage of staff and introduce unexpected price increases for some goods and services * There are savings targets in the financial plan without completed delivery plans	* The CCG has done work to understand the impact of inequalities on healthcare and has sought external support to improve its own approach to population health management * The CCG is reviewing the framework and governance work in progress * External pressures may create a shortage of staff and introduce unexpected price increases for some goods and services * External factors cannot be controlled, but the CCG is ready to identify any impacts on staff, goods or services, discuss these with NHSEI and key partners, and take mitigating action as required.	1. Development of effective efficiency savings 2. Maintain staff resilience using workforce strategy 3. Establishment of robust governance framework for Lincolnshire as part of the new ICB	1. Ongoing 2. Ongoing 3. July 2022	4	4	16	M Gaunt	14/06/2022	Existing	??				
M Gaunt	14/06/2022	LCOG 3.02	Financial Sustainability	Finance	There is a risk that the transition to an Integrated Care Board and the introduction of a new general ledger temporarily weakens the financial control environment, creating opportunities for financial errors, mis-statements and fraud	* Professional training of existing staff and continuity of their employment * Project management structure for the ICB transition * Oversight of the transition process by local senior manager and NHSEI	* The volume of work may become problematic * There may be technical issues with the new ledger * Implementation delays or poor communication with existing suppliers could create payment delays for suppliers, which potentially could disrupt the provision of services * Procedures and processes may need a review once the ICB is established	* The CCG has engaged Arden GEM CSU to provide project management support. Internal Audit are part of this process * The CCG has already merged the legacy CCGs into one organisation. This has removed one tier of complexity * Validation and cleansing of older transactions will simplify the transition of datasets to the new ledger * The CCG has a business continuity plan to support key functions such as payment to suppliers and the completion of statutory accounts * The CCG has also engaged external advice to support the transition to the ICB and provide a 'critical friend' for decision-making.	1. ICB transition implementation plan 2. Submission of statutory accounts 3. Ongoing data cleanse and review of financial procedures	1. National Timetable 2. National Timetable 3. Ongoing	3	3	9	M Gaunt	14/06/2022	Existing	??				

## BOARD MEETING – PUBLIC

<b>Date of Meeting:</b>	29 <sup>th</sup> June 2022	<b>Agenda item:</b>	13.
<b>Title of Report:</b>	PCCC Public Update		
<b>Report Author and Title:</b>	Dr Gerry McSorley, Chair of PCCC Sarah-Jane Mills, Chief Operating Officer (West Locality) Sarah Bates, Deputy Board Secretary		
<b>Appendices:</b>	PCCC Committee Handover		

<b>1.</b>	<b>Purpose of the Report (including link to objectives)</b>
<p>This paper provides an update on the discussions that took place at the last PCCC Public meeting held on 15<sup>th</sup> June 2022.</p>	

<b>2.</b>	<b>Recommendations</b>
<p>The Board is asked to note the update and progress to date.</p>	

<b>3.</b>	<b>Executive Summary</b>
<p>The June 2022 PCCC Public meeting focused on the following agenda items:</p> <ul style="list-style-type: none"> <li> <p>● <b>Quality, Patient Experience and Effectiveness Update:</b> it was noted that there continues to be a significant demand for GP and other healthcare services. In addition, general practice is still experiencing some staff absences due to Covid-19 which is having an impact on the delivery of services. It was highlighted that patient feedback has indicated that there are still some access issues and where there are trends the CCG is supporting Practices. It was noted that three Practices have been rated as “Requires Improvement” by the CQC: Branston, Marisco and Spalding. An update was provided in relation to the 20-week support programme that Practices can access voluntarily when Practices are experiencing significant pressures. The LMC GP Improvement Team has been developed and will provide targeted support to those Practices that are most challenged.</p> </li> <li> <p>● <b>Lakeside Practice:</b> it was noted that the Practice had been re-inspected by the CQC in March 2022 and that the report has recently been published. The Practice has been rated as “Requires Improvement” and “Inadequate” in the safety domain and will remain in Special Measures for a period of six months. It was noted that the Practice is required to submit an Action Plan to the CQC to address the issues highlighted that predominantly relate to the processes to support structured medications, long term condition reviews, dispensary management, issues with risk assessment processes and the review and learning from incidents. An update was provided that the CCG is meeting the Practice on 23.06.22 to review the CQC Action Plan and understand the actions. In addition, a meeting had taken place with Gareth Davies MP, John Turner and Sarah-Jane Mills on 10.06.22.</p> </li> </ul>	

- **Health Checks for Patients with a Learning Disability and Severe Mental Illness:** an update as provided in relation to the Learning Disability Annual Health Checks and that these were provided to 3,513 people in 2021/22 – 79% of the total number of people on GP Practice Learning Disability registers. It was highlighted that this is above the national target (75%) but below the local stretch target and lower than the previous year by around 5% (237 checks) and that the reasons for the reduction was due to the management and treatment of patients with urgent care needs, delivery of the Covid-19 Spring Booster programme and the workforce capacity constraints within primary care.

In relation to Severe Mental Illness Physical Health Checks, it was noted that 44% of the total number of people on GP Practice Severe Mental Illness registers had received a health check which is lower than the national target of 60%. Lincolnshire's performance is in line with that of both national and regional data. Work is taking place on delivering a coordinated community model with Lincolnshire Partnership NHS Foundation Trust to provide increased access.

- **Community Pharmacy and Respecting NHS Staff Campaign:** An update was provided in relation to the two public awareness campaigns that the CCG delivered across Lincolnshire during April and May 2022. It was noted that the CCG received a budget to undertake the campaigns and appointed media buying ad agency Forward & Thinking to support with the campaign delivery. The campaigns aimed to support GP Practices over busy periods by encouraging patients to use community pharmacies for a range of minor ailments and reminding patients to always be respectful towards NHS staff. An update was provided in terms of how the campaigns were delivered, the potential reach of the campaigns, and the plans to evaluate the campaigns effectiveness.
- **List Closure Extension for Merton Lodge Practice:** Members were asked to extend the approval for the list closure application for an additional three months which would allow breathing space for the Practice to pursue options to ensure the continuity of the GMS contract and continuity for patients. It was noted that the Committee had approved the temporary six-month closure in January 2022 which concludes on 27.07.22. It was highlighted that a three-month extension to the list closure would allow the CCG and Dr Tant to support discussions with interested partners to make the Practice more resilient. Members supported the recommendation.
- **PCN Development and DES Delivery Update:** An update was provided to the Committee in relation to the Primary Care Network (PCN) development and delivery of the PCN Network Contract Directed Enhanced Service (DES). It was noted that PCNs are formed via sign up to the Network Contract Directed Enhanced Service (DES) Contract Specification, which was first introduced on 1 July 2019 and sets out core requirements and entitlements for a PCN and that there are 15 PCNs in Lincolnshire covering the entire County. It was reported that the most recent formal review of PCN development was carried out in October 2021 using the national PCN Maturity Matrix tool. PCNs self-assessed their maturity against a range of criteria with maturity levels. As part of this exercise PCNs were asked what the main challenges and barriers were and what support would be helpful. The main barriers included:

- PCN capacity including clinical leadership
- Recruitment issues
- Wider primary care workforce shortages
- Unforeseen disruptions including the covid pandemic

The support identified included:

- Clear guidance on PCN DES requirements and how these will be monitored
- Administration support
- Support with recruitment

An update was provided in relation to the progress in delivering the PCN DES areas across Lincolnshire PCNs and that this had been RAG rated. It was noted that early cancer diagnosis and hypertension are the areas that are being progressed.

- **LMC Update:** Dr Baker advised the Committee that general practice continues to experience significant challenges in meeting the needs of their patients and that the pattern of seeing a reduction in the number of requests for appointments in the summer is not being seen. It was noted that patients are presenting with new and significant medication conditions. Furthermore, there is an ongoing impact of Covid-19 in terms of capacity and mental health and that there have been difficulties in recruiting Mental Health Practitioners to Practices. An update was provided on the GPAS system which highlights the level of demand and the implications with a reduced workforce and that this level of pressure cannot be sustained long term.
- **HealthWatch Update:** it was noted that the general feedback relates to access to both GP and dental appointments. Furthermore, there has been concern expressed that some Practices are switching off the digital services at Practices. Discussions took place that Practices have switched off their digital services when patient safety issues have been highlighted which is constrained by capacity. Dr Baker advised that patients can still access Practices via the telephone or visiting the Practice to request an appointment. Further discussions took place regarding the patients experience and keeping patients informed and that further communication education exercises on the appropriate use of the system will take place. It was noted that Lincolnshire County Council are currently conducting a survey on oral health and that all aspects are being reviewed across the County.
- **Data Update:** an update was provided on the GP appointment numbers for the latest 8-week period and are 7% higher than the “like” pre-COVID 8-week period from 3 years ago in 2019. The latest period has a similar number of appointments completed by a GP, a higher proportion dealt with within 7 days, but a lower proportion recorded as face-to-face.
- **Investment/Disinvestment/Risk and Mitigations:** no issues to escalate.
- **Public Primary Care Commissioning Committee Risk Register:** it was noted that the Risk Register has been reviewed and updated by the risk owners and that there are two risks with a score of 12 and over. These relate to Additional Roles and that the risk has been maintained and Access to Primary Care again the risk has been maintained.
- **Board Committee Handover Template:** an update was provided that the Template will be populated and shared with members prior to presenting at the last CCG Board meeting at the end of June 2022 (attached at Appendix One).

The Committee agreed to escalate the following to the Board:

- Lakeside Medical Practice.
- Community Pharmacy and Respecting NHS Staff Campaign.

#### 4. Management of Conflicts of Interest

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

#### 5. Finance, QIPP and Resource Implications

No areas to escalate.

#### 6. Legal/NHS Constitution Considerations

Legal considerations include:

- the statutory duty to consult and engage on service changes as set out above
- primary medical services contractual compliance and formalities

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

**7. Analysis of Risk including Assessments**

The Primary Care risk register provides the current assessment of risks that may impact on the delivery of primary care services across Lincolnshire.

Please state if the risk is on the CCG Risk Register.

Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
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**8. Outline engagement – clinical, stakeholder and public/patient**

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

**9. Outcome of Impact Assessments**

N/A

**10. Assurance Departments/Organisations who will be affected have been consulted**

Insert details of the departments you have worked with or consulted during the process:

Finance	<input checked="" type="checkbox"/>
Commissioning	<input checked="" type="checkbox"/>
Contracting	<input checked="" type="checkbox"/>
Medicines Optimisation	
Clinical Leads	
Quality	<input checked="" type="checkbox"/>
Safeguarding	
Other - (Estates and Communications)	<input checked="" type="checkbox"/>

**11. Report previously presented at:**

Regular bi-monthly progress updates have been provided at the PCCC meetings.

**12. For further information or for any enquiries relating to this report, please contact**

Sarah-Jane Mills, Chief Operating Officer, (West Locality)

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## BOARD COMMITTEE

### HANDOVER TEMPLATE

<b>Committee:</b> Primary Care Commissioning Committee (PCCC)	<b>Name of the Committee Chair:</b> Gerry McSorley
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<b>Date:</b> 15 June 2022	<b>Author:</b> Nick Blake
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#### Summary of Key issues/areas of focus in 2021/22:

- GP practice risk, resilience and quality issues (monitored through the Practice Risk Register)
  - Lakeside Stamford quality (following CQC inspections) and access issues
  - GP practice and PCN workforce issues: recruitment and retention
- GP practice and PCN estates issues (monitored and managed through the Primary Care Estates Group)
- GP Practice contractual and commissioning issues including dispensary closure, practice merger and procurements
- PCN membership and boundary changes
- Winter Access Fund 2021/22 – planning and delivery
- Primary care recovery and access to primary care
  - Including Extended Access delivery and preparation for transfer to PCN delivery in 2022

#### Position of these key issues/areas of focus as of 30<sup>th</sup> June 2022:

- Ongoing GP practice risk issues include:
  - Lakeside Stamford: quality issues and remedial actions following CQC reinspection in March 2022. Primary Care and Quality teams reviewing actions and monitoring progress.
  - Caskgate: estates and recruitment issues. Ongoing support from LMC and CCG.
  - Richmond MC: staffing (following Crossroads list absorption) and financial issues

- Church Walk: staffing and contractual issues
- Ongoing Estates issues:
  - CHP review of primary care estates is progressing
- Ongoing support to GP practices is in place through the Primary Care and Quality Teams as well as the LMC
- Ongoing GP contractual issues:
  - Spalding GP Practices: proposed list dispersal process underway
  - Stackyard transfer to ELLR CCG area
  - Sidings practice procurement process and issues relating to unexpected costs for the incoming provider
- All PCN changes are completed
- Winter Access Fund work is now completed
- Extended Access transfer to PCNs is going ahead as planned – no significant issues

**Any key considerations, risks, challenges etc for the ICB Board and its Committees to be aware of:**

- Lakeside Stamford remains in special measures – progress over the next 3-6 months to address issues highlighted by the CQC and to ensure care is safe is critically important. Ongoing work is planned with Lakeside with a review scheduled for 23 June 2022.
- PCN and GP practice staff recruitment and retention remain a challenge with consequent impact on service delivery and resilience. The CCG continues to work with PCNs and practices to support through the dedicated Primary Care People’s Group and programme lead. Optimising use of PCN workforce funding for Additional Roles is being managed through the PCN Business Managers Group with CCG/ICB support.
- Other factors affecting GP practice resilience include the ongoing risk of workforce absence through covid infection, increased patient demand and patient care back logs due to the pandemic.
- Rapid roll out of digital technology and online consultation systems during the covid pandemic to primary care without a comprehensive training and support offer to practice teams represents a risk to practice team resilience and patient access. A digital review is underway to optimise use and outcomes and to identify support requirements.
- PCN maturity and development is variable across the County, this may affect the delivery of some elements of the Network Contract DES as well as some PCNs having the capacity to engage fully with wider system programmes. The Primary Care Team and PCNA are supporting PCN development.
- The transfer of Pharmacy, Optometry and Dentistry commissioning responsibilities from NHSE/I to the ICB is ongoing and due to be completed in April 2023.